



(Please note that recently signed legislation changes the terms of state continuation law for group employer policies and contracts issued or renewed in Ohio on or after April 2, 2009.)

Continuation Coverage Election Notice

(For use where coverage is subject to State continuation requirements during the period that begins with Feb. 17, 2009 and ends with December 31, 2009.)

[Enter date of notice]

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

This notice contains important information about your right to continue your health care 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) reduces the continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 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, reference 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 with your completed Election Form.**

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to us.

If you do not elect continuation coverage, your coverage under the Plan will end on [enter date] due to [check appropriate box(es)]:

- End of employment
- Involuntary Voluntary

Eligible employees are entitled to elect continuation coverage for themselves and their eligible dependents which will continue group health care coverage under the Plan for up to 6 months. 12 months for group employer policies or contracts issued or renewed on or after April 2, 2009.

If elected, continuation coverage will begin on [enter date] and can last until [enter date - consult the employer group policy to determine if the coverage lasts for six months(contracts issued or renewed on or before April 1, 2009) or for twelve months for those issued on or after April 2, 2009].

[Add, if appropriate: You may elect any of the following options for continuation coverage: [list available coverage options].

[If the issuer 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, insert: “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: [insert list of available coverage options].” 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 arrangement (FSA), including a health reimbursement arrangement that qualifies as an FSA, or an on-site medical clinic.]

Continuation coverage will cost: *[enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods]*. If you qualify as an “Assistance Eligible Individual” this cost can be reduced to *[include the amount that is 35 percent of the amount above for each option]* for up to nine months. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact *[enter name of party responsible for continuation coverage administration for the issuer, with telephone number and address]*.

Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under state law you have a limited number of days to decide whether you want to elect continuation coverage. Your employer must receive the request:

- (a) 10 days after the date your coverage would end if your employer has notified you of your continuation right prior to that date; or
- (b) 10 days after your employer notifies you of your right to continuation if the notice is given after the date your coverage ends; or
- (c) 31 days after your coverage ends if that date is earlier than the date you get notice under (b).

Send completed Election Form to: *[Enter Name and Address]*

This Election 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]*.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting continuation coverage, your continuation coverage will begin on the date you furnish the completed Election Form.

I (We) elect continuation coverage in the *[enter name of plan]* (the Plan) as indicated below:

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

[Add if appropriate: Coverage option(s): _____]

b. _____

[Add if appropriate: Coverage option(s): _____]

c. _____

[Add if appropriate: Coverage option(s): _____]

Signature

Date

Print Name

Print Address

Telephone number

[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 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 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 CONTINUATION COVERAGE.

I (We) would like to change the 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)
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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

Print Address

Telephone number

Important Information about Your Continuation Coverage Rights

What is continuation coverage?

State law requires group sickness and accident policies and group health insuring corporation contracts to provide continuation coverage to eligible employees, and their eligible dependents. You are an eligible employee if you have been covered under your former employer's health care coverage for the past three months, you are entitled to unemployment compensation coverage, and you are not covered by or eligible for coverage under Medicare or any other group health care coverage. Group employer policies or contracts issued or renewed on or after April 2, 2009, eliminate the requirement that the employee be entitled to unemployment compensation and instead require that the employee has been involuntarily terminated for other than gross misconduct.

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, except that under state law the continuation coverage is not required to include benefits in addition to hospital, surgical or major medical coverage. Group employer policies or contracts issued or renewed on or after April 2, 2009, must include prescription drugs in any continuation coverage if those were covered under the group policy or contract.

How long will continuation coverage last?

State continuation coverage lasts for six months; this has been temporarily extended to twelve months for group employer policies or contracts issued or renewed on or after April 2, 2009, in order to allow Ohioans to take advantage of the full nine months of the federal premium reduction opportunity.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form.

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 continuation coverage cost?

[Insert general information regarding the cost of continuation coverage.]

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation 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 beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the continuation coverage premium otherwise due to the issuer. This premium reduction is available for up to nine months, but is limited to the extent you are eligible for state 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.

[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% 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% 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 continuation coverage be made?

[Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.]

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

Your payment(s) for continuation coverage should be sent to:

[enter appropriate payment address]

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from *[enter appropriate contact information for the party responsible for continuation coverage administration under the Plan]*.

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

For more information about your rights under state law, contact the Ohio Department of Insurance at 1(800) 686-1526.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep [*enter name and contact information for the appropriate party responsible for continuation coverage administration under the Plan*] 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 [*enter the name of the party responsible for continuation coverage administration under the Plan*].

Summary of the Continuation Coverage Premium Reduction Provisions under ARRA



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 9 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 state 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 continuation coverage you can contact [*enter name of party responsible for continuation coverage 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 issuer 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.cms.hhs.gov/COBRAContinuationofCov or 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 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 Continuation Coverage Premium Reduction Provisions Under ARRA."

[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, you must be able to check 'Yes' for all statements.

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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 ISSUER 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.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/>
3. Individual did not elect continuation coverage.	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

Signature of party responsible for continuation coverage 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) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> 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) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> 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) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> 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 issuers to distribute to qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the issuer if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your issuer that you are eligible for other group health plan coverage or Medicare.

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 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:
