

**\*\*NOTICE OF YOUR CONTINUATION RIGHTS UNDER COBRA\*\***  
**For Participants in the Employee Medical & Prescription Drug Plan**

**Introduction**

You are receiving this notice because you are covered under the Hope Enterprises, Inc. Geisinger Health Plan. 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 and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**What is COBRA Continuation Coverage?**

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. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an **employee**, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. 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 will lose your coverage under the Plan because of any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

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

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated;
6. The child stops being eligible for coverage under the Plan as a "dependent child."

**When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

## **You Must Give Notice of Some Qualifying Events**

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days. You must send this notice to the Human Resources Department, P.O. Box 384, 100 Terrace Lane, Danville PA 17821.**

## **How is COBRA Coverage Provided?**

Once the Plan Administrator 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.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation lasts for up to 36 months.

When the qualifying event is the end of the 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 employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability Extension of 18-month period of continuation coverage**

**If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Human Resources Department, P.O. Box 384, 100 Terrace Lane, Danville PA 17821.**

### **Second Qualifying Event extension for 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare (Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, **but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.**

**In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Human Resources Department, P.O. Box 384, 100 Terrace Lane, Danville PA 17821.**

## **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website.)

**Keep Your Plan Informed of Address Changes**

**In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.** You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan Contact Information**

The Plan Administrator is Hope Enterprises, Inc., Attn: Human Resources Coordinator, **P.O. Box 384, 100 Terrace Lane, Danville PA 17821.**

Attachment: **Qualifying Event Notification/Additional Extension Event Notification Form**

LMG: 11/07

Personnel/General/Health Plan-COBRA Rights Notice CMSU

**COBRA QUALIFYING EVENT NOTIFICATION/  
ADDITIONAL EXTENSION EVENT NOTIFICATION**

Send to: Plan Administrator  
Hope Enterprises Employee Medical & Prescription Drug Plan  
c/o Human Resources Coordinator  
P.O. Box 384, 100 Terrace Lane, Danville, PA 17821

Employer: Hope Enterprises, Inc.

Employee: \_\_\_\_\_

Other Affected Covered Person(s) (if any): \_\_\_\_\_

**This Notice must be completed and provided within 60 days of the relevant Event. See Plan Document for full details of notification requirements. Failure to meet requirements may result in denial of coverage, requested extension, or other adverse consequences. Submission of this form does not guarantee eligibility, and submission of additional documents or other information may be required to verify eligibility for COBRA coverage.**

**A. Please check below the appropriate Event that is the subject of this Notice:**

- Qualifying Event:
  - Employee's Divorce
  - Employee's Legal Separation
  - Dependent Child No Longer Eligible as a Dependent Under Plan
- Additional Extension Event
  - Determination of Disability by Social Security Administration (as to disability existing during first 60 days of COBRA coverage)
- Other
  - Determination that the individual is no longer Disabled

**B. Please provide the date of the above Event:** \_\_\_\_\_

I, \_\_\_\_\_, hereby notify the Plan Administrator that the foregoing information is true and complete. I understand that submission of this Notice does not, by itself, guarantee any additional benefits under the Plan, and that the Plan Administrator is entitled to obtain and review additional documents and information to fully determine any eligibility for COBRA coverage under the Plan.

\_\_\_\_\_  
Employee or Qualified Beneficiary's Signature  
(or authorized representative)

Date: \_\_\_\_\_