Mini-COBRA Continuation Coverage Election and Subsidy Notice with Coverage Options–Revised March 2010 Instructions for Employers

For qualified beneficiaries who have not yet elected or been notified of their right to elect mini-COBRA continuation of coverage due to qualifying events that occur/occurred during the period that begins with September 1, 2008 and ends with March 31, 2010, to advise them of their election rights and the potential availability of premium reduction and lower cost plan option.

1. This notice must be sent to all beneficiaries who have not yet elected or been notified of their right to elect mini-COBRA continuation of coverage due to qualifying events that occur/occurred during the period that begins with September 1, 2008 and ends with March 31, 2010, to advise them of their election rights and the potential availability of premium reduction and lower cost plan option. (Note: Individuals who experienced a qualifying event on or after October 31, 2009 and have already elected mini-COBRA do not need to complete new forms.)

2. This form (Mini-COBRA Continuation Coverage Election and Subsidy Notice with Coverage Options–Revised March 2010) should be used **ONLY** if you 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. 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 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.

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

7. **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.

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

9. 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 who have not yet elected or been notified of their right to elect mini-COBRA continuation of coverage due to qualifying events that occur/occurred during the period that begins with September 1, 2008 and ends with March 31, 2010, to advise them of their election rights and the potential availability of 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, reduces the continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a qualifying event that was an involuntary termination of employment that occurred during the period that begins with September 1, 2008 and ends with March 31, 2010, may be eligible for 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" 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, follow the instructions on the following pages to complete the enclosed Continuation Coverage Election Form and submit it to us. (If you have already completed and returned a Continuation Coverage Election form, you do not need to complete a new one.)

If you do not elect Massachusetts mini-COBRA continuation coverage, your coverage under the group health plan will end on _____.

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

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 fifteen 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 on the previous page.

Notice of Right to Continue Group Health Coverage for Mini-COBRA
Including Important Information About Premium Reduction Under Federal Law

What is mini-COBRA continuation coverage?
State law gives you (and your spouse and/or dependents if they were covered under your plan) the right to continue coverage under your present group health plan if you wish. The length of time you may continue coverage is shown under each situation listed below.

- **Death of an employee**
  - The surviving spouse and/or any dependent children may continue group coverage for up to 36 months.
- **The employee becomes ineligible for group health coverage after involuntary or voluntary termination of employment or reduction of work hours.**
  - All family members covered under the employee's health plan may continue group health coverage for up to 18 months. Note: If you are qualified for Medicare disability at the time you lose coverage, or within 60 days of your loss of coverage, you must notify us 60 days before the end of the 18-month period to continue coverage for an additional 11 months. The premium for the additional 11 months may be up to 150 percent of the premium for active employees.
- **Divorce or legal separation**
  - The spouse and/or any covered dependent children may continue group health coverage for up to 36 months.
- **The employee becomes entitled to Medicare coverage.**
  - The spouse, if not also enrolled in Medicare, and/or any dependent children may continue group coverage for up to 36 months.
- **A child ceases to be a dependent under the employee's family membership**.
  - The child may continue group coverage for up to 36 months.
- **A retiree substantially loses coverage within one year before or after we file for bankruptcy**.
  - The retiree, spouse, and/or dependents may continue coverage until the death of the retiree, or up to 36 months after the death of the retiree for the qualified surviving spouse and dependents.

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

- We cease to maintain a group health plan;
- You fail to pay the premium on time;
- You are covered under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition; or
- You are 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 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), as amended by the Department of Defense Appropriations Act, 2010, and further amended by the Temporary 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 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 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**.

[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).

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 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.

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.

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, 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
_____	
_____	
_____	_____
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 ARRA, as Amended

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. On December 19, 2009, the President signed the Department of Defense Appropriations Act, 2010. 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.*

Individuals whose nine month premium reduction ended also have an opportunity to make a payment to continue coverage at the reduced rates. These payments must be made by the later of February 17, 2010, 30 days from the date the notice regarding the ARRA amendment that extended the premium reduction to 15 months was provided, or the end of the otherwise applicable payment grace period.

♦ 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**

* 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, as Amended."

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 March 31, 2010.	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 March 31, 2010.	☐
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:

_____ _____

_____ _____