Mini-COBRA Continuation Coverage Supplemental Information Subsidy Notice

Instructions for Employers

For qualified beneficiaries who elected and maintained mini-COBRA continuation coverage based on a qualifying event that was a reduction of hours that occurred from September 1, 2008 through May 31, 2010, followed by a termination of employment that occurred from March 2, 2010 through May 31, 2010 to advise them of the potential availability of the premium reduction.

1. All of the following pages must be sent to all beneficiaries who elected and currently maintain mini-COBRA continuation coverage due to a qualifying event that was a reduction in hours that occurred from September 1, 2008 through May 31, 2010, followed by a termination of employment that occurred from March 2, 2010 through May 31, 2010 to advise them of the potential availability of the premium reduction.

2. The following pages should be sent if you **DO NOT** 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.

3. In the **Mini-COBRA Continuation Coverage Supplemental Information Subsidy Notice**, 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. **Continuation coverage currently costs:** Enter the amount each qualified beneficiary is currently paying per month of coverage.

5. **This cost can be reduced to:** Enter the amount that is 35 percent of the continuation coverage cost.

6. **Until your mini-COBRA coverage expires:** Enter the date that is 18 months from the date the reduction of work hours occurred.

7. **The date your premium reduction would be effective is:** Enter the date the next coverage period begins, following the involuntary termination of employment.

8. 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 Supplemental Information Subsidy Notice

For qualified beneficiaries who elected and maintained mini-COBRA continuation coverage based on a qualifying event that was a reduction in hours that occurred from September 1, 2008 through May 31, 2010, and was followed by a termination of employment that occurred from March 2, 2010 through May 31, 2010 to advise them of the potential availability of the premium reduction.

Date:_____

Dear:_____

This notice contains important information about additional rights you may have related to your mini-COBRA continuation 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), the Temporary Extension Act of 2010 (TEA), and the Continuing Extension Act of 2010, reduces the mini-COBRA continuation coverage premium in some cases. You are receiving this notice because you elected mini-COBRA continuation coverage after experiencing a qualifying event that was a reduction of hours that occurred from September 1, 2008 through May 31, 2010 and was followed by a termination of employment that occured from March 2, 2010 through May 31, 2010. If your termination of employment was involuntary, you may be eligible for the temporary premium reduction for up to fifteen months or until your mini-COBRA coverage expires, whichever occurs first. 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 believe you meet the criteria for the premium reduction, complete the Request for Treatment as an Assistance Eligible Individual and return it to us.**

Your mini-COBRA continuation coverage currently costs_____.

If you qualify as an assistance eligible individual this cost can be reduced to_____ for up to fifteen months or until your mini-COBRA coverage expires on_____ (the date that is 18 months from the date the reduction in work hours occurred), whichever occurs first.

The date your premium reduction would be effective is_____.

Please see the following Q&A for more details.

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), as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010 (TEA), and further amended by the Continuing Extension Act of 2010, 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 May 31, 2010, or a qualifying event that is a reduction of hours occurring at any point from September 1, 2008 through May 31, 2010 followed by an involuntary termination occurring on or after March 2, 2010 through May 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, or until your mini-COBRA coverage expires, whichever occurs first. If your mini-COBRA continuation coverage lasts for more than fifteen 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, 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**.

Other than the amount, nothing else about your mini-COBRA coverage or payments will change. You may contact us to confirm the correct amount of your first payment or to discuss payment issues related to this ARRA premium reduction.

If you have any questions about this notice, please contact us at the number listed on the first page of this notice.

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).

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 on three occasions: On December 19, 2009, by the Department of Defense Appropriations Act, 2010, on March 2, 2010 by the Temporary Extension Act of 2010, and on April 15, 2010 by the Continuing 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 May 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 May 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.

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 May 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 May 31, 2010, AND the loss of employment occurred from March 2, 2010 through May 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 May 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 May 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:

_____ _____

_____ _____