



COBRA & DIRECT PAY JOB AID

Table of Contents.....	3
Direct Pay	5
Invoicing & Terms of Payment.....	5
Premium Remittance	6
Non-Sufficient Funds and Stop Payment.....	6
Cancellation of Coverage	7
for Non-Payment	7
At Participant’s Request.....	7
Other Correspondence	7
Carrier Notification	7
Appeals.....	7
Contact Information.....	7
Sample Direct Pay Documents.....	8
Sample Invoice (p.1):	8
Sample Invoice (p. 2).....	9
Sample Friendly Reminder Letter	10
Sample Short Pay Letter.....	11
Sample Termination Letter	12
COBRA Services	14
COBRA Qualified Events Package Generation	14
COBRA Initial Rights Notification	14
COBRA Election Packet	14
Invoicing & Terms of Payment.....	15
Premium Remittance	16
Non-Sufficient Funds & Stop Payment Process	16
Cancellation for Non-Payment or at Participant’s Request.....	16
For Non-Payment.....	16
At Participant’s Request.....	16
Coverage Effective Date.....	17
Carrier Notification	17
Appeals.....	17
Open Enrollment.....	17

Other Correspondence	17
Accessing ADP's COBRA Site	18
Contact	18
Sample COBRA Documents.....	18
Sample Ongoing Cover Letter with Invoice (p.1)	19
Sample Ongoing Cover Letter with Invoice (p. 2)	20
Sample COBRA Election Package	21
Sample General Notice of COBRA Rights	28
Samples Insignificant Shortfall Letter	30
Sample Significant Shortfall Letter	31
Sample Welcome Letter.....	32
Sample Confirmation Letter.....	34
Sample Early Termination Letter	36
Sample Termination Conversion Letter	37



DIRECT PAY

In certain circumstances, a member may be required to be billed for the cost of their health care coverage. When this occurs, the following applies:

Invoicing & Terms of Payment

All invoices and related correspondence are generated by ADP, and sent via regular postal mail.

- Invoices are generated on or before the 7th of the month and mailed on or before the 10th of the month for the following month's premium.
- Payment is due the first of the following month.
- Example:
 - Coverage month = December
 - Invoice generated by November 10
 - Payment due = December 1
- Any payments made in advance (prepayment) or made late will be reflected in the following month's invoice. Note: Prepayments cannot be made online.
- There is a 30-day grace period from the payment due date. Members are strongly encouraged to make payments by the due date each month to ensure continuation of coverage without interruption.

Sample invoice (see the Direct Pay samples section for a full statement):

Page 1 of 2

To ensure a faster and more secure payment, PAY ONLINE with ADP Selfpay. See the reverse side of the invoice stub below for more details. If you prefer to pay by mail, please remove the portion below and return with payment using the reply envelope provided. In order to ensure more timely and accurate payment processing, please include your account number on your payment. Please do not overnight payments to the PO Box.

<p>State Health Benefit Plan</p> <p>SMITH, KAT 11 STREET CITY, ST 12345 1111</p>	<p>Please send a personal check, money order, or cashier's check payable to: ADP Benefit Services KY, Inc.</p>	<p>DIRECT BILL MONTHLY STATEMENT</p> <p>Invoice Number: 3164 Account Number: 00389-000003480-7 Invoice Period: 08/01/2014 - 08/31/2014 Payment Due Date: August 1, 2014 Total Amount Due: \$51.78</p>
<p>ADP Continuation Services PO Box 105413 Atlanta, GA 30348-5413</p>		<p>Amount Remitted: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>

0000003164 1 003890000034807 00003165 0005178 8 0001 001 7

Premium Remittance

Monthly premium payments can be remitted through one of the following methods:

- One-time or Recurring Online Payment through the secure online payment application (Selfpay), available 24 hours a day, 7 days a week. Refer to the Selfpay message below as it appears on the monthly invoice.

PAY ONLINE with Selfpay

Paying online is easier than mailing your payment and you'll receive an email confirmation of your payment from our bank, JP Morgan Chase. Don't risk a lapse in coverage because of a delay in mail delivery.

Sign up for Your Free Selfpay Account:

1. Visit <https://selfpay.adp.com>
2. Click "Don't have a password yet?"
3. Enter the Account Number from page 1 of your invoice.
4. Enter the Invoice Number and Amount of your latest invoice.
5. Receive validation and your login and password, which you'll use to access Selfpay.

- By check, mailed to:

ADP
Continuation Services
P.O. Box 105413
Atlanta, GA 30348-5413

Premium payments should be placed in the return envelope along with the payment invoice to expedite processing, and mailed to the address located on the payment invoice. Failure to include the payment invoice with the premium payment will delay processing of payment.

Non-Sufficient Funds and Stop Payment

In the event of a returned check due to non-sufficient funds or a stop payment being placed on the check, ADP will send a letter to the participant requesting resubmission of payment. Coverage will be cancelled, as noted below, for non-payment beyond the grace period.

Cancellation of Coverage

FOR NON-PAYMENT

Coverage is cancelled at the end of the grace period if payment has not been received. The grace period for Direct Pay payment is 30 days.

AT PARTICIPANT'S REQUEST

A participant may request that coverage be cancelled by calling SHBP Member Services or submitting a letter in writing to:

ADP
Continuation Services
P.O. Box 34240
Louisville, KY 40232

Other Correspondence

Any correspondence not related to payments should be sent to the address below. No premium payments should be sent to this address.

ADP
Continuation Services
P.O. Box 34240
Louisville, KY 40232

Carrier Notification

ADP is responsible for notifying carriers of coverage updates. Allow 7 – 10 business days from the time the payment has been received in order for coverage to be active with the carrier.

Note: This time frame includes the processing of payments received.

Appeals

A member whose coverage has been cancelled for non-payment may contact SHBP Member Services at 1-800-610-1863 to discuss the appeal process. ADP will provide Tier 1 appeals support based on pre-established guidelines with SHBP. If a resolution to the appeal cannot be reached through Tier 1 support, members will be instructed to submit an appeal to SHBP at 1-866-828-4796 within 60 days of the cancellation notice. The appeal must include the reason and pertinent information.

Contact Information

Call SHBP Member Services for questions related to Direct Pay at 1-800-610-1863.

Sample Direct Pay Documents

Important: Sample Direct Pay documents are included for general reference only to understand the information that is typically sent to participants. These documents are subject to change, and should not be shared directly with any participants.

SAMPLE INVOICE (P.1):

State Health Benefit Plan

ADP Continuation Services, PO Box 34240, Louisville, KY 40232

DIRECT BILL MONTHLY STATEMENT

SMITH, KAT
11 STREET
CITY, ST 12345 1111

Invoice Number: 3164
Account Number: 00389-000003480-7
Invoice Period: 08/01/2014 - 08/31/2014
Due Date: August 1, 2014

Amount Due: \$51.78

STATEMENT OF ACCOUNT

Previous Balance	\$0.00
Payment Received (Payments received after 07/16/2014 are not reflected.)	\$0.00
Current Period Activity (Detail on reverse side)	\$51.78
Total Amount Due	\$51.78

NOTE: Negative value indicates a credit balance

IMPORTANT NOTICE:

Your "Current Period Activity" premium is due on the date shown above. You are allowed a 30-day grace period; that is, your "Current Period Activity" premium payment must be received within 30 days of the due date. The amount listed as "Previous Balance" is past due and is not included in the grace period. Please remit the past due amount upon receipt of this invoice.

Payment of the invoice does not guarantee coverage. If you become ineligible for coverage, premiums paid for any period after the coverage termination date will be refunded promptly. Late payments cannot be accepted and will be refunded.

Any correspondence (such as change of address) sent with this payment will not be reviewed. Please see the reverse side for an address to use for correspondence.

Prepared by ADP. If questions or discrepancies, please call 1 (800) 610-1863

Page 1 of 2

To ensure a faster and more secure payment, PAY ONLINE with ADP Selfpay. See the reverse side of the invoice stub below for more details. If you prefer to pay by mail, please remove the portion below and return with payment using the reply envelope provided. In order to ensure more timely and accurate payment processing, please include your account number on your payment. Please do not overnight payments to the PO Box.

State Health Benefit Plan

SMITH, KAT
11 STREET
CITY, ST 12345 1111

Please send a personal check, money order, or cashier's check payable to: **ADP Benefit Services KY, Inc.**



ADP
Continuation Services
PO Box 105413
Atlanta, GA 30348-5413

DIRECT BILL MONTHLY STATEMENT

Invoice Number: 3164
Account Number: 00389-000003480-7
Invoice Period: 08/01/2014 - 08/31/2014
Payment Due Date: August 1, 2014
Total Amount Due: \$51.78

Amount Remitted:

0000003164 1 003890000034807 00003165 0005178 8 0001 001 7

State Health Benefit Plan

ADP Continuation Services, PO Box 34240, Louisville, KY 40232

DIRECT BILL MONTHLY STATEMENT

DETAIL

COVERAGE PERIOD	BENEFIT	OPTION	COVERAGE CATEGORY	AMOUNT
8/2014	Medical Plan	BCBS Medicare Advantage Standard	Participant & Spouse	\$51.78
TOTAL AMOUNT				\$51.78
Previous Balance:				\$0.00
Payments:				\$0.00
Current Amount:				\$51.78
Amount Due 08/01/2014 :				\$51.78

Page 2 of 2

PAY ONLINE with ADP Selfpay

Paying online is easier than mailing your payment and you'll receive an email confirmation of your payment from our bank, JP Morgan Chase. Don't risk a lapse in coverage because of a delay in mail delivery.

Sign up for Your Free Selfpay Account:

1. Visit <https://selfpay.adp.com>
2. Click "Don't have a password yet?"
3. Enter the Account Number from page 1 of your invoice.
4. Enter the Invoice Number and Amount of your latest invoice.
5. Receive validation and your login and password, which you'll use to access Selfpay.

Please send any correspondence to:

**ADP Continuation
Services
P.O. Box 34240
Louisville, KY 40232**

Reminder: Do not mail premium payments to this address... Premium payments should be placed in the return envelope along with the payment coupon to expedite processing and mailed to the address located on the payment coupon. Failure to include the payment coupon with your premium payment will delay processing of that payment.

SAMPLE FRIENDLY REMINDER LETTER

05/01/2014



JOHN DOE
ADDRESS
CITY_STATE_ZIP

RE: Direct Bill Employer ABC Reminder Letter
Social Security Number: ***-**-1234

Dear JOHN DOE:

According to our records, we have not received your July premium payment for your Direct Bill medical coverage. Please submit July, and any prior overdue premium payments, by July 31, 2014 to ensure there is no interruption in your coverage. If full payment is not received by this date, termination of your Direct Bill medical coverage will proceed. Please submit payment to the following address:

ADP Continuation Services
P.O. Box 105413
Atlanta, GA 30348-5413

If you have any questions, please contact ADP Continuation Services at 1-800-610-1863, 8:30 a.m. - 5:00 p.m. EST, Monday through Friday.

Sincerely,

ADP Continuation Services

SAMPLE SHORT PAY LETTER

05/01/2014



JOHN DOE
ADDRESS
CITY_STATE_ZIP

RE: Premium Shortage for Direct Bill Medical Coverage
Social Security Number: ***-**-1234

Dear JOHN DOE:

This is to inform you that there is a shortage on your premium payment and to provide you with the opportunity to bring your account current.

Your account is short \$555.55 for your coverage through 06/24/2012.

Your payment must be received before 6/30/2012 to avoid termination of your Direct Bill medical coverage back to the last fully paid month.

Please send payment to:

ADP Continuation Services
P.O. Box 105413
Atlanta, GA 30348-5413

If you have any questions, please contact ADP Continuation Services at 1-800-610-1863, 8:30 a.m. - 5:00 p.m. EST, Monday through Friday.

Sincerely,

ADP Continuation Services

SAMPLE TERMINATION LETTER

06/13/2014



JOHN DOE & Family
ADDRESS
CITY_STATE_ZIP

RE: Employer ABC Eligibility Determination for Direct Bill Continuation Coverage
Social Security Number: ***-**-1234

Dear JOHN DOE & Family:

The purpose of this letter is to notify you and any eligible family members that your Direct Bill medical coverage offered by Employer ABC has been terminated for non payment of premiums effective 12/31/2014.

Any payments received after the date of this notice will be refunded to you.

You must submit your appeal request to SHBP in writing or fax to 866-828-4796 within 60 days of this notice. Your appeal must include your reason and pertinent information.

Send your appeal to:

SHBP
PO BOX 1990
Atlanta, GA 30303-1990

If you have any questions, please contact ADP Continuation Services at 1-800-610-1863, 8:30 a.m. - 5:00 p.m. EST, Monday through Friday.

Sincerely,

ADP Continuation Services



COBRA SERVICES

COBRA services, including notification of COBRA rights upon hire/health care benefits eligibility, continuation of health care, and the receipt and distribution of funds is administered by ADP, LLC.

COBRA Qualified Events Package Generation

COBRA INITIAL RIGHTS NOTIFICATION

Once a member elects health care coverage, ADP generates and mails a COBRA Initial Rights Notice (IRN).

- The COBRA IRN is sent to the employee and a covered spouse, if applicable. See the Sample COBRA Documents section for a sample packet.
- COBRA IRN mailings are processed daily.

COBRA ELECTION PACKET

Once a termination event is entered in the SHBP Enrollment Portal (either through IDM or via file upload), ADP generates and mails a COBRA Election Packet to the member and/or qualified beneficiaries. See the Sample COBRA Documents section for a sample packet.

1. The COBRA Election Packet includes the information needed to make an election to continue coverage.
2. Both the election and payment can be made online via ADP's secure application.
3. The first premium is due within 45 calendar days of the election.
4. Eligibility is passed to the carrier once the initial payment is received.

The following information is an excerpt from the COBRA Election packet regarding fast activation for COBRA. Going online is the fastest way for members to make their election and make payment.

You have up to 45 calendar days from the date you elect COBRA within which to make your first required premium payment. However, to activate your coverage as quickly as possible, it is recommended that you make your first payment at the same time as your election so your insurance carrier can be notified sooner.

To elect and pay online:	OR, Mail completed form to:	OR, Fax completed form to:
http://www.benedirect.adp.com	ADP COBRA Services P.O. Box 2698 Alpharetta, GA 30023-2698 Make checks payable to ADP COBRA Services Note: Future payments will be sent to a different address, which will be noted on your next bill.	1-770-619-7160


Invoicing & Terms of Payment

All COBRA invoices and related correspondence are generated by ADP and sent via regular postal mail.

- Invoices are generated 25 days in advance of the due date for the following month's premium.
- Payment is due on the first of the month.
- Example:
 - Coverage month = December
 - Invoice generated on or about the November 5th
 - Payment due = December 1
- Any payments made in advance (prepayment) or made late will be reflected in the following month's invoice. Note: Prepayments cannot be made online.
- The initial payment is due 45 calendar days from the date of the election.

Sample invoice:

Please send the coupon below with your payment

BENEFITS CONTINUATION COUPON		Coupon #1	
Payment Due: x/xx/xx	Coverage Period: xx/xx/xx - xx/xx/xx	Grace Date: xx/xx/xx	Send correspondence other than payments & coupons to: ADP Benefit Services P.O. Box 27478 Salt Lake City, UT 84127-0478
Address:			
Amount Due	Plan	Send Payment with Coupon to:	
\$ xxx.xx	CREDIT CARRIED FORWARD	ADP Benefit Services P.O. Box 7247-0367 Philadelphia, PA 19170-0367	
\$ xxx.xx	Health ABC		
\$ xxx.xx	Total Due		

1200609280001720108894687000271320000756003

Premium Remittance

Participants can make a one-time payment online or access account information through ADP COBRA at <https://www.benedirect.adp.com>. Participants may also send in a check to the address on the invoice.

Non-Sufficient Funds & Stop Payment Process

In the event of a returned check due to non-sufficient funds or a stop payment being placed on the check, ADP will send a letter to the participant and request resubmission of payment. Coverage will be cancelled as noted below for non-payment beyond the grace period.

Cancellation for Non-Payment or at Participant's Request

FOR NON-PAYMENT

Coverage is cancelled at the end of the grace period if payment has not been received. The grace periods for COBRA participants are:

- Initial election grace period: 60 calendar days
- Initial payment grace period: 45 calendar days
- Subsequent payment grace period: 31 calendar days

AT PARTICIPANT'S REQUEST

A participant may request that coverage be cancelled by calling SHBP Member Services or submitting a letter in writing to:

ADP COBRA Services
P.O. Box 2968
Alpharetta, GA 30023-2968

Coverage Effective Date

Coverage goes into effect once the election is made, even if first payment has not yet been received. However, confirmation of coverage is not sent to the carrier until the premium payment is processed by ADP. In addition, if the initial premium is never received by ADP, then the COBRA coverage is terminated retroactively back to the last day of active coverage.

Carrier Notification

ADP sends eligibility data to carriers. Allow 7 – 10 business days from the time the payment has been received in order for coverage to be active with the carrier. ADP recommends that members call the number on their insurance card to confirm that COBRA coverage has been activated with the carrier. Previously denied claims can be reprocessed by carriers once COBRA coverage has been activated. Note: This time frame includes the processing of payments received.

Appeals

A member whose coverage has been cancelled for non-payment may contact SHBP Member Services at 1-800-610-1863 to discuss the appeal process. ADP will provide Tier 1 appeals support based on pre-established guidelines with SHBP. If a resolution to the appeal cannot be reached through Tier 1 support, members will be instructed to submit an appeal to SHBP at 1-866-828-4796 within 60 days of the cancellation notice. The appeal must include the reason and pertinent information.

Open Enrollment

ADP generates Open Enrollment packets (including Summary of Benefits and Coverage forms and other materials that may be required and provided by SHBP). Participants may make a change via SHBP Member Services or fax.

Other Correspondence

Any correspondence not related to payments should be sent to the address below. No premium payments should be sent to this address.

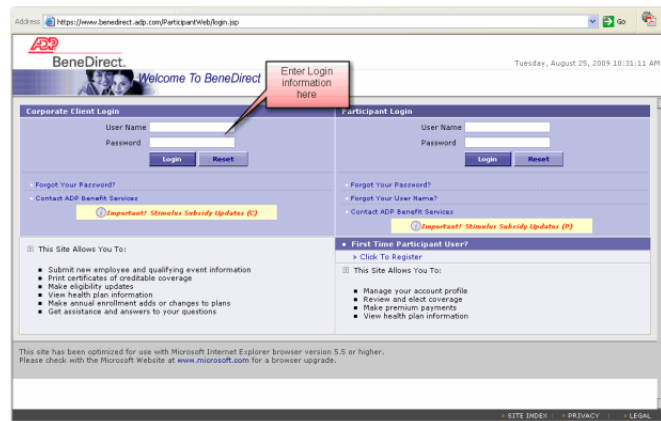
ADP
PO Box 2968
Alpharetta, GA 30023-2968

Accessing ADP's COBRA Site

Participants can access the site to:

- Make a one-time payment
- Request eligibility updates to carriers
- View health plan information
- Get assistance and answers to questions

Logon to <https://www.benedirect.adp.com>



Contacts

Call SHBP Member Services for questions related to COBRA @ 1-800-610-1863.

Sample COBRA Documents

Important: Sample COBRA documents are included for reference only to understand the information that is typically sent to participants. These documents are subject to change, and should not be shared directly with any participants.

Ongoing Coupon Cover Letter

ADP Benefit Services
P.O. Box 27478
Salt Lake City, UT 84127
794Y 0001 CASCPN

Sally Sample
123 Anyplace Street
Anywhere, US 12345

BL-xxxxxxx

RE: IMPORTANT INFORMATION ABOUT YOUR HEALTHCARE COVERAGE

Dear Sally Sample:

Enclosed is your monthly bill and remittance coupon for your healthcare coverage through Company ABC. To ensure continuous coverage and to avoid delays in processing your payment, you should remit payment with the coupon provided with each month's bill.

Your payment is due the first day of the month, and it is best to remit your payment by the due date. However, payments not received by the Grace Period Date (45 days from the due date), will result in termination of benefit coverage. Terminated coverage may not be reinstated.

It is important that you include the correct remittance coupon with each payment and that you include your account number on each check that you send. Please make your check payable to ADP Benefit Services and mail it to the address printed on the coupon:

ADP Benefit Services
P.O. Box 7247-0365
Philadelphia, PA 19170-0365

As a reminder, you also have the option of having your payments automatically deducted from your bank account, instead of remitting a monthly coupon and check. If you are interested in taking advantage of the automatic payment deduction, contact ADP Benefit Services at 1-800-240-7149.

The acceptance of any late or partial payments by ADP Benefit Services does not constitute agreement of Benefits Continuation Coverage. Instances of late or partial payments will result in a refund and termination of Benefits Continuation Coverage. Refunds will be handled through the normal processing schedule for ADP Benefit Services.

ADP Benefit Services is not an insurance company and this is not a change in your insurance provider. If you have questions regarding claims or procedures covered under your benefit plan please contact your insurance provider.

If you have questions with regard to your remittance payment or coverage levels, please contact ADP Benefit Services at 1-800-553-3803, or visit us at www.benedirect.adp.com.

Thank you,

ADP Benefit Services


SAMPLE ONGOING COVER LETTER WITH INVOICE (P. 2)

ADP Benefit Services
 P.O. Box 27478
 Salt Lake City, UT 84127

Please read the enclosed letter for requirements relating to remittance of premium payments. This information is critical to your on-going continuation of coverage. Following is your payment coupon from ADP Benefit Services. This coupon was printed on xx/xx/xxxx for coverage from xx/xx/xxxx to xx/xx/xxxx.

In order to expedite the processing of your payment, please tear the coupon along the perforation.

Please send the coupon below with your payment

BENEFITS CONTINUATION COUPON		Coupon #1														
Payment Due: x/xx/xx Coverage Period: xx/xx/xx - xx/xx/xx Grace Date: xx/xx/xx	Send correspondence other than payments & coupons to: ADP Benefit Services P.O. Box 27478 Salt Lake City, UT 84127-0478	Address:														
<table border="1"> <thead> <tr> <th>Amount Due</th> <th>Plan</th> </tr> </thead> <tbody> <tr> <td>\$ xxx.xx</td> <td>CREDIT CARRIED FORWARD</td> </tr> <tr> <td>\$ xxx.xx</td> <td>Dental 100% Higher Schedule</td> </tr> <tr> <td>\$ xxx.xx</td> <td>Health ABC</td> </tr> <tr> <td>\$ xxx.xx</td> <td>Health DEF</td> </tr> <tr> <td>\$ xxx.xx</td> <td>Dental ABC</td> </tr> <tr> <td>\$ xxx.xx</td> <td>Total Due</td> </tr> </tbody> </table>	Amount Due	Plan	\$ xxx.xx	CREDIT CARRIED FORWARD	\$ xxx.xx	Dental 100% Higher Schedule	\$ xxx.xx	Health ABC	\$ xxx.xx	Health DEF	\$ xxx.xx	Dental ABC	\$ xxx.xx	Total Due	Send Payment with Coupon to: ADP Benefit Services P.O. Box 7247-0367 Philadelphia, PA 19170-0367	
Amount Due	Plan															
\$ xxx.xx	CREDIT CARRIED FORWARD															
\$ xxx.xx	Dental 100% Higher Schedule															
\$ xxx.xx	Health ABC															
\$ xxx.xx	Health DEF															
\$ xxx.xx	Dental ABC															
\$ xxx.xx	Total Due															

1200609280001720108894687000271320000756003

ADP COBRA Services
P.O. Box 2968
Alpharetta, GA 30023-2968



COBRA Continuation Coverage Election Notice
<DATE>

<NAME>
<ADDRESS>
<CITY> <ST> <ZIP>

Dear <NAME>:

This notice contains important information about your right to continue your health care coverage in the <EMPLOYER> Group Health Plan (the Plan) 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.

To elect COBRA continuation coverage, follow the instructions on the enclosed Election Form.

Please note: Although ADP COBRA Services has contracted with the employer to provide various COBRA administration services, ADP is not the Plan Administrator. The Plan Administrator is the sponsor of the Plan.

If you do not elect to continue your health care coverage either by completing the enclosed "Election Form" and returning it to us or by electing online, your coverage under the Plan will end on <DATE> due to <REASON>.

Each person (qualified beneficiary) below is entitled to elect COBRA continuation coverage under the Plan.

<QB>

Because of the event (listed above) that will end coverage under the Plan, those individuals indicated above, are entitled to continue health care coverage for up to 18 months. If elected, COBRA continuation coverage will begin on <DATE> and can last until <DATE>.

<Employer Custom Message Here>

Monthly Cost of COBRA Continuation Coverage:

Beneficiary Only (*)

<PLAN>

<RATE>

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Form 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. Coverage will not be active until your premium payment has been received and your insurance carrier is notified. Important additional information about payment for COBRA continuation coverage is included in this notice.

There may be other coverage options for you and your family. As a result of certain provisions of the health care law, you will be able to buy coverage through the Health Insurance Marketplace (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. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you have any questions concerning your rights to COBRA coverage, you should contact:

ADP COBRA Services
P.O. Box 2968
Alpharetta, GA 30023-2968
<PHONE>

IMPORTANT - If you want to elect continuation coverage and you are enrolling in all of the plan options that are offered and you are not adding or dropping dependents, you can elect online by going to <http://www.benefdirect.adp.com> (Internet Explorer 5.5 or higher required). The website is provided to you as a courtesy. In cases where the website is down for maintenance and unavailable, you continue to be responsible for timely elections, otherwise your coverage may be cancelled. If you do not elect online, you **MUST** complete the enclosed Election Form and return it to ADP COBRA Services by fax or by mailing it to the address shown on the Election Form. **The completed Election Form must be postmarked, faxed, or submitted online by <DATE>**. If you do not submit a completed Election Form or enroll online by this date, you will lose your right to elect continuation coverage.

IMPORTANT NOTE: Please read the enclosed COBRA election notice carefully as it contains important information regarding your rights and responsibilities.

Quick Start Guide

4 Key Steps to Activating COBRA Coverage

1. Election - You must elect and pay the required premium for COBRA continuation coverage to be activated with your insurance carriers or group health plan. If you will be selecting all available coverage options, we recommend that you enroll online and pay at <http://www.benedirect.adp.com>. If you will not be selecting all available coverage options, we recommend that you fax your enrollment form to 1-770-619-7160. Mailed elections and payments may result in delayed processing due to possible mail system delays. See the election form at the back of this packet for details.

2. Payment - You must make your first full month's premium payment before your insurance carriers or group health plan will be notified that your coverage has been continued. If you fail to pay any full COBRA premium in a timely fashion, your coverage will be discontinued and may not be reinstated.

3. Insurance Carrier Notification - Your carriers will typically be notified within 7-10 business days once your first required premium payment is received. ADP recommends that you call the number on your Insurance ID card to confirm that your COBRA coverage has been activated with your carrier. Previously denied claims can be reprocessed by carriers once COBRA coverage has been activated.

4. Fast Activation - You legally have up to 45 days from the date you elect COBRA within which to make your first required premium payment. However, to activate your coverage as quickly as possible, it is recommended that you make your first payment at the same time as your election so that your insurance carrier or group health plan can be notified sooner.

To elect and pay online to go:	Or: Mail completed form to:	Or: Fax completed form to:
http://www.benedirect.adp.com	ADP COBRA Services P.O. Box 2968 Alpharetta, GA 30023-2968 Note: Future payments will be sent to a different address, which will be noted on your next bill. Make checks payable to ADP COBRA Services	1-770-619-7160

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 (or retired employee) covered under the group health plan, a covered employee's spouse, 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 <EMPLOYER NAME, ADDRESS, PHONE>.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: There are limitations on plans' ability to impose pre-existing condition exclusions and such exclusions will become prohibited for plan years beginning in 2014 under the Affordable Care Act),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage,
- 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).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify ADP COBRA Services of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify ADP COBRA Services of the disability determination within 60 days from the latest of: 1) the date of SSA's disability determination; 2) the date on which the qualifying event occurs; 3) the date on which the qualifying beneficiary loses coverage as a result of the qualifying event; or 4) the date on which the qualifying beneficiary is provided the plan's procedures for responsibility to notify the plan through the summary plan description or the COBRA general notice. However, notification must be made before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on the previous page 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 ADP COBRA Services of that fact within 30 days of SSA's determination. Where a disability event occurs, please locate the required form and instructions for providing notice to ADP

COBRA Services at <http://www.benedirect.adp.com>. If you do not have access to the Internet, or wish to have this information sent to you, please contact ADP COBRA Services at <PHONE>.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses 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 or separation from the covered employee, the covered employee becoming entitled to Medicare benefits (under Part A, Part B, or both) or a dependent child ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualifying beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify ADP COBRA Services within 60 days after a second qualifying event occurs or within 60 days of your loss of coverage under the Plan as required under the terms of the Plan. Please see your Plan's Summary Plan Description (SPD) to determine the required time frame for the submission of second qualifying events. Where a second qualifying event occurs, please locate the required form and instructions for providing notice to ADP COBRA Services at <http://www.benedirect.adp.com>. If you do not have access to the Internet, or wish to have this information sent to you, please contact ADP COBRA Services at <PHONE>.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary listed in this notice has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all qualified beneficiaries. 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. Note that effective with plan years and policy years beginning in 2014, the Affordable Care Act generally prohibits plans and insurers from imposing pre-existing condition exclusions. 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?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to 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 each continuation coverage period for each option is described in this notice.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Form is postmarked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact ADP COBRA Services at <PHONE> to confirm the correct amount of your first payment.

If you wish to make a payment now you have two options:

- A. Make your election online and then make a one-time online payment using the Direct Debit feature on the Web.
- B. Include your payment with your election form and mail it to:

P.O. Box 2968
Alpharetta, GA 30023-2968.

Please include your account number, <BL#>, in the memo field of your check.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, these periodic payments for continuation coverage are due on first day of the coverage month, subject to a 30-day grace period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. ADP COBRA Services, as instructed by the Plan Administrator, will send periodic notices of payments due for these coverage periods. However, should you not receive a periodic notice you are still responsible for sending full payment by the applicable grace date. Periodic payments for continuation coverage should be sent to:

P.O. Box 7247-0367
Philadelphia, PA 19170-0367.

Please always include this account number, <BL#>, with your payment.

Grace periods for periodic payments

Although periodic payments are due on the first day of the coverage 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 before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to first day of the coverage period) when the periodic 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 periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

For more information

This notice is intended to comply with the requirements of the Federal law governing continuation coverage. There is no intent to provide any information regarding continuation coverage beyond the minimum Federal law requirements, such as those mandated under State law. You should contact your State Insurance Department to determine if additional rights are available under State law.

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. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact <EMPLOYER NAME, ADDRESS, PHONE>

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 or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Administrator 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 or to ADP COBRA Services. It is also advisable that you obtain and retain proof of mail, including the postmark date, for notices or payments you mail.

ADP COBRA Services
 P.O. Box 2968
 Alpharetta, GA 30023-2968

<DATE>

COBRA CONTINUATION COVERAGE ELECTION FORM

IMPORTANT: You must elect by <DATE>. Your COBRA account number is <BL#>. Include this account number in all correspondence and in the memo field of your checks when making payments.

INSTRUCTIONS:

- o To make your elections online, go to <http://www.benedirect.adp.com>. You can also make your initial payment online at this time.
- o To elect using this form, indicate with a check mark the coverage that each person listed wishes to continue under COBRA.
- o If a dependent or spouse name is not present on this election form or if one needs to be added, please call ADP COBRA Services at <PHONE>.
- o Please correct any name that is misspelled.
- o Mail (postmark) or fax your election form by the election due date above.
- o If making a payment, include the account number <BL#> in the memo field of your check.

NAME

<PLAN>

<# PERSONS COVERED>

Please indicate address and telephone changes or correction:

Address: _____

Telephone: (____) _____

I (We) elect COBRA as indicated above and certify that I (we) have accurately completed this form.

Signature of <NAME>(REQUIRED): _____ Date _____

To elect and pay online to go:	Or: Mail completed form to:	Or: Fax completed form to:
http://www.benedirect.adp.com	ADP COBRA Services P.O. Box 2968 Alpharetta, GA 30023-2968 Note: Future payments will be sent to a different address, which will be noted on your next bill. Make checks payable to ADP COBRA Services	1-770-619-7160 Fax must be received no later than 12:00 AM (midnight), Eastern Standard Time, on <DATE>.
Complete online election no later than 12:00 AM (midnight) Eastern Standard Time, on <DATE>.	If mailed, election form must be postmarked no later than <DATE>.	If you have questions, call: <PHONE>

SAMPLE GENERAL NOTICE OF COBRA RIGHTS

Client Name
123 Main Street
Suite 999
Anywhere, ZZ 99999-9999



^PRINTDATE

^SALUTION
^ADDRESS

INITIAL/GENERAL NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under ^GROUPHEALTHPLANNAME (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **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.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

The Plan Administrator is ^PLANAADMINNAME, ^PLANAADMINADDR, ^PLANAADMINPHONE. The Plan Administrator is responsible for administering COBRA continuation coverage.

What is 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. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. If you are required to pay for COBRA continuation coverage, you will be notified at the time you are offered COBRA continuation coverage of the amount and the date payment is due.

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

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. Generally Plans require that notification of such events be provided to the Plan Administrator within 60 days after the qualifying event has occurred. However, your Plan may allow a longer period of time to provide notification. Please consult your Plan's SPD to determine the Plan's qualifying event notification requirements. You must send this notice to: ^PLANAADMINNAME and as directed under the terms of the Plan located in the SPD.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for

This notice should be sent to: ^PLANAADMINNAME or other party as indicated in the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage.*

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to ^PLANAADMINNAME or other party as indicated in the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage.*

* **Please note:** At the time you are being provided with this Initial General Notice of COBRA Rights, ^ADMINNAME is your employer's COBRA administrator. In the future, you should refer to the COBRA Election Notice you receive at the time you are offered COBRA continuation coverage to confirm that ^ADMINNAME still performs this function for your employer and that ^ADMINNAME remains the appropriate place for you to send notice of a Social Security Disability or Second Qualifying event.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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 nearest Regional or District Office of the U.S. Department of Labor's Employee

Sample Insignificant Shortfall Letter

ADP COBRA Services
123 Main Street
Suite 999
Anywhere, ZZ 99999-9999



<DATE>
<BENEID>

<BENENAME>
<BENEADDRESS>

Dear <BENENAME>

The last payment for continuation of your COBRA coverage received by ^ADMINNAME is check #^CheckNbr, in the amount of \$^CheckAmt. ^ADMINNAME posted this payment to your account, resulting in continuation of your COBRA coverage through ^PaidThru and a credit balance of \$^OvrPayAmt.

The credit balance is less than \$^PremiumDue, the amount of the full monthly premium due for the coverage period of ^CoveragePeriod, and as such is considered a "partial" payment. In order to continue your COBRA coverage beyond ^PaidThru, you must send \$^ShortFallAmt and postmark it no later than ^GraceDate. Should you fail to postmark this payment on or before the grace date of ^GraceDate, your COBRA coverage will terminate on ^PaidThru, the last day of the period for which full payment was made. You may also make premium payments through our website at www.benedirect.adp.com. The website is provided to you as a courtesy. In cases where the website is down and unavailable, you continue to be responsible for timely payment, otherwise your coverage may be canceled.

The acceptance of a late or partial payment by ^ADMINNAME does not constitute agreement of COBRA continuation of coverage. Should the continuation of your COBRA coverage terminate, ^ADMINNAME will refund, within its normal processing schedule, any remaining credit balance on your account. You will receive no further notice regarding this partial payment.

If you have any questions regarding this partial payment, please call our Customer Service Department at ^CORRPHONE.
^ADMINNAME

Tear Here and Return with Payment

.....
^ShortFallAmt
^GraceDate
^BENEID
^BeneName
^BENEADDRESS
^ADMINNAME
^CORRADDRESS
^ADMINNAME
^PaymentAddress
^BeneID
^EmployerID
^PaymentZip

SAMPLE SIGNIFICANT SHORTFALL LETTER

ADP COBRA Services
123 Main Street
Suite 999
Anywhere, ZZ 99999-9999



<DATE>
<BENEID>
<BENENAME>
<BENEADDRESS>

Dear <BENENAME>

The last payment for continuation of your COBRA coverage received by ^ADMINNAME is check #^CheckNbr, in the amount of \$^CheckAmt. ADP posted this payment to your account, resulting in a credit balance of \$^OvrPayAmt and continuation of your COBRA coverage through ^PaidThru.

You are required to remit monthly COBRA premiums in full and to postmark them within the stipulated grace period. The credit balance on your account is significantly less than \$^PremiumDue, the full monthly premium due for the coverage period of ^CoveragePeriod, and as such is considered a "partial" payment. In order for your COBRA coverage to continue beyond ^PaidThru, a payment for the balance due of \$^ShortFallAmt must be postmarked on or before ^GraceDate. Failure to do so will cause your COBRA coverage to terminate on ^PaidThru. You may also make premium payments through our website at www.benedirect.adp.com. The website is provided to you as a courtesy. In cases where the website is down and unavailable, you continue to be responsible for timely payment, otherwise your coverage may be canceled.

The acceptance of a late or partial payment by ^ADMINNAME does not constitute agreement of COBRA continuation of coverage. ^ADMINNAME provided this notice of "partial" payment solely as a courtesy and regardless of any applicable grace date having possibly expired. COBRA regulations do not allow for, nor does this notice serve as, an extension of applicable grace period. Should the continuation of your COBRA coverage terminate, ^ADMINNAME will refund, within its normal processing schedule, any remaining credit balance on your account. You will receive no further notice regarding this partial payment.

Sincerely,
^ADMINNAME

..... Tear Here and Return with Payment
.....

^ShortFallAmt
^GraceDate
^BENEID
^BeneName
^BENEADDRESS
^ADMINNAME
^COBRADDRESS
^ADMINNAME
^PaymentAddress
^BeneID
^EmployerID
^PaymentZip

SAMPLE WELCOME LETTER

ADP COBRA Services
123 Main Street
Suite 999
Anywhere, ZZ 99999-9999



<DATE>
<ACCOUNT>

<BENENAME>
<BENEADDRESS>

Dear <BENENAME>

You are currently continuing your healthcare coverage through ^EMPLOYERNAME. To better meet your needs, ^EMPLOYERNAME has contracted with ^ADMINNAME to provide billing and premium collection services in accordance with COBRA continuation requirements.

Claims

The procedures for obtaining health care services and claims processing will remain the same. Please contact your health plan(s) directly for information about your benefits, provider directories, ID cards, and claims processing. Do not send claims to ^ADMINNAME for processing.

Sending Correspondence to ^ADMINNAME

Please send all correspondence (do not include payments) to the following address:

^ADMINNAME
^CORRADDRESS

Sending Your Payment

^ENCLOSEDCOUPONSSTMT Every month, please send the appropriate coupon along with a check for the full amount due and made payable to ^ADMINNAME to the address shown on the coupon. A delay in processing may occur if payment is sent without the appropriate coupon. **You may also make premium payments through our website at www.benedirect.adp.com.** If you are a first time user, you will be required to register on the website.

Please DO NOT mail payments and correspondence together.

When Your FIRST Payment Is Due

If you have just elected COBRA continuation your first premium payment must be received by ^ADMINNAME within 45 days from the date you postmarked your COBRA election. Your first coupon will reflect the coverage period(s), the amount due for the retroactive coverage, and the grace date in which payment must be postmarked or COBRA coverage will cease. There cannot be a lapse in coverage and coverage will not be reinstated until payment for a coverage period is received.

When Your Subsequent Payments are Due

Each coupon indicates the 'Due Date' and the 'Grace Date'. **We strongly encourage you to remit payment in full prior to the Due Date.** Eligibility may be denied until payment is credited to your account and the insurance carriers are updated.

If ^ADMINNAME does not receive full premium payment postmarked on or before the grace date, as specified by law, your COBRA coverage will be terminated on the last day of the period for which full payment was made.

Page 1 of 2

ONCE COVERAGE IS TERMINATED, IT CANNOT BE REINSTATED.

Please note:

The acceptance of any late or partial payment by ^ADMINNAME does not constitute agreement of COBRA continuation of coverage. Instances of late or partial payments will result in a refund and termination of COBRA coverage. Refunds will be handled through the normal processing schedule for ^ADMINNAME.

Life Status Changes; Second Qualifying Events; Social Security Disability

You are responsible for notifying ^ADMINNAME in writing of any life status changes, second qualifying events, or Social Security disability that occur. Your Plan's Summary Plan Description (SPD) stipulates the required time frame under your Plan for the submission of notification of such events to ^ADMINNAME. Generally, however, you will be required to notify ^ADMINNAME as follows:

For events such as marriage, birth, or adoption, you must notify ^ADMINNAME in writing within 30 days of the event.

For events that may lead to an extension of COBRA, including the events of divorce, legal separation, dependent child losing eligibility under the plan, or Social Security Administration determined disability, you must notify ^ADMINNAME within 60 days after such event occurs. You can obtain the required form and instructions for providing notice to ^ADMINNAME at www.benedirect.adp.com. If you do not have access to the Internet, or wish to have this information sent to you, please contact ^ADMINNAME at ^CORRPHONE.

Other Group Coverage or Medicare

It is your responsibility to notify ^ADMINNAME immediately if, after your date of COBRA election, you first become covered under Medicare or another group health plan that does not contain an exclusion or limitation with respect to a pre-existing condition.

Should you have any other questions relating to COBRA continuation coverage, please contact ^ADMINNAME at ^CORRPHONE, or visit us at www.benedirect.adp.com.

Thank you,

^ADMINNAME

SAMPLE CONFIRMATION LETTER

ADP COBRA Services
123 Main Street
Suite 999
Anywhere, ZZ 99999-9999



<DATE>
<ACCOUNT>

<BENENAME>
<BENEADDRESS>

RE: ^EMPLOYERNAME Benefits Continuation

Dear ^BENENAME:

Following is the latest information on your continuation of benefits coverage. This information is being provided to you as confirmation of an election of continuation of coverage, a recent change you have made to your health coverage, or due to a change to ^EMPLOYERNAME's Health Plan affecting your health coverage. Please review all information carefully.

Sending Your Payment

^ENCLOSEDCOUPONSSTMT Each month, please send the appropriate coupon and full payment to the address shown on your coupon. If you continue coverage into next year, you will receive the appropriate coupons towards the end of the plan year (as soon as the new premium rates are available).

Your checks must be made payable to “^ADMINNAME” and mailed to the address shown on your coupon. **You may also make premium payments through our website at www.benedirect.adp.com. The website is provided to you as a courtesy. In cases where the website is down for maintenance and unavailable, you continue to be responsible for timely payment, otherwise your coverage may be cancelled.**

When Your Payment Is Due

Each coupon indicates the 'Due Date' and the 'Grace Date'. **We strongly encourage you to remit payment in full prior to the Due Date.** Eligibility may be denied until payment is credited to your account and the insurance carriers are updated.

Note: If you fail to make a payment for a coverage period before the end of the grace date for that coverage period, you will lose all rights to continuation coverage under the plan. Any letters or coupons you receive after failure to timely pay for any coverage period will not extend your grace date for any payment.

Please note:

^ADMINNAME's acceptance of any late or partial payments does not constitute agreement of continuation of coverage. Instances of late or partial payments will result in refunds through ^ADMINNAME's normal processing schedule and termination of coverage.

Changes in Life Status

You are responsible for notifying ^ADMINNAME of any life status changes that occur. Any changes in life status may result in an adjustment to your premium. Notification is required as follows:

- > Within 30 days of events such as marriage, birth, or adoption (or defined under the employer's Plan Document).
- > Within 60 days of events such as divorce, legal separation, death, or loss of dependent status.

All correspondence must be sent to the following address:

Page 1 of 2

^ADMINNAME
^CORRADDRESS

The procedures for obtaining health care services and claims processing will remain the same. Please contact your health plan(s) directly for information about your benefits, provider directories, ID cards, and claims processing. **DO NOT SEND CLAIMS TO ^ADMINNAME FOR PROCESSING.**

If you have any questions regarding the coverage, please feel free to contact ^ADMINNAME at ^CORRPHONE.

Thank you,

^ADMINNAME

Page 2 of 2

SAMPLE EARLY TERMINATION LETTER

ADP COBRA Services
123 Main Street
Suite 999
Anywhere, ZZ 99999-9999



<DATE>

<BENENAME>
<BENEADDRESS>

Account Number: ^ACCOUNT

Notice of COBRA Coverage Termination

Dear ^BENENAME:

On ^TERMINATIONDATE, the COBRA continuation coverage under the ^GROUPHEALTHPLAN (the Plan) terminates in relation to the following individual(s):

* The **reason codes for termination of COBRA** coverage prior to the end of the COBRA coverage period are as follows:

- A. You failed to pay the applicable premium, in full, by the applicable grace date.
- B. You voluntarily cancelled COBRA coverage(s).
- C. You became entitled to Medicare (Part A, Part B, or both) after the date of your COBRA election.
- D. You became covered, after the date of your COBRA election, under another group health plan that do not limit or exclude preexisting conditions as defined by its terms.
- E. All of the company's group health plans have terminated.

In Case of Error or for More Information

If you believe that the termination date of your COBRA continuation coverage is inaccurate, please notify ^ADMINNAME immediately at the address noted above or call us at ^CORRPHONE. You may have the right to request a review of this termination. Please refer to your Summary Plan Description for further details regarding these rights.

Right to Convert to an Individual Health Insurance Policy

Depending on the reason your COBRA coverage is terminating, you may have the right to convert to an individual health insurance policy as provided by the Plan. Eligibility determination, enrollment forms, and other information can be requested through your former employer and/or insurance carrier. Note that if you qualify for the conversion policy, there may be deadlines by which you must submit your application or premium payment. If you are interested in a conversion policy, it is strongly recommended that you contact your former employer or insurance carrier immediately.

Sincerely,
^ADMINNAME

SAMPLE TERMINATION CONVERSION LETTER

ADP COBRA Services
123 Main Street
Suite 999
Anywhere, ZZ 99999-9999



<DATE>
<ACCOUNT>

<BENENAME>
<BENEADDRESS>

Dear <BENENAME>

Your Benefits Continuation of Coverage will be expiring on ^EXPIREDATE assuming full premium is paid through this date.

Upon termination of this coverage, you may have the option to convert this group coverage(s) to an individual plan with your current medical and/or dental carrier. For more information regarding the option to convert, please contact your insurer directly. Rates, premium billing and payment will be a matter between you and your carrier.

It has been our pleasure to serve you.

Thank you,
^ADMINNAME