## < EMPLOYER to Prepare on the Business' Letterhead >

Follow bracketed/italicized prompts provided throughout this template letter. It is suggested that the information be provided, and the prompts be removed from the final copy.

## PA MINI-COBRA Model Notice for Use by Employers

[Enter date of notice]
Dear: [Identify the qualified beneficiary(ies), by name or status]
This notice contains the <b>Continuation Coverage Election Form and Important Information</b> about your right to continue your health care coverage in the <b>[enter name of group health plan]</b> (the <b>Plan</b> ). 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 [enter date] due to [check appropriate box(es)]:
<ul> <li>□ End of employment</li> <li>□ Involuntary</li> <li>□ Divorce or legal separation</li> <li>□ Death of employee</li> <li>□ Entitlement to Medicare</li> <li>□ Reduction in hours of employment</li> <li>□ Loss of dependent child status</li> </ul>
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 [Check appropriate box or boxes; names may be added]:
<ul> <li>□ Employee or former employee</li> <li>□ Spouse or former spouse</li> <li>□ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage</li> <li>□ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan</li> </ul>

If elected, continuation coverage will begin on [enter date] and can last until [enter date].

Continuation coverage will cost: [enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods – not more than 105% of the group rate of the insurance being continued on the due date of each payment]. 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 [enter name of party responsible for continuation coverage administration, with telephone number and address].

# **Continuation Coverage Election Form**

Pennsylva			Election Form and return it to us. Under his notice to decide whether you want to elect
Send com	pleted Election Form	n to: [Enter Name and Address]	
_		ompleted and returned by mail   ost-marked no later than [ <i>enter d</i>	[or describe other means of submission and due [ate].
elect cont	inuation coverage. I		nte shown above, you will lose your right to nge before the due date, you may change your te the due date.
Read the	important informati	on about your rights included in	n the pages after the Election Form.
<b></b>			
I (We) elect co	ontinuation coverage	e in the [ <i>enter name of plan</i> ] (th	ne Plan) as indicated below:
Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a.			
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 healthcare.gov

## 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 [enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods – not more than 105% of the group rate of the insurance being continued on the due date of each payment]. You do not have to send any payment with the Continuation Coverage Election Form.

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

[Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.]

You may contact [enter appropriate contact information for the party responsible for continuation coverage administration under the Plan] to confirm the correct amount of your first payment.

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

[enter appropriate payment address]

#### For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from [enter appropriate contact information for the party responsible for continuation coverage administration under the Plan].

If you have any questions concerning the information in this notice, your rights to coverage you should contact [enter name of party responsible for continuation coverage administration, with telephone number and address].

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 [enter name and contact information for the appropriate party responsible for continuation coverage administration] 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 [enter the name of the party responsible for continuation coverage administration]