



## Summary of the COBRA Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.\*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

### ◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at [www.irs.gov](http://www.irs.gov).

For general information regarding your plan's COBRA coverage or the ARRA Premium Reduction contact your former employer. To notify the plan of your ineligibility to continue paying reduced premiums, contact your former employer and the plan.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: [www.continuationcoverage.net](http://www.continuationcoverage.net), call 866-400-6689 (TTY: 866-631-5610) or send an email to: [continuationcoverage@maximus.com](mailto:continuationcoverage@maximus.com).

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\*Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

## COBRA Continuation Conversion Supplemental Notice

**This notice contains important information about your right to continue your health care coverage in the Plan(s) identified in the cover letter you received with this notice from your employer. Please read the information contained in this notice very carefully.**

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. You are receiving this election notice because:

- You experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 and you may be eligible for the temporary premium reduction for up to nine months.
- OR
- You experienced a loss of coverage at some time from September 1, 2008 through February 16, 2009. If your loss of coverage was due to an involuntary termination of employment, you may be eligible for a second COBRA election opportunity and the temporary premium reduction for up to nine months. If elected, COBRA continuation coverage begins retroactively on March 1, 2009.

To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the *Request for Treatment as an Assistance Eligible Individual* form. **If you believe you meet the criteria for the premium reduction, complete the *Request for Treatment as an Assistance Eligible Individual* form and return it with your completed application form.**

To change the coverage option(s) for your COBRA continuation coverage to something different than what you had on the last day of employment you must complete a new application listing the new plan option or coverage level. The new plan option must cost the same or less than the coverage you had on the last day of employment.

### **Important Note applicable to the University of Wisconsin System:**

Anyone who works in a Student Assistant or Employee-in-Training title who receives a STIPEND is NOT eligible for the COBRA premium reduction. There is no official employer/employee relationship – the payroll system is used to pay the stipend and to allow payroll deduction of benefits. Ineligible appointment titles include:

- Advanced Opportunity Fellow
- Fellow
- Research assistant
- Scholar
- Trainee
- Graduate Intern/Trainee
- Postdoctoral Fellow
- Postdoctoral Trainee



## REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

*To apply for ARRA Premium Reduction, complete this form and return it to your former employer along with your completed continuation election form(s). If you are changing coverage type or plan options, you will also need to submit a completed application form.*

*If you are electing continuation coverage for any of the optional plans, such as dental, you must complete and submit a separate continuation election form for each plan you wish to continue.*

### Section A: PERSONAL INFORMATION FOR EMPLOYEE -List dependent information on back.

Name of Employee (First Name, Middle Initial, Last Name)	Employee's Social Security Number _____ - _____ - _____
Mailing Address	Telephone Number (     ) _____ - _____
Email Address	

### Section B: QUALIFICATION - To qualify, you must be able to check 'Yes' for all statements.\*

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage.*	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

**\*If you checked NO for statement 3, you may still be eligible if you qualify for an ADDITIONAL ELECTION PERIOD.** If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. You should receive a new election notice with an election form that you **MUST** complete and return. If you believe you should have received this additional notice but have not, contact your former employer at the phone number listed on the letter that was sent with this form.

### Section C: SIGNATURE OF APPLICANT

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Type or print name \_\_\_\_\_ Relationship to employee \_\_\_\_\_

#### FOR EMPLOYER USE ONLY – Return copy of completed form to the applicant

Date Employment Terminated \_\_\_\_\_  
 Coverage(s) in effect at time of termination:  Health  Anthem DentalBlue  OptumHealth Vision  EPIC  
 Other \_\_\_\_\_  
 This application is:  Approved  Denied  Approved for some/denied for others (explain in #4 below)

#### IF DENIED, REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.*	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

**\*If you checked number 3, was individual eligible for, and given, the Additional Election Period described above?**

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan  
 \_\_\_\_\_ Date \_\_\_\_\_  
 Type or print name \_\_\_\_\_  
 Telephone number \_\_\_\_\_ E-mail address \_\_\_\_\_



**Section D: DEPENDENT INFORMATION – If applying for family coverage, complete the information for each eligible dependent. Attach additional copies of this form if you have more than 4 eligible dependents. (Parent or guardian should sign for minor children.)**

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
1. I elected (or am electing) COBRA continuation coverage.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.			
Signature _____		Date _____	
Type or print name _____		Relationship to employee _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
1. I elected (or am electing) COBRA continuation coverage.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.			
Signature _____		Date _____	
Type or print name _____		Relationship to employee _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
1. I elected (or am electing) COBRA continuation coverage.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.			
Signature _____		Date _____	
Type or print name _____		Relationship to employee _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
1. I elected (or am electing) COBRA continuation coverage.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.			
Signature _____		Date _____	
Type or print name _____		Relationship to employee _____	

## **Enrollment Information for COBRA and/or Premium Assistance**

The COBRA premium assistance and special enrollment opportunity may provide a number of options available to you. The following describes what steps you must take for each scenario.

You have 60-days from the date of the cover letter to provide all of needed forms to your previous employer.

Enclosed you will find the COBRA election form for each benefit plan in which you are/were enrolled. Applications are not included as you do not need to complete and submit an application unless you elect to switch to a plan option that costs the same or less than plan you had on your last day of employment, you are changing your level of coverage (e.g., family to single) from what you had on your last day of employment or any of your dependents are making an individual election to continue coverage. The links to the on-line applications are provided in the cover letter. If you prefer a paper copy, please contact us. Any change you (or a dependent if electing individual coverage) elect will be effective on or after the first of the month in which we receive the application. If you terminated employment on or before February 28, 2009, the effective date of coverage is March 1, 2009.

**If you are enrolling in COBRA and Eligible for Premium Assistance:** If, after reviewing the attached information, you wish to enroll in COBRA continuation coverage and you believe you are eligible for the premium assistance (i.e., the COBRA offering is due to an involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009), you must:

1. Complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue.
2. You must also complete the *Request for Treatment as an Assistance Eligible Individual* form.
3. Return the completed forms to us at the address shown on the cover letter.

We will complete the employer section of the *Request for Treatment as an Assistance Eligible Individual* form letting you know whether you are approved or denied for the premium assistance. If you are approved, you will also receive important information on making your premium payment.

**If you are Enrolling in COBRA and you are NOT Eligible for Premium Assistance:** If this is your initial enrollment opportunity for COBRA continuation coverage and you wish to enroll but are not eligible for the premium assistance as explained in the attached information, you must:

1. Complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue.
2. Submit the completed forms to continue your health insurance coverage to the Department of Employee Trust Funds.
3. Submit all other (e.g., dental and vision) continuation election forms and applications, if required, to the address listed on the form.

**If you Initially Declined Enrollment in COBRA or Enrolled but Subsequently Discontinued COBRA and you ARE Eligible for Premium Assistance:** If you experienced a loss of coverage at some time from September 1, 2008 through February 28, 2009 and either chose not to elect COBRA continuation coverage at that time OR elected COBRA but subsequently discontinued that coverage, you may have an extended election period. COBRA continuation coverage, if elected, begins retroactively on March 1, 2009. If, after reviewing the attached information, you wish to enroll in COBRA continuation coverage and you believe you are eligible for the premium assistance (i.e., the COBRA offering is due to an involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009), you must:

1. Complete the continuation election form for the coverage(s) that you wish to continue.
2. Complete the application form(s), if required,
3. You must also complete the *Request for Treatment as an Assistance Eligible Individual* form.
4. Return these completed forms to us at the address on the cover letter.

We will complete the employer section of the *Request for Treatment as an Assistance Eligible Individual* form letting you know whether you are approved or denied for the premium assistance. If you are approved, you will also receive important information on making your premium payment.

**If you are Currently Enrolled in COBRA and Eligible for Premium Assistance:** If, after reviewing the attached information, you believe you are eligible for the premium assistance and you are already enrolled in COBRA continuation coverage, you must:

1. Complete the *Request for Treatment as an Assistance Eligible Individual* form. Note on the top of the form that you are currently enrolled in COBRA.
2. Submit the completed form to us at the address on the cover letter.

We will complete the employer section of the *Request for Treatment as an Assistance Eligible Individual* form letting you know whether you are approved or denied for the premium assistance. If you are approved, you will also receive important information on making your premium payment.

**Note:** If you are approved for the premium assistance and you paid premiums for COBRA continuation coverage for periods of coverage after ARRA was enacted (March, April, May 2009) contact us for reimbursement for the overpaid premiums.

**If you are Declining COBRA:** If, after reviewing the attached information, you do not wish to enroll in COBRA continuation coverage, you do not need to take any further action.

**For employees who Terminated Employment due to Involuntary Layoff ONLY:** You have the following two options. Once you elect an option you cannot change.

1. You may convert unused sick leave credits to pay for your health insurance premium until the earliest of the following events: you are eligible for other group coverage, the sick leave credits are exhausted, you die or five years have elapsed. You will be eligible for the premium reduction after your sick leave credits are exhausted or five years have elapsed since you began using your sick leave credits provided that occurs on or before December 31, 2009.
  - a. If your sick leave credits are exhausted without being sufficient to cover the full month's health insurance premium, you will need to pay the difference by personal check, cashier's check or money order.
  - b. The COBRA premium assistance will start on the first of the following month provided it is effective on or before December 31, 2009.
2. You may elect to take advantage of the COBRA premium assistance immediately. You will not convert your sick leave into credits. In this case the credits will be lost unless you return to state service within five years (three years for unclassified employees).

**Lay-off** is defined in the WI Human Resources Handbook, Chapter 232, as: *The termination of the services of an employee with permanent status in class from a position in a layoff group approved by the DMRS administrator, or agency head if delegated, in which a reduction in force is to be accomplished.*

## Questions and Answers about Involuntary Terminations

### What is an Involuntary Termination?

For purposes of determining whether there is an involuntary termination under section 3001 of ARRA (including new Code sections added by section 3001 of ARRA), the following questions and answers are excerpted from IRS Notice 2009-27. To view the entire IRS document, please visit <http://www.irs.gov/pub/irs-drop/n-09-27.pdf>.

Q-1. What circumstances constitute an involuntary termination for purposes of the definition of an assistance eligible individual?

A-1 Involuntary termination is the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services. An involuntary termination may include the employer's failure to renew a contract at the time the contract expires, if the employee was willing and able to execute a new contract providing terms and conditions similar to those in the expiring contract and to continue providing the services. In addition, an employee-initiated termination from employment constitutes an involuntary termination from employment for purposes of the premium reduction if the termination from employment constitutes a termination for good reason due to employer action that causes a material negative change in the employment relationship for the employee.

Involuntary termination is the involuntary termination of employment, not the involuntary termination of health coverage. Thus, qualifying events other than an involuntary termination, such as divorce or a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan (such as loss of dependent status due to aging out of eligibility), are not involuntary terminations qualifying an individual for the premium reduction. In addition, involuntary termination does not include the death of an employee or absence from work due to illness or disability.

The determination of whether a termination is involuntary is based on all the facts and circumstances. For example, if a termination is designated as voluntary or as a resignation, but the facts and circumstances indicate that, absent such voluntary termination, the employer would have terminated the employee's services, and that the employee had knowledge that the employee would be terminated, the termination is involuntary.

Q-2. Does an involuntary termination include a lay-off period with a right of recall or a temporary furlough period?

A-2. Yes. An involuntary reduction to zero hours, such as a lay-off, furlough, or other suspension of employment, resulting in a loss of health coverage is an involuntary termination for purposes of the premium reduction.

Q-3. Does an involuntary termination include a reduction in hours?

A-3. Generally no. If the reduction in hours is not a reduction to zero, the mere reduction in hours is not an involuntary termination. However, an employee's voluntary termination in response to an employer-imposed reduction in hours may be an involuntary termination if the reduction in hours is a material negative change in the employment relationship for the employee.

- Q-4. Does involuntary termination include an employer's action to end an individual's employment while the individual is absent from work due to illness or disability?
- A-4: Involuntary termination occurs when the employer takes action to end the individual's employment status (but mere absence from work due to illness or disability before the employer has taken action to end the individual's employment status is not an involuntary termination).
- Q-5. Does an involuntary termination include retirement?
- A-5. If the facts and circumstances indicate that, absent retirement, the employer would have terminated the employee's services, and the employee had knowledge that the employee would be terminated, the retirement is an involuntary termination.
- Q-6. Does involuntary termination include involuntary termination for cause?
- A-6. Yes. However, for purposes of Federal COBRA, if the termination of employment is due to gross misconduct of the employee, the termination is not a qualifying event and the employee and other family members losing health coverage by reason of the employee's termination of employment are not eligible for COBRA.
- Q-7. Does an involuntary termination include a resignation as the result of a material change in the geographic location of employment for the employee?
- A-7. Yes.
- Q-8. Does an involuntary termination include a work stoppage as the result of a strike initiated by employees or their representatives?
- A-8. No. However, a lockout initiated by the employer is an involuntary termination.
- Q-9. Does an involuntary termination include a termination elected by the employee in return for a severance package (a "buy-out") where the employer indicates that after the offer period for the severance package, a certain number of remaining employees in the employee's group will be terminated?
- A-9. Yes.

If you have any questions about this information or your rights to COBRA continuation coverage, you should contact us.

# **Important Information About Your COBRA Continuation Coverage Rights**

## **What is continuation coverage?**

Federal law requires that most group health plans (including this Plan) 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” under Federal law 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. State law and plan contracts may allow you to cover other dependents who are not qualified beneficiaries under Federal law. These other dependents are eligible to continue coverage under COBRA, but they are not eligible for COBRA premium assistance. Dependents who are not qualified beneficiaries under Federal law are non-Assistance Eligible Individuals (non-AEI). Contact the office listed on the front page of this letter for more information about how continuing coverage for a non-AEI(s) affects the amount of COBRA premium assistance available to you.

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?**

Health insurance coverage generally may be continued only for up to a total of 36 months. The continuation periods are 18 months for OptumHealth and also for terminated employees (not retirees) under Anthem DentalBlue. 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 first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary (you lose eligibility for the COBRA premium assistance when you become eligible for another group health plan even if you do not enroll in that plan),
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, 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 elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the continuation election form(s) and submit 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 a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, 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 required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan (and your former employer will pay 65 percent). This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

If you have questions about this provision, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

### **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 your 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 your employer who provided you with this notice to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

#### *Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to make periodic 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 when indicated on the billing statement 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 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 or the due date indicated on the premium bill, whichever is later, 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. However, 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 under the Plan 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 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 periodic payments for continuation coverage should be submitted directly to the Plan. If you are eligible for the ARRA premium reduction, your employer will provide you with information on submitting your premium. You and the former employer must both make payment to the health plan within the grace period. As such, you should submit your 35% of the premium to the employer as much prior to the due date as possible.

#### **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.

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 your employer.

State and local government employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, should contact HHS-CMS at [www.cms.hhs.gov/COBRAContinuationofCov/](http://www.cms.hhs.gov/COBRAContinuationofCov/) or by email at [NewCobraRights@cms.hhs.gov](mailto:NewCobraRights@cms.hhs.gov).

#### **Keep Your Plan Informed of Address Changes**

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

**Intentionally blank**

# PARTICIPANT NOTIFICATION

**Keep this form.** If you are approved for COBRA premium assistance, you must notify your former employer and your plan if you become eligible for other group health plan coverage or Medicare and therefore become ineligible for reduced premiums under ARRA. To notify your former employer and plan, complete and submit this form.

***Failure to provide this notice may subject you to a tax penalty.***

Section A: PERSONAL INFORMATION	
Name (First Name, Middle Initial, Last Name)	Employee's Social Security Number
Mailing Address	Telephone Number
Section B: PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one.	
I am eligible for coverage under another group health plan. If any dependents are also eligible, list their names below.  Insert date you become eligible _____	<input type="checkbox"/>
I am eligible for Medicare.  Insert date you become eligible _____	<input type="checkbox"/>
<p><b>IMPORTANT</b></p> <p><b>If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.</b></p> <p style="text-align: center;"><b>Eligibility is determined regardless of whether you take or decline the other coverage.</b></p> <p style="text-align: center;"><b>However, eligibility for coverage does not include any time spent in a waiting period.</b></p>	
Section C: SIGNATURE	
To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.	
Signature _____	Date _____
Type or print name _____	
Section D: DEPENDENT INFORMATION	
If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:	
_____	_____
_____	_____
_____	_____

Return to Your Employer's Benefits Office  
AND  
To Your Health Plan (and Dental or Vision Plan, if applicable)