Mini-COBRA Continuation Coverage New Election Period and Subsidy Notice with Coverage Options

Instructions for Employers

For qualified beneficiaries who experienced a qualifying event that was a reduction of hours that occurred from September 1, 2008 through March 31, 2010, followed by an involuntary termination of employment that occurred from March 2, 2010 through March 31, 2010 to advise them of a new election right and the potential availability of the premium reduction and lower cost plan option.

1. All of the following pages must be sent to all beneficiaries who (1) experienced a qualifying event that was a reduction in hours from September 1, 2008 through March 31, 2010, (2) did not elect or elected but subsequently discontinued mini-COBRA coverage, and (3) then had an involuntary termination of employment that occurred from March 2, 2010 through March 31, 2010 to advise them of a new mini-COBRA election right and the potential availability of the premium reduction and lower cost plan option.

2. The following pages should be sent **ONLY** if you wish to permit assistance eligible individuals to enroll in a lower cost coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred. In addition, you should fill in the blanks that are on the following pages.

   Please note that the different coverage must (1) cost the same or less than the coverage the individual had at the time of the qualifying event, (2) be offered to active employees and (3) cannot be limited to only dental coverage, vision coverage, counseling coverage, a flexible spending arrangement (FSA), including a health reimbursement arrangement that qualifies as an FSA, or an on-site medical clinic.

3. In the **Mini-COBRA Continuation Coverage New Election Period and Subsidy Notice with Coverage Options**, please 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. **Coverage options are:** List the available coverage option(s) that cost the same or less than what the individual had at the time of the qualifying event.

5. **Continuation coverage will begin on:** Enter the date immediately following the involuntary termination of employment.

6. **Can last until:** Enter the date that is 18 months after the loss of coverage related to the reduction of hours (Please note, the 18 months is measured from the reduction in hours, not the termination of employment).

7. **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.

8. **Assistance eligible individual cost can be reduced to:** Enter the amount that is 35 percent of the continuation coverage cost.

9. In the **Important Information About Your Mini-COBRA Rights** notice, restate the date mini-COBRA coverage will begin. This is the date immediately following the involuntary termination of employment.

10. **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.

11. In the **Continuation Coverage Election with Coverage Options Form,** enter the eligibility expiration date (which is the date that is 60 days after the date you issue this notice to the member), account name, and contact name, address, and telephone number.

12. 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 New Election Period and Subsidy Notice with Coverage Options

For qualified beneficiaries who (1) experienced a qualifying event that was a reduction in hours that occurred from September 1, 2008 through March 31, 2010, (2) did not elect or elected but subsequently discontinued mini-COBRA coverage, and (3) then had an involuntary termination of employment that occurred from March 2, 2010 through March 31, 2010 to advise them of a new election right and the potential availability of the premium reduction and lower cost plan option.

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), as amended by the Department of Defense Appropriations Act, 2010 (2010 DOD Act) and the Temporary Extension Act of 2010 (TEA), reduces the mini-COBRA coverage premium in some cases. You are receiving this election notice because you experienced a qualifying event that was a reduction of hours that occurred from September 1, 2008 through March 31, 2010. Regardless of whether you chose not to elect at that time or elected but subsequently discontinued mini-COBRA coverage, you have new rights. If your qualifying event was followed by an involuntary termination of employment that occurred from March 2, 2010 through March 31, 2010, you may be eligible for a second mini-COBRA election opportunity and the temporary premium reduction for up to fifteen 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, as Amended for details regarding eligibility, restrictions, and obligations, and the Request for Treatment as an Assistance Eligible Individual. **If you do not currently have mini-COBRA coverage (either because you never elected the coverage or because you elected but later discontinued the coverage) and believe you meet the criteria for the premium reduction, complete the Request for Treatment as an Assistance Eligible Individual and return it with your completed Continuation Coverage Election with Coverage Options Form.**

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

To change the coverage option(s) for your continuation coverage to something different than what you had at the time of your reduction in hours, select the appropriate box on the enclosed Continuation Coverage Election with Coverage Options Form. Available coverage options are:

_____.

If elected, continuation coverage will begin retroactively on _____ (the date immediately after your involuntary termination) and can last until _____ (the date 18 months after your reduction in hours).

Continuation coverage will cost _____ or _____ for the lower cost option. If you qualify as an assistance eligible individual, this cost can be reduced to_____or_____for the lower cost option for up to fifteen months.

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

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 Rights

Including Important Information About Premium Reduction Under Federal Law

Am I eligible to elect mini-COBRA coverage at this time?

Only individuals who (a) lose group health coverage due to a reduction of hours that occurs at any time from September 1, 2008 through March 31, 2010 and (b) who then experience an involuntary termination of employment from March 2, 2010 through March 31, 2010, and (c) who do not elect mini-COBRA continuation coverage during their first election period OR who elect but subsequently discontinue 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 between those 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 March 31, 2010 due to an involuntary termination or a reduction of hours occurring from September 1, 2008 through March 31, 2010 followed by an involuntary termination of employment that occurred from March 2, 2010 through March 31, 2010, 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 coverage cost?"

How long will continuation coverage last?

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

Mini-COBRA coverage will be terminated before the end of the 18 month period if:

- We cease to maintain a group health plan;
- You fail to pay the premium in a timely manner (see question below entitled "When and how must payment for mini-COBRA continuation coverage be made?");
- You become covered, after electing mini-COBRA coverage, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition; or
- You become entitled to Medicare benefits after electing mini-COBRA coverage.
- Mini-COBRA coverage may also be terminated for any reason the employer would terminate coverage of a participant or beneficiary not receiving mini-COBRA coverage (such as fraud).

How can you extend the length of mini-COBRA coverage?

If you elect mini-COBRA 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 your employer of a disability or a second qualifying event in order to extend the period of mini-COBRA coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of mini-COBRA coverage.

Disability

An 11-month extension of mini-COBRA may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of mini-COBRA coverage and must last at least until the end of the 18-month period of mini-COBRA coverage. Each qualified beneficiary who has elected mini-COBRA 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 your employer 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 mini-COBRA coverage if a second qualifying event occurs during the first 18 months of mini-COBRA coverage. The maximum amount of mini-COBRA 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 your employer within 60 days after a second qualifying event occurs if you want to extend your mini-COBRA coverage.

How can you elect mini-COBRA continuation coverage?

To elect continuation coverage, you must complete the Continuation Coverage Election with Coverage Options Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect mini-COBRA coverage. **Under Massachusetts mini-COBRA law, you have 60 days after the date of this notice to decide whether you want to elect mini-COBRA 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. If you do elect mini-COBRA coverage under this additional election period, the period from your qualifying event to the date coverage begins under your election will not count as a break in coverage for determining whether you had a 63-day break in coverage.

How much does mini-COBRA 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), as amended by the Department of Defense Appropriations Act, 2010, and further amended by the Temporary Extension Act of 2010 (TEA), reduces the mini-COBRA coverage premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to continuation coverage that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with March 31, 2010, or a qualifying event that is a reduction of hours occurring at any point from September 1, 2008 through March 31, 2010 followed by an involuntary termination occurring on or after March 2, 2010 through March 31, 2010. 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 fifteen months. If your mini-COBRA coverage lasts for more than fifteen months, you will have to pay the full amount to continue your mini-COBRA coverage. If you have fewer than fifteen months of mini-COBRA coverage available (based on the date of the original reduction of hours qualifying event) you are only entitled to pay reduced premiums for the remaining months. **See the attached Summary of the Continuation Coverage Premium Reduction Provisions under ARRA, as Amended 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, your first payment will be due within 45 days of the date we receive your Continuation Coverage Election with Coverage Options Form. This bill will cover the time period from the date continued coverage begins through the month we receive your Continuation Coverage Election with Coverage Options 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 subsequent premium payments must be received each month on the _____ day of the month. Although premium payments are due on the date shown, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. If you fail to make a monthly payment before the end of the grace period, you will lose all rights to mini-COBRA coverage.

Keep Us Informed of Address Changes

In order to protect you 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 with Coverage Options Form

Instructions: Under the American Recovery and Reinvestment Act you are only entitled to elect mini-COBRA coverage at this time if you lost group health plan coverage due to a reduction of hours during the period that begins with September 1, 2008 and ends with March 31, 2010 and subsequently experienced an involuntary termination between March 2, 2010 and March 31, 2010. To elect mini-COBRA coverage, complete this Continuation Coverage Election with Coverage Options 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 mini-COBRA coverage.

If you do not submit a completed Continuation Coverage Election with Coverage Options Form by the eligibility expiration date, you will lose your right to elect mini-COBRA coverage. If you reject mini-COBRA coverage before the due date, you may change your mind as long as you furnish a completed Continuation Coverage Election with Coverage Options Form before the eligibility expiration date.

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

I am aware that coverage under my employer's 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, I (we) elect continuation coverage in my group level health benefit program and wish to change my continuation coverage option to my group health plan's _____ lower cost plan, if applicable.

❒ Yes, my spouse and/or dependents were covered under my 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

_____

Telephone Number

Current Address _____

_____

Following to be completed by the employer:

Eligibility expiration date: _____

Account name: _____

Contact name: _____

Street address: _____

City:_____State:_____Zip code:_____

Telephone number:_____

Summary of the Continuation Coverage Premium Reduction Provisions under ARRA, as Amended

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. ARRA has been amended twice: On December 19, 2009, the President signed the Department of Defense Appropriations Act, 2010 and on March 2, 2010 the President signed the Temporary Extension Act of 2010. These laws give "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 15 months.

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

- **MUST** have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at any time from September 1, 2008 through March 31, 2010;*
- **MUST** elect the coverage;
- **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.[1]

* The involuntary termination must occur on or after March 2, 2010 if it is preceded by a qualifying event that was a reduction of hours occurring at any time from September 1, 2008 through March 31, 2010.

♦ IMPORTANT ♦

- ◊ If, after you elect continuation coverage 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.

For general information regarding our continuation coverage please contact us.

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.ContinuationCoverage.net or call **(866) 400-6689**

[1] 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 with Coverage Options 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, as Amended.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Account Name	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, none of your answers below can be No.

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 March 31, 2010.	Yes ❒	No ❒
3. If the loss of employment was preceded by a qualifying event that was a reduction of hours, the reduction of hours took place at some point from September 1, 2008 through March 31, 2010, AND the loss of employment occurred from March 2, 2010 through March 31, 2010.	Yes ❒	No ❒ N/A ❒
4. I elected (or am electing) continuation coverage.	Yes ❒	No ❒
5. 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 ❒
6. 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 #5 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 from September 1, 2008 through March 31, 2010.	❒
3. The qualifying event was a reduction of hours and was not followed by a termination of employment (or the termination occurred prior to March 2, 2010 or after March 31, 2010).	❒
4. Individual did not elect continuation coverage.	❒
5. Other (please explain)	❒

Beneficiary's Blue Cross Blue Shield of Massachusetts 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.

Relationship to Beneficiary	Social Security Number	Name	Date of Birth

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.

Relationship to Beneficiary	Social Security Number	Name	Date of Birth

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.

Participant Notification

Employer name:	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:

_____ _____

_____ _____