Employees of the University of Virginia or its Health System covered under the UVa Health Plan, UVa Dental Plan, or Davis Vision Plan who: 1) terminate employment for any reason other than as the result of gross misconduct; 2) become a part-time employee who would otherwise no longer be eligible for coverage; or 3) become a non-salaried employee no longer eligible for coverage, may elect to continue coverage on a self-payment basis through the COBRA plan for themselves, their spouse, and/or their dependents from the date coverage in the active employee group would otherwise end. Covered spouses or dependents who lose coverage because they no longer qualify as a dependent or spouse under the terms of the Plan (examples of these qualifying events are divorce and reaching age limits) may also elect to continue coverage on a self-payment basis through the COBRA plan for themselves from the date coverage as a qualified dependent would otherwise end.

- COBRA coverage begins the day after coverage in the active employee plan ends.
- Enrollment in the COBRA plan is not an opportunity to change from one option to another (for example, from Choice Health to Value Health or vice versa); COBRA participants can choose enrollment only in the same option in which they were enrolled on their last day of coverage in the active employee plan.

If the employee has a spouse or dependents who are covered under the Health, Dental, or Vision Plans, the employee and each covered spouse and/or dependent have independent election rights. COBRA law allows the employee and each covered spouse and/or dependent to choose coverage that is the same as the coverage that was in effect at the time of the Qualifying Event. If not all dependents and/or the spouse want to continue, do not include their names on the Enrollment Form. The employee’s name must be included on the Enrollment Form’s list of eligible persons if the employee wants coverage.

- The employee, spouse, and/or dependents have 60 days from the date their active coverage under the UVa Health Plan, the UVa Dental Plan, or the Davis Vision Plan ends to apply for COBRA coverage.
- Postmark dates are used as submission dates for COBRA Enrollment Forms.
- Enrollees are allowed to delay the premium payment for up to forty-five days after they have dated the Enrollment Form. However, the COBRA Enrollment Form will not be processed and coverage in the UVa Health Plan, UVa Dental Plan, or the Davis Vision Plan reinstated until both the Enrollment Form and the Initial Premium payment have been received. The initial premium payment includes the first month’s premium as well as premiums for any other month beyond the first that has begun when the initial payment is made.
- Any claims submitted for expenses incurred as of the continued coverage effective date will be denied until all premiums, which are due, have been paid.
- Reimbursement for prescriptions that have been filled before coverage is reinstated without presenting a valid ID card can be obtained from the same pharmacy within 30 days of the filled date. Reimbursement amounts may be less than the paid amount if the request is made by submitting a paper claim.

Future premiums are due on the first of each month thereafter, and should be mailed on or before the due date. If full premium payments are not received by the first of the month, claims will be put on hold until the premium is paid.

- Failure to pay premiums within 30 days of the due date will terminate participation under the UVa Health Plan, UVa Dental Plan, or the Davis Vision Plan. Postmark dates are used as premium payment dates.
- Premiums and benefits are subject to change based on the UVa Health Plan, UVa Dental Plan, or the Davis Vision Plan.
Continuation under the UVa Health Plan, UVa Dental Plan, or Davis Vision Plan is based on eligibility. The Plan Administrators reserve the right to retroactively cancel coverage if it is determined that the Enrollee is not eligible. Also, please be aware that any break in coverage of more than sixty-three days may cause loss of coverage portability.

- If you are interested in enrolling in the COBRA plan, complete the attached Enrollment Form and submit it to the University Human Resources Benefits Division.
- When payment accompanies the Enrollment Form, reinstatement will take place within two weeks assuming appropriate entries have been made by you or your department in the Academic or Medical Center payroll system. Otherwise, reinstatement will not take place unless payment is received within 45 days of signing the Enrollment Form.

COBRA PREMIUMS Effective 1/1/14

**UVa Health Plan**

<table>
<thead>
<tr>
<th></th>
<th>Choice Health</th>
<th>Value Health</th>
<th>Basic Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$510</td>
<td>$470.22</td>
<td>$437.58</td>
</tr>
<tr>
<td>Single + Child(ren)</td>
<td>$1000.62</td>
<td>$868.02</td>
<td>$805.80</td>
</tr>
<tr>
<td>Single + Spouse</td>
<td>$1031.22</td>
<td>$877.20</td>
<td>$814.98</td>
</tr>
<tr>
<td>Family</td>
<td>$1604.46</td>
<td>$1320.90</td>
<td>$1227.06</td>
</tr>
</tbody>
</table>

**UVa Dental Plan**

<table>
<thead>
<tr>
<th></th>
<th>Enhanced Dental</th>
<th>Basic Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$28.56</td>
<td>$22.44</td>
</tr>
<tr>
<td>Single + Child(ren)</td>
<td>$56.10</td>
<td>$40.80</td>
</tr>
<tr>
<td>Single + Spouse</td>
<td>$58.14</td>
<td>$41.82</td>
</tr>
<tr>
<td>Family</td>
<td>$90.78</td>
<td>$63.24</td>
</tr>
</tbody>
</table>

**Davis Vision Plan**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$6.42</td>
</tr>
<tr>
<td>Single + Child(ren)</td>
<td>$11.23</td>
</tr>
<tr>
<td>Single + Spouse</td>
<td>$11.56</td>
</tr>
<tr>
<td>Family</td>
<td>$17.97</td>
</tr>
</tbody>
</table>

Return COBRA Enrollment Forms and initial premium payments to: UHR Benefits Division, 914 Emmet Street, P.O. Box 400127, Charlottesville, VA 22904-4127. Make checks payable to UVa. Within two weeks of receipt of this form at UVa and entry of appropriate changes in your payroll system by you or your department, you will receive information and monthly coupons from Chard Snyder, UVa’s COBRA Administrator. Chard Snyder can be reached at 888-878-6175.
1) PERSON ENROLLING:
Name: _____________________________________________
Address: __________________________________________
__________________________________________________
City: _______________________________________________
State, Zip: __________________________________________
E-mail Address: _____________________________________
Phone: _____________________________________________
ID # of Active Employee if Different from name above: ___________________________________________
Name of Active Employee if Different from above: ___________________________________________

2) QUALIFYING EVENT:
Qualifying Event Date: _____ / _____ / _____
(Example: termination date, divorce date)
COBRA Effective Date: _____ / _____ / _____
(First day of the month following qualifying event date)
Reason for Termination of Active Employee Insurance: __________________________

3) HEALTH/DENTAL PLAN OPTIONS:
Write the appropriate plan option below. You must choose the same options in which you were enrolled as an active employee or eligible dependent.

<table>
<thead>
<tr>
<th>UVa Health Plan Options:</th>
<th>UVa Dental Plan Options:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice Health, Value Health, or Basic Health</td>
<td>Enhanced Dental or Basic Dental</td>
</tr>
</tbody>
</table>

- Single
- Single & Child(ren)
- Single & Spouse
- Family

4) PERSONS TO BE COVERED IN HEALTH/DENTAL PLAN: Circle Health and/or Dental for each person.
Include yourself below. Only persons previously covered by the UVa Health Plan or UVa Dental Plan are eligible for coverage.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M</th>
<th>Date of Birth: _____ / _____ / _____</th>
<th>Gender:</th>
<th>Soc. Sec#:</th>
<th>Circle Health and/or Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>M</td>
<td>Date of Birth: _____ / _____ / _____</td>
<td>Gender:</td>
<td>Soc. Sec#:</td>
<td>Circle Health and/or Dental</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>M</td>
<td>Date of Birth: _____ / _____ / _____</td>
<td>Gender:</td>
<td>Soc. Sec#:</td>
<td>Circle Health and/or Dental</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>M</td>
<td>Date of Birth: _____ / _____ / _____</td>
<td>Gender:</td>
<td>Soc. Sec#:</td>
<td>Circle Health and/or Dental</td>
</tr>
</tbody>
</table>

5) STATEMENT OF UNDERSTANDING AND ELECTION:
I hereby request enrollment for continuation of the health and/or dental benefits for myself and eligible qualified dependents I have listed on this form, and I agree to pay the premium as required. I understand that continuation of coverage will terminate, after this election, under several circumstances, including: the date I or a continued dependent become covered under another group health or dental plan or become entitled to Medicare, when my full premium payment is not received timely, or the date on which the employer’s group health or dental plan ends. I also understand that any break in continued coverage of more than sixty-three days may cause loss of coverage “portability” and that I will not receive late notices when my premium is not received by the due date or the end of the grace period.

________________________________________
Signature of Enrollee

________________________________________
Date

COBRA Continuation coverage will be initiated upon receipt of Initial Premium Payment which must include premiums for all retroactive months as well as the current month’s premium.

University Human Resources Benefits Division * 914 Emmet St., P.O. Box 400127 * Charlottesville, VA 22904-4127
Phone: 434-982-0123 * Fax: 434-924-4486
1/1/14
COBRA ENROLLMENT 2014 – CONTINUED

DAVIS VISION
VISION COBRA ENROLLMENT FORM – 2014

1) VISION PLAN DESCRIPTION:
DAVIS VISION PLAN: Choose Election below and fill out section 1 (Person Enrolling) and section 2 (Qualifying Event) on the front side of this page.

Employee Only ________       Employee & Child(ren) ________       Employee & Spouse ________        Family ________

2) PERSONS TO BE COVERED IN VISION PLAN:
Include yourself – Only persons previously covered by the Davis Vision Plan are eligible for coverage.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>M</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>M</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>M</td>
</tr>
</tbody>
</table>

3) STATEMENT OF UNDERSTANDING AND ELECTION: I hereby request enrollment for continuation of the Vision benefits for myself and eligible qualified dependents I have listed on this form, and I agree to pay the premium as required. I understand that continuation of coverage will terminate, after this election, under several circumstances, including: when my full premium payment is not received timely, or the date on which the employer’s group vision plan ends. I also understand that I will not receive late notices when my premium is not received by the due date or the end of the grace period.

Signature of Enrollee ______________________       Date ______________________

COBRA Continuation coverage will be initiated upon receipt of Initial Premium Payment which must include premiums for all retroactive months as well as the current month’s premium.

UNIVERSITY OF VIRGINIA
FULL OR LIMITED FLEXIBLE SPENDING ACCOUNT COBRA ENROLLMENT FORM - 2014

1) Full or Limited Flexible Spending Account: Choose Election below and fill out section 1 (Person Enrolling) and section 2 (Qualifying Event) on the front side of this page.

I wish to continue my Full or Limited Flexible Spending Account under my COBRA rights:
YES ________       NO ________

You have the right to continue participation in the Flexible Spending Account for up to 18 months. In order to continue your FSA participation, you must pay your monthly contribution and monthly fee. In addition, you will be charged a 2% administrative fee to provide this benefit continuation.

Signature of Enrollee ______________________       Date ______________________

University Human Resources Benefits Division * 914 Emmet St., P.O. Box 400127 * Charlottesville, VA 22904-4127
Phone: 434-982-0123 * Fax: 434-924-4486

1/1/14