DATE

Name

Address

Address

Dear Name:

This notice contains the **Continuation Coverage Election Form and Important Information** about your right to continue your health care coverage in the **Company Name Group Health Plan (the Plan).** Please read the information contained in this notice very carefully.

***To elect continuation coverage, you must complete and return the enclosed Continuation Coverage Election Form within (30) days of the date of this Notice.***

If you do not elect continuation coverage, your coverage under the Plan will end on **DATE** due to:

□ End of employment

□ Divorce or legal separation

□ Death of employee

□ Entitlement to Medicare

□ Reduction in hours of employment

□ Loss of dependent child status

Each person in the category(ies) checked below is entitled to elect continuation coverage, which will continue group health care coverage under the Plan for up to nine (9) months:

□ 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 or she is no

longer a dependent under the Plan

If elected, continuation coverage will begin on **DATE** and can last until **DATE.**

Continuation coverage will cost: COST INFORMATION

**You do not have to send any payment with the Election Form**. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact COMPANY CONTACT INFO.

###### Continuation Coverage Election Form

**Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under Pennsylvania law, you have thirty (30) days after the date of this notice to decide whether you want to elect continuation coverage.**

**Send completed Election Form to: Attn: CONTACT NAME**

**COMPANY NAME  
 ADDRESS**

**ADDRESS**

**This Election Form must be completed and returned by mail or email by DATE, it must be post-marked no later than DATE. If emailed, it must be transmitted by DATE to EMAIL.**

**If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.**

**Read the important information about your rights included in the pages after the Election Form.**

I (We) elect continuation coverage in the COMPANY NAME Group Health Plan (the Plan)as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Relationship to individual(s) listed above

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Address Telephone number

**Important Information about Your Continuation Coverage Rights:**

### What is continuation coverage, also known as Pennsylvania Mini COBRA?

Pennsylvania law requires this group health insurance coverage give employees and their families the opportunity to continue their coverage for up to nine months 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, covered employees and eligible dependents may include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse and the dependent children of the covered employee.

Continuation coverage is the same coverage, without interruption, 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.

**Is there an alternative to PA Mini COBRA?**

You may also want to consider purchasing coverage through the Marketplace. The Marketplace is a website where a person or family may shop for coverage; if qualified, you can get help paying premiums and/or meeting cost sharing responsibilities (i.e. co-pays, deductibles, and co-insurance). Learn more by visiting [www.pennie.com](http://www.pennie.com).

**Who is eligible for Mini-COBRA continuation coverage, and how long will the coverage last?**

Employees and eligible dependents who have been continuously insured under the group policy or for similar benefits under any group policy which it replaced, for the three consecutive months ending with the employee’s termination by a qualifying event. Continuation coverage is not available if:

(1) the employee or eligible dependent is eligible for coverage under Medicare;

(2) the employee or eligible dependent fails to verify that he is ineligible for employer-based group health insurance as an eligible dependent; or

(3) the employee or eligible dependent is, or could be covered by any other insured or uninsured arrangements that provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to the termination of the employee’s group coverage (excluding Medicaid and CHIP – the Children’s Health Insurance Program).

Coverage may be continued for up to nine (9) months. However, if any of these three events happens after continuation coverage has begun, eligibility for coverage ends, and the employee or eligible dependent is required to provide written notice to the administrator within fourteen (14) days that coverage should not occur.

In addition, continuation coverage will end:

(1) if the employee or eligible dependent fails to make timely payment of a required premium contribution; or

(2) if the group coverage is terminated.

### How can you elect continuation coverage?

To elect continuation coverage, each covered employee or eligible dependent must complete the Continuation Coverage Election Form and furnish it according to the directions on the Form. Unless an eligible dependent’s election otherwise specifies, election of continuation coverage by an eligible dependent will be deemed an election of continuation coverage on behalf of any other eligible dependent who would lose coverage by reason of the qualifying event.

### How much does continuation coverage cost?

Continuation coverage will cost: INSERT COST INFORMATION

You do not have to send any payment with the Continuation Coverage Election Form.

### When and how must payment for continuation coverage be made?

*First payment for continuation coverage*

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don’t make your first payment in full no later than 45 days after the date of your election, you’ll lose all continuation coverage rights under the Plan. You’re responsible for making sure that the amount of your first payment is correct. You may contact CONTACT at PHONE NUMBER to confirm the correct amount of your first payment.

*Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you’ll have to make periodic payments for each coverage period that follows. 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, each of these periodic payments for continuation coverage is due by the 1st of the month for that coverage 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. The Plan will not send periodic notices of payments due for these coverage periods.

*Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you’ll be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. You’ll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. 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 will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the 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 don’t make a periodic payment before the end of the grace period for that coverage period, you’ll lose all rights to continuation coverage under the Plan.

Your payment(s) for continuation coverage should be sent to:

Attn: CONTACT

COMPANY NAME

ADDRESS  
ADDRESS

Please make checks payable to: *CONTACT*

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### For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from CONTACT, COMPANY NAME, ADDRESS, PHONE.

If you have any questions concerning the information in this notice, your rights to coverage you should contact CONTACT, COMPANY NAME, ADDRESS, PHONE

For more information about your rights under state law, contact:

Pennsylvania Insurance Department

Toll-free at 1-877-881-6388

Visit the Department’s Website: www.insurance.pa.gov

**Keep Your Administrator Informed of Address Changes**

In order to protect your and your family’s rights, you should keep CONTACT, COMPANY NAME, ADDRESS, PHONE.informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to CONTACT at COMPANY NAME.