Mini-COBRA Subsidy Notice with Coverage Options

For qualified beneficiaries currently enrolled in Massachusetts mini-COBRA coverage due to qualifying events that occurred on or after September 1, 2008, to advise them of the potential availability of the premium reduction and lower cost plan option.

1. This notice must be sent to all beneficiaries currently enrolled in Massachusetts mini-COBRA coverage due to qualifying events that occurred on or after September 1, 2008, to advise them of the potential availability of the premium reduction and lower cost plan option.

2. This form (Mini-COBRA Subsidy Notice with Coverage Options) should be used **ONLY** if you wish to permit Assistance Eligible Individuals to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred. Please note that the different coverage must cost the same or less than the coverage the individual had at the time of the qualifying event; be offered to active employees; and cannot be limited to only dental coverage, vision coverage, counseling coverage, a Flexible Spending Account (FSA), including a Health Reimbursement Arrangement that qualifies as an FSA, or an on-site medical clinic.

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

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

6. **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.

7. **Form for Switching Continuation Coverage Options:** Enter the date by which the form should be returned to you.

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

Account name: ___________________________________
Contact name: __________________________________
Street address: _________________________________
City, State, Zip Code: ____________________________
Telephone number: ______________________________

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For qualified beneficiaries currently enrolled in Massachusetts mini-COBRA coverage due to qualifying events that occurred on or after September 1, 2008, to advise them of 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) reduces the continuation coverage premium in some cases. You are receiving this notice because you experienced a loss of coverage at some time on or after September 1, 2008 and chose to elect Massachusetts mini-COBRA continuation coverage. If your loss of health coverage was due to an involuntary termination of employment, you 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 to us at the above address.**

To change the coverage option(s) for your continuation coverage to something different than what you had on the last day of employment, complete the "Form for Switching Continuation Coverage Benefit Options" and return it to us. Available coverage options are: ____

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

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 number above.

Notice of Right to Continue Group Health Coverage for Mini-COBRA

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 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?
Whether or not you qualify for the premium subsidy, your premium payment must be received in full each month on or by the ____ day of the month to ensure that your coverage remains current. Late or missing payments may result in an interruption or cancellation of mini-COBRA coverage.

For More Information
This notice does not fully describe mini-COBRA continuation coverage. More information about continuation coverage and your rights under your group health plan is available in your original mini-COBRA election notice, the summary plan description, or from us at the address on the previous page.

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.

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[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.

Form for Switching Continuation Coverage Benefit Options

Instructions: To change the benefit option(s) for your continuation coverage to something different than what you had on the last day of employment, complete this form and return it to us.
Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.

Send the completed form to the address listed below.
It must be post-marked no later than ___________________________

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

Please check one box:

Yes, I (We) would like to change to my group health plan's lower cost plan, if available.

No, I (We) do not wish to change to my group health plan's lower cost plan, if available.

______________________________________ ______________________________

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 at the address listed below.

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.

Statement	
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

Reason	
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:

____________________________________ ____________________________________

____________________________________ ____________________________________