Model COBRA Continuation Coverage Supplemental Notice
(For use by group health plans for qualified beneficiaries currently enrolled in COBRA coverage to advise them of the availability of the premium reduction.)

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies), by name or status*]

This notice contains important information about additional rights you may have related to your COBRA continuation coverage in the [*enter name of group health plan*] (the 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, and the Temporary Extension Act of 2010 (TEA), reduces the COBRA premium in some cases. You are receiving this notice because you elected COBRA continuation coverage after experiencing a qualifying event that was:

- a termination of employment at some time on or after March 1, 2010 OR
- a reduction of hours that occurred during the period from September 1, 2008 through March 31, 2010 and was followed by a termination of employment that occurred on or after March 2, 2010 but by March 31, 2010.

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 15 months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" for 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 [*insert mailing address*].**

[*Only use this model form if the plan permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred.*]

Form for Switching COBRA Continuation Coverage Benefit Options

Instructions: To change the benefit option(s) for your COBRA 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 completed form to: [*Enter Name and Address*]

This form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

THIS IS NOT YOUR ELECTION NOTICE
YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR COBRA CONTINUATION COVERAGE.

I (We) would like to change the COBRA continuation coverage option(s) in the [*enter name of plan*] (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

Old Coverage Option: _____

New Coverage Option: _____

b. _____

Old Coverage Option: _____

New Coverage Option: _____

c. _____

Old Coverage Option: _____

New Coverage Option: _____

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____

_____ _____

Print Address Telephone number

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

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 [*add if applicable:* open enrollment and] special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[*If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:*]

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation 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 employee 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 the Temporary Extensions Act of 2010 reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to COBRA 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 and by March 31, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

[*If employees might be eligible for trade adjustment assistance, the following information must be added*: 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). 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 nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

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. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.]

When and how must payment for COBRA continuation coverage be made?

Other than the amount, nothing else about the payment has changed. All periodic payments for continuation coverage should be sent to: [*enter appropriate payment address*]

You may contact [*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov.

Keep Your Plan Informed of Address Changes

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

Summary of the COBRA 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 COBRA 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 from September 1, 2008 through March 31, 2010.

◆ 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 on ARRA at www.irs.gov.

For general information regarding your plan's COBRA coverage you can contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For specific information related to your plan's administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact [*enter name of party responsible for ARRA Premium Reduction administration for the Plan, with telephone number and address*].

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.dol.gov/COBRA or call 1-866-444-EBSA (3272)

[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 Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: [*Enter Name and Address*]

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA, as Amended."

[*Insert Plan Name*]	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	[*Insert Plan Mailing Address*]

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number E-mail 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 between September 1, 2008 and March 31, 2010 AND the loss of employment occurred on or after March 2, 2010.	☐ Yes ☐ No ☐ N/A
4. I elected (or am electing) COBRA 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 employee → _____

FOR EMPLOYER OR PLAN 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 between September 1, 2008 and 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 COBRA coverage.	☐
5. Other (please explain)	☐

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

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

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. I elected (or am electing) COBRA 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 employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. I elected (or am electing) COBRA 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 employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. I elected (or am electing) COBRA 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 employee → _____

This form is designed for plans to distribute to COBRA qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

Plan Name	**Participant Notification**	Plan Mailing Address

PERSONAL INFORMATION

Name and mailing address	Telephone number
	E-mail 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 plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA 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:

_____ _____