Mini-COBRA Continuation Coverage Additional Election and Subsidy Notice
Instructions for Employers

For qualified beneficiaries who are or would be an Assistance Eligible Individual but are not enrolled in Mini-COBRA coverage, with qualifying events that occurred during the period from September 1, 2008 through February 16, 2009, to advise them of their additional election rights and the potential availability of the premium reduction. (This includes beneficiaries who never elected and those who elected but subsequently discontinued coverage).

1. This notice must be sent to all beneficiaries who have not yet elected and those who elected but subsequently discontinued mini-COBRA coverage due to an involuntary termination of employment that occurred during the period from September 1, 2008 through February 16, 2009, to advise them of their additional election rights and the potential availability of the premium reduction. The additional election period does not extend the maximum coverage period available under mini-COBRA. The 18-month mini-COBRA coverage period is measured from the date of the individual's qualifying event (i.e. termination of employment) and not from the date coverage is reinstated as a result of this additional mini-COBRA election period.

2. This form (Mini-COBRA Continuation Coverage Additional Election and Subsidy Notice) should be used **ONLY** if you **DO NOT** wish to permit Assistance Eligible Individuals to enroll in lower cost coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred.

3. Enter your account name, your address, the contact name of the individual responsible for mini-COBRA administration, and the telephone number for the contact person as applicable.

4. **Continuation of coverage will begin on:** Enter the date of the first day of the first coverage period beginning on or after July 2, 2009.

5. **If elected, continuation coverage can last until:** Enter the date that is 18 months from the date of the involuntary termination of employment.

6. **Continuation coverage will cost:** Enter the amount each qualified beneficiary will be required to pay per month of coverage and any other permitted coverage periods.

7. **Assistance Eligible Individual cost can be reduced to:** Enter the amount that is 35 percent of the continuation coverage cost.

8. **Mini-COBRA Continuation Coverage Additional Election and Subsidy Notice:** Enter the applicable information in the blank spaces.

9. **When and how payment for mini-COBRA continuation coverage must be made:** Enter the deadline for the beneficiary to submit his/her monthly premium payment.

10. **Continuation Coverage Election Form:** Enter the eligibility expiration date, account name, contact name, address, and telephone number.

11. The entire package should be sent to the beneficiary.

Account name: _____
Contact name: _____
Street address: _____
City, State, Zip Code: _____
Telephone number: _____

Mini-COBRA Continuation Coverage Additional Election and Subsidy Notice

For qualified beneficiaries who are or would be Assistance Eligible Individuals due to an involuntary termination of employment that occurred during the period from September 1, 2008 through February 16, 2009, but are not enrolled in mini-COBRA coverage, to advise them of their additional election rights and the potential availability of the premium reduction. (This includes beneficiaries who never elected and those who elected but subsequently discontinued coverage.

Date: _____

Dear: _____

This notice contains important information about additional rights you may have related to your health care coverage in your group health plan. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with an involuntary termination of employment that occurred during the period from September 1, 2008 through February 16, 2009, and either chose not to elect mini-COBRA continuation coverage at that time or elected mini-COBRA but subsequently discontinued that coverage, are eligible for a second mini-COBRA election opportunity and may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, refer to the "Summary of the Continuation Coverage Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations, and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Continuation Coverage Election Form.**

To elect Massachusetts mini-COBRA continuation coverage, read the instructions on the following pages, complete the enclosed Continuation Coverage Election Form, and submit it to us.

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

Continuation coverage will cost _____. If you qualify as an Assistance Eligible Individual this cost can be reduced to _____for up to nine months.

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

If you have any questions about this notice or your rights to continuation coverage, please contact us at the phone number above.

Important Information About Your Mini-COBRA Continuation Coverage Rights, Including Premium Reduction Under Federal Law

Am I eligible to elect mini-COBRA continuation coverage at this time?
Only individuals who lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period, and who did not elect mini-COBRA continuation coverage during their first election period OR who elected but subsequently discontinued mini-COBRA coverage (for reasons other than becoming eligible for another group health plan or Medicare), are entitled to elect coverage at this time. If you lost group health coverage for any other reason (other than an involuntary termination of employment) between these dates and did not elect mini-COBRA continuation coverage when it was first offered, you are not entitled to this second election period.

Am I eligible for the premium reduction?
If you lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below under the question, "How much does mini-COBRA continuation coverage cost?"

How long will continuation coverage last?
Your coverage will begin retroactively on _____ and can generally continue for up to 18 months from the date of your involuntary termination of employment. The duration of the premium reduction is determined separately and may not last for the entire length of your mini-COBRA coverage. See the question below entitled "How much does mini-COBRA continuation coverage cost?"

Although you are allowed by law to continue group health coverage at your own expense with the ARRA subsidy, if applicable under the above circumstances, continued coverage will be terminated if:

- We cease to maintain a group health plan;
- You fail to pay the premium on time;
- You become covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition; or
- You become entitled to Medicare benefits.

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 open enrollment and special enrollment rights.

How can you extend the length of mini-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 in order to extend the period of continuation coverage. Failure to provide notice of a disability or 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 under the Social Security Act (SSA) to be disabled. The qualified beneficiary has to have been disabled as of the time of the qualifying event and the disability must last at least until the end of the 18-month period of

continuation coverage. The qualified beneficiary must notify _____ within 60 days of the determination that the individual was disabled for purposes of the Social Security Act (SSA). 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 to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if 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. 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 mini-COBRA continuation coverage?
To elect continuation coverage, you must complete the Continuation Coverage Election Form and furnish it according to the directions on the form. **Under Massachusetts Mini-COBRA law, you have 60 days after the date of this notice to decide whether you want to elect continuation coverage.**

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 mini-COBRA continuation coverage cost?
Generally, each qualified beneficiary may be required to pay the entire cost of mini-COBRA 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 beneficiary contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving 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 mini-COBRA coverage 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 from September 1, 2008 through December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the mini-COBRA coverage premium otherwise due to your employer. This premium reduction is available for up to nine months. If your mini-COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to

continue your mini-COBRA continuation coverage. **See the attached "Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA" for more details, restrictions, and obligations, as well as the form necessary to establish eligibility.**

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC).[1]

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at **1-866-628-4282 (TTY: 1-866-626-4282)**. More information about the Trade Act is also available at **www.doleta.gov/tradeact**.

When and how must payment for mini-COBRA continuation coverage be made?
If you decide to continue coverage, whether or not your premium is reduced under ARRA, your first payment will be due within 45 days of the date we receive your Continuation Coverage Election Form. This bill will cover the time period from the date continued coverage begins through the month we receive your Continuation Coverage Election Form. (Please note, therefore, that your first payment will be smaller if you make your decision within 30 days.)

Once you have made the first payment for continued coverage, your premium payment must be received each month on or by the _____ day of the month to ensure that your mini-COBRA coverage remains current. Late or missing payments may result in an interruption or cancellation of your coverage.

Keep Us Informed of Address Changes
In order to protect your and your family's rights, you should keep us informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to us for your records.

[1] Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80 percent of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a non-forfeitable right to a benefit, any portion of which is to be paid by the PBGC and TAA-eligible individuals).

Continuation Coverage Election Form

Instructions: To elect mini-COBRA continuation coverage, complete this Continuation Coverage Election Form by the eligibility expiration date shown below and return it to us.
Under Massachusetts mini-COBRA law, you have 60 days after the date of this notice to decide whether you want to elect continuation coverage.

If you do not submit a completed Continuation Coverage Election Form by the eligibility expiration date, you will lose your right to elect mini-COBRA continuation coverage. If you reject mini-COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Continuation Coverage Election Form before the eligibility expiration date. However, if you change your mind after first rejecting mini-COBRA continuation coverage, your continuation coverage will begin on the date you furnish the completed Continuation Coverage Election Form.

Read the important information about your rights included in the pages following the Continuation Coverage Election Form.

I am aware that coverage under my current health plan can be extended for a certain length of time at my expense.

Check the appropriate boxes:

☐ Yes, I (We) elect continuation coverage in my group-level health benefit program.

☐ Yes, my spouse and/or dependents were covered under my group-level health benefit program **and** they also choose to continue coverage.

☐ Yes, my spouse and/or dependents were covered under my health benefit program BUT they choose NOT to continue coverage.

☐ No, I do not wish to continue in my current health benefit program for the following reason:

- ☐ I have other group health insurance coverage.
- ☐ I have elected to convert to non-group coverage.
- ☐ I am moving out of state.
- ☐ This coverage is too expensive.
- ☐ Other: _____

_____ _____

Signature of beneficiary Date

_____ _____

Print name Social Security Number

_____

_____

_____ _____

Current address Telephone number

Eligibility expiration date: _____
Account name: _____
Contact name: _____
Street address: _____
City, State, Zip Code: _____
Telephone number: _____

Summary of the Continuation Coverage Premium Reduction Provisions Under the American Recovery and Reinvestment Act

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 continuation coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to nine 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.*

♦ 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 regarding ARRA at **www.irs.gov**.

For specific information related to our administration of the ARRA Premium Reduction or to notify us of your ineligibility to continue paying reduced premiums, please contact us.

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.cms.hhs.gov/COBRAContinuationofCov or email NewCobraRights@cms.hhs.gov

* 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.

To apply for ARRA Premium Reduction, complete this form and return it to us along with your Continuation Coverage Election Form.

You may also want to read the important information about your rights included in the "Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA."

Account Name	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	Account Mailing Address

PERSONAL INFORMATION

Name and mailing address of beneficiary (list any dependents on the back of this form)	Telephone number
	Email address (optional)

To qualify, you must be able to check 'Yes' for all statements.

1. The loss of employment was involuntary.	Yes ☐ No ☐
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	Yes ☐ No ☐
3. I elected (or am electing) continuation coverage.	Yes ☐ 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).	Yes ☐ 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).	Yes ☐ 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 beneficiary _____

FOR EMPLOYER USE ONLY

This application is: Approved> ☐ Denied> ☐ Approved for some/denied for others (explain in #4 below)> ☐

Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual did not elect continuation coverage.	☐
4. Other (please explain)	☐

Beneficiary's BCBSMA ID number _____ **Beneficiary's Social Security number**_____

Beneficiary's effective date of mini-COBRA coverage _____

Beneficiary's premium responsibility: $_____

Signature of party responsible for continuation coverage administration for the employer_____

Date _____

Type or print name _____

Telephone number _____ Email address _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

a. _____

Name Date of Birth Relationship to Beneficiary Social Security Number

1. I elected (or am electing) continuation coverage.	Yes No
2. I am NOT eligible for other group health plan coverage.	Yes No
3. I am NOT eligible for Medicare.	Yes 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 beneficiary _____

b. _____

Name Date of Birth Relationship to Beneficiary Social Security Number

1. I elected (or am electing) continuation coverage.	Yes No
2. I am NOT eligible for other group health plan coverage.	Yes No
3. I am NOT eligible for Medicare.	Yes 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 beneficiary _____

c. _____

Name Date of Birth Relationship to Beneficiary Social Security Number

1. I elected (or am electing) continuation coverage.	Yes No
2. I am NOT eligible for other group health plan coverage.	Yes No
3. I am NOT eligible for Medicare.	Yes 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 beneficiary _____

Qualified beneficiaries who are paying reduced premiums pursuant to ARRA should use this form so they can notify the employer if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your employer that you are eligible for other group health plan coverage or Medicare.

Employer Name	**Participant Notification**	Employer Mailing Address

PERSONAL INFORMATION

Name and mailing address	Telephone number
	Email address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below. Insert date you became eligible_____	☐
I am eligible for Medicare. Insert date you became eligible_____	☐

IMPORTANT

If you fail to notify your issuer of becoming eligible for other group health plan coverage or Medicare, AND continue to pay reduced continuation coverage premiums, you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage; however, eligibility for coverage does not include any time spent in a waiting period.

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 _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____ _____

_____ _____