



POSTDOCTORAL SCHOLARS BENEFITS PACKAGE

HR Employee Services 480.965.2701	E-FAX NUMBERS Benefits & Leaves 480.993.0007
HR Faculty Services 480.727.9900	Retirement 480.993.0008

Employee benefits are handled by the Human Resources Benefits Design & Management Office and the Employee Service Center. Visit Benefits online at www.asu.edu/hr/benefits for details on the plans offered.

ORIENTATION

We encourage you to attend New Employee Orientation to learn about benefit options.

BENEFITS

Benefits enrollment must be completed within 31 days from your date of hire.

Please complete the appropriate Benefits Enrollment Form.

Information/enrollment instructions: www.asu.edu/hr/benefits/enrollmentforms.html

Submit via fax to 480.993.0007.

VACATION HOURS

Postdoctoral Scholars With a fiscal appointment, accrue 10 vacation days in the first year of service (employment) and 15 days in subsequent years. Unused accrued hours may not be carried over from one calendar year to the next nor are they paid out at separation.

Postdoctoral Scholars with an academic appointment do not accrue vacation.

SICK HOURS

All Postdoctoral Scholars accrue sick hours at 3.69 hours per pay period.

RETIREMENT

Postdoctoral Scholars are not eligible to participate in a retirement plan.

LONG-TERM DISABILITY

Coverage is provided by the State with Standard Insurance Co.

FORMS

The following forms must be completed and submitted to the HR Employee Service Center.

Benefits: Declaration of Understanding of Benefit Enrollment Policy and COBRA

Acknowledgement (*see page 7 of this document*) **Payroll:** You can get the **New Employee Payroll Packet** on the **HR FORMS page:** www.asu.edu/hr/forms.

PAYROLL DATA

You must go to to [MyASU](#) > **Human Resources Info** > **Paycheck and Payroll**

Information to:

Change your federal withholding on the W-4, if desired (The default is Single, 0 allowances)

Request direct deposit, if desired

HR Office of Human Resources | Benefits Design & Management



POSTDOCTORAL SCHOLARS BENEFITS PACKAGE

(Contracts effective January 1, 2008 or after)

COBRA Notification

Continuation of Insurance Coverage

Definitions	
Employer/ former employer	Arizona State University Human Resources PO BOX 875612 Tempe, AZ 85287-5612 480.965.2701
Contract Holder	AZ Dept. of Administration 100 N. 15th Avenue, #103 Phoenix, AZ 85007 602.542.5008
United Healthcare	Plan Administrator for United Healthcare EPO & PPO
Harrington	Plan Administrator for RAN+AMN EPO, Arizona Foundation PPO and BeechStreet PPO
Hiring Department	Employee/former employee's employing unit within Arizona State University
Other Insurance Companies	Delta Dental, Total Dental or Avesis Vision

Introduction

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 Description or contact your employer.

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 must pay for COBRA continuation coverage.



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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:

- Your hours of employment are reduced, or
- 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:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?

The Employer will offer COBRA continuation coverage to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the hiring department will notify Arizona State University, Human Resources.

You Must Give Notice of Some Qualifying Events

For the other qualifying events [divorce or legal separation of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), and spouse or a dependent child’s losing eligibility for coverage as a dependent child], you must notify your employer within 60 days after the qualifying event occurs. You must provide written notice to Arizona State University, Human Resources. You will be required to complete a *Declaration for Change* form and *Employee Enrollment/Change* form and attach related documents as proof of your qualifying event.

Get the forms you need on the **HR FORMS** page at www.asu.edu/hr/forms.



POSTDOCTORAL SCHOLARS BENEFITS PACKAGE

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How long will continuation coverage last?

Once your employer 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.

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if 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 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify plan administrator 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 are disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify *plan administrator* of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one 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 plan administrator of that fact within 30 days of SSA's determination.

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 legal separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for



POSTDOCTORAL SCHOLARS BENEFITS PACKAGE

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coverage as a dependent under the Plan. You must notify the plan administrator and/or insurance company within 60 days after a second qualifying event occurs.

More Info

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 plan description or from your employer. Get a copy of your plan description from the plan administrator or online: www.benefitoptions.az.gov.

For more information about your rights under 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.

Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send.



POSTDOCTORAL SCHOLARS BENEFITS PACKAGE

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EMPLOYEE ACKNOWLEDGEMENTS

BENEFIT ENROLLMENT POLICY

I understand that the medical, dental, vision, supplemental life, short-term disability and/or Flexible Spending Account plans that I elect are **effective the first day of the pay period following online enrollment**—provided I enroll no later than 31 days from date of hire or when I become eligible for benefits.

(For more information, go to www.asu.edu/hr/benefits/effectivedates.html).

I understand that if I have not completed enrollment within 31 days from my date of hire, I will not be allowed the opportunity to enroll in ASU-sponsored benefit programs until Open Enrollment for the next plan year or until I have a qualified status change as outlined in the Benefits Guide.

In addition, I acknowledge that it is my responsibility to ensure that the correct election premiums are being withheld from my paycheck and to notify Human Resources if there is any discrepancy.

COBRA

I understand that it is my responsibility to read the **Continuation of Group Health Coverage Notice**, which provides guidelines on the policies and procedures related to COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). I accept responsibility for familiarizing myself with the information and will seek verification or clarification of its terms or guidance where necessary.

Print Name
Signature
Affiliate ID#
Date