

COBRA NOTICE

[PRT.DT,D2/]

[EMP.NM]
[EMP.ADD1]
[EMP.CSZ]

RE: Member # [EMP.ID], Policy # [GRP.NUM]

Dear [MBR.NM,L#27]:

This notice contains important information about your right to continue your health care coverage through COBRA. Please read the information below very carefully.

Please note that if life insurance and accidental death & dismemberment benefits were included in your previous health plan, the COBRA plan does not include these benefits, but you may request an individual conversion policy. Please refer to your Hartford Life policy's insurance certificate for details on the conversion privileges.

CONTINUATION OF COVERAGE:

Your coverage under [GRP.NM] will end or has ended on [MBR.MEDTRM,D2-,R#9] due to one of the following reasons below.

- | | |
|--|---|
| <input type="checkbox"/> End of Employment | <input type="checkbox"/> Reduction in Hours of Employment |
| <input type="checkbox"/> Death of Employee | <input type="checkbox"/> Divorce or Legal Separation |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> Loss of Status for Dependent (Child) |

Please note that only individuals whose loss of health coverage was due to an involuntary termination of employment are eligible for this reduced premium.

You have 60 days from the date of this letter to elect COBRA continuation of coverage.

Each person ("qualified beneficiary") in the category(ies) below may be eligible to elect COBRA continuation coverage.

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he/she is no longer a dependent under the Plan

DURATION OF COBRA COVERAGE:

1. Applies to Employee/Spouse/Child
 - If due to loss of employment or reduction in hours: 18 months
 - If disability is deemed by the Social Security Administration within the first 60 days of COBRA election: 29 months
2. Applies to Spouse/Child only
 - If due to Medicare entitlement, death of the employee, divorce or legal separation, or ceasing to be a dependent (child) as defined under the plan: 36 months

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

1. Any required premium is not paid in full by the payment due date;
2. A qualified beneficiary becomes covered, after electing continuation of coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
3. A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation of coverage; or
4. 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 the coverage of a participant or beneficiary who is not receiving continuation coverage (such as fraud).

INFORM HMAA OF ANY CHANGES:

In order to protect your and your family's rights, you should keep us informed of any changes to your or your family members' mailing address. For your records, you should also keep a copy of any notices that you send to us.

FOR ADDITIONAL INFORMATION:

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.

If you have any questions about the information in this notice, your rights to COBRA continuation coverage, or if you want a copy of your Summary Plan Description, please contact:

HMAA
Customer Service Center
737 Bishop Street, Suite 1200
Honolulu, HI 96813

Phone: (808) 941-4622
Toll-Free: (888) 941-4622
E-mail: CustomerSvc@hmaa.com

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 U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

COBRA ELECTION AND PAYMENT INFORMATION:

To continue coverage through COBRA, your first premium payment is due within 45 days after you have elected COBRA continuation coverage. Subsequent payments are due on the first day of each month for which coverage is expected. Please indicate your HMAA member identification number on your check. Coverage may be elected for any or all dependents enrolled at the time coverage was terminated.

Your monthly rates are as follows:

Single *	Employee+Spouse	Employee+Child	Family
[RATE]	[RATE]	[RATE]	[RATE]

* If only your dependent(s) elect COBRA, the single rate will apply to each dependent who was already on the plan.

Your rate or benefits may be adjusted on your group's anniversary date with HMAA, or with any other rate or benefit change for your group. If you choose to continue your coverage, you will be notified of any change to the rate or benefits.

If payment is not received within 30 days from the due date, your coverage will be terminated. Your coverage termination date will be the last day of the month for which payment was made in full.

**** NOTE: YOU WILL NOT RECEIVE ANY BILLS OR PREMIUM PAYMENT REMINDERS ****

INSTRUCTIONS:

To elect COBRA continuation coverage, complete the enclosed Election Form and return it to HMAA. This Election Form must be returned by mail, fax, or in person. It must be received or postmarked no later than 60 days after this notice date. Under federal law, you will lose your right to elect COBRA continuation coverage if you do not submit a completed Election Form by this date.

If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA coverage, your COBRA coverage will begin on the first of the month following the date you return the completed Election Form.

You may also include your first payment with this Election Form. Your first payment should include all premiums due from your effective date of COBRA coverage through the date of payment. Example: If you are electing coverage effective March 1 and you are mailing the election form and your payment on May 1, you should include payments for the months of March, April, and May.

REMINDERS:

** PAYMENTS MUST BE RECEIVED BY HMAA ON OR BEFORE THE FIRST DAY OF EACH MONTH FOR WHICH COVERAGE IS EXPECTED.

** YOU WILL NOT RECEIVE ANY BILLS OR PREMIUM PAYMENT REMINDERS.

**COBRA CONTINUATION COVERAGE
ELECTION FORM**

[EMP.NM]

[PRT.DT,D2/]

Policy # [GRP.NUM]

Member # [EMP.ID]

I understand that payments must be received by HMAA on or before the FIRST DAY OF EACH MONTH for which coverage is expected. I further understand that I will NOT RECEIVE ANY BILLS OR PREMIUM PAYMENT REMINDERS.

I (we) elect COBRA continuation coverage:

<u>Name</u>	<u>Date of Birth</u>	<u>Relationship to Subscriber</u>
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Signature

Date

Print Name

Relationship to Subscriber

Address

City, State, ZIP

Phone Number

Send this completed form to:

HMAA
Billing and Member Services Department
737 Bishop Street, Suite 1200
Honolulu, HI 96813

Or fax it to: (808) 535-8353