COBRA & Continuation Election Notice

Instructions: Pages 1-7 to be completed by group and given to the employee.
Page 7 only to be completed by the plan administrator and employee and returned to BCBSM, P.O. Box 64024, St. Paul, MN 55164 or return it via fax to 1-651-662-2745.

Date: _____

Enter Name of Employer:_____

Dear: _____
[Identify the qualified beneficiary(ies), by name]

This notice contains important information about your right to continue your health care coverage in the plan as well as other health coverage alternatives that may be available to you.

Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on _____ due to: (enter date)

- ☐ End of employment (18 months)
- ☐ Active military service (24 months)
- ☐ Death of employee (36 months or indefinite)
- ☐ Entitlement to Medicare (36 months total)
- ☐ Reduction in hours of employment (18 months)
- ☐ Divorce (36 months or indefinite)
- ☐ Loss of dependent child status (36 months)

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to _____ months *[enter 18, 36, or indefinite as appropriate and check appropriate box or boxes]:*

Relationship:	**Name:**
☐ 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, COBRA continuation coverage will begin on _____ *[enter date]* and can last until _____ *[enter date]*

You may elect any of the following options for COBRA continuation coverage:
☐ Health ☐ Dental ☐ Vision

COBRA continuation coverage will cost:

Health:		**Dental:**		**Vision:**	
Single	_____	Single	_____	Single	_____
Family	_____	Family	_____	Family	_____

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

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for special enrollment opportunity for another group health

plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact: _____
[enter name of party responsible for COBRA administration for the Plan, with telephone number & address]
There may be other coverage options for you and your family through the Health Insurance MarketPlace. You could be eligible for a tax credit that lowers your monthly premiums. You may also be eligible for a special enrollment into another Group Plan for which you may be eligible (e.g. a Spouses Plan).

IMPORTANT INFORMATION
ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law and Minnesota law require that most group health plans give employees and their families the opportunity to continue their health care coverage 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, "qualified beneficiaries" can 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 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, including special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. However, if a loss of employment or reduction in hours occurs as a result of active military service, coverage may be continued for up to 24 months. In the case of losses of coverage due to an employee's death, divorce, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employees last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

For fully insured plans, Minnesota law permits an indefinite period of continuation when the qualifying event is the employee's death or divorce. In these two circumstances continuation will continue until:

1) such time as the group ceases offering group health coverage to any employees;
2) the qualified beneficiary fails to pay the required premium;
3) coverage of the qualified beneficiary is terminated for cause (e.g. submitting fraudulent claims.);
4) enrollment in other group coverage.

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

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, (Note: pre-existing condition exclusions will be eliminated as plans renew through 2014),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage except for fully insured plans under Minnesota law, or
- 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 COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify

_____ of a disability or a second qualifying event
[enter name of party responsible for COBRA administration]
in order to extend the period of continuation coverage. Failure to provide notice of a disability or a 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 is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has 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 the Plan of that fact within 30 days after SSA's determination.

Under Minnesota State law, the employee is considered disabled for the first 24 months if he or she is unable to perform their regular duties, even without a Social Security Administration disability determination. After 24 months, a disabled employee may stay on the plan as long as they are unable to engage in any paid employment. While only the employee's disability is considered, eligible dependents may also continue coverage.

Second Qualifying Event

An 18-month extension of coverage, upon the occurrence of a second qualifying event, is available to spouses and dependent children who elect continuation coverage if the first qualifying event is a loss of employment or a reduction in hours and 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 (or longer for fully insured plans under Minnesota law). Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situation plan participant or beneficiary who is not receiving continuation coverage. An employee who continues under the disability provisions of Minnesota law may be charged up to the cost to the employer only. The required payment for each continuation coverage period for each option is described in this notice.

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

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage **in full** not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.

You may contact _____
[enter appropriate contact information for COBRA administration under the Plan]

to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make period payments for each subsequent coverage period. 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 on the

_____
[enter due day for each monthly payment]

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 will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all period payments 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 under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact

_____

[enter name of party responsible for COBRA administration for the Plan, with telephone number & address]

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa, or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a health insurance marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect you and your family's rights, you should keep the Plan Administrator 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 the Plan Administrator.

COBRA CONTINUATION COVERAGE ELECTION/WAIVER FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under Federal law, you must have 60 days after the date of this notice, or from the date your health coverage ends, whichever is later, to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to:

_____
[Enter Name and Address]

This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than _____
[enter date]

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation 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 continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included with the Election Form.

COVERAGE ELECTION/WAIVER

Please indicate whether you wish to continue your coverage. Your signature is required whether you elect to continue coverage or not. The signature of a parent or guardian is binding for any dependent under age 18.

I (We) elect/waive COBRA continuation coverage in the _____ (Plan) as indicated below:
[enter name of employer]

Name	Member ID. No.	Relationship	Health	Dental	Vision	Primary Care Clinic No. (Blue Plus Only)
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

_____ _____
Signature and relationship to employee Date

_____
Print Name

_____

_____ _____
Print Address Telephone number

Plan Administrator/Employer: Please complete information in the box below.

Employee Name: _____Member Identification Number _____
COBRA Start Date: _____COBRA End Date: _____ Date of Qualifying Event: _____
Qualifying Event: _____
Group Numbers: Health _____ Dental _____ Vision _____
Approved by: _____ Date_____

Employer/Plan Administrator: **Please return only this page of the form** (if member is electing coverage) **via mail** to: BlueCross BlueShield of Minnesota, P.O. Box 64024, St. Paul, MN 55164 or **via fax** to: 1-651-662-2745. Please retain a copy for your records. Do not return this form to us if member is waiving coverage.

This information is also available in other ways to people with disabilities by calling customer service at **(651) 662-8000** (voice), or **1-800-382-2000** (toll free).

For TTY:
Call **(651) 662-8700**, or **1-888-878-0137** (TTY), or 711, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877-627-3848** (Speech-to-Speech).

Hours: 7 a.m. to 8 p.m. Central Time, Monday through Friday

Attention: If you want free help translating this information, call the above number.
Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.