pennsylvania
INSURANCE DEPARTMENT

Model Continuation Coverage Election Notice
(For use where coverage is subject to State continuation (mini-COBRA) requirements during the period that begins with July 10, 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 federal 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 July 10, 2009 and ends with December 31, 2009 may be eligible for the temporary premium reduction for the nine months of continuation coverage. 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 federal "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 Continuation Coverage Election Form.**

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Continuation Coverage 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
- £ Divorce or legal separation
- £ Death of employee
- £ Entitlement to Medicare
- £ Reduction in hours of employment
- £ Loss of dependent child status

Each person in the category(ies) checked below is entitled to elect continuation coverage, which will continue group health care coverage under the Plan for up to nine (9) months *[Check appropriate box or boxes; names may be added]*:

- £ Employee or former employee
- £ Spouse or former spouse
- £ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- £ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, continuation coverage will begin on [*enter date*] and can last until [*enter date*].

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 – not more than 105% of the group rate of the insurance being continued on the due date of each payment*]. If you qualify as an "Assistance Eligible Individual" this cost may be reduced to [*include the amount that is 35 percent of the amount above for each option*] for each of the nine months of continuation coverage. You do not have to send any payment with the Election Form. 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, with telephone number and address*].

Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under Pennsylvania law, you have thirty (30) days after the date of this notice to decide whether you want to elect continuation coverage.

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.

Read the important information about your rights included in the pages after the 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)
a.			
b.			
c.			

_____ _____

Signature Date

_____ _____

Print Name Relationship to individual(s) listed above

_____

_____

_____ _____

Print Address Telephone number

Important Information about Your Continuation Coverage Rights

What is continuation coverage?

Pennsylvania law requires this group health insurance coverage give employees and their families the opportunity to continue their coverage for up to nine months 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, covered employees and eligible dependents may 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, with no break in 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.

Who is eligible, and how long will continuation coverage last?

Employees and eligible dependents who have been continuously insured under the group policy or for similar benefits under any group policy which it replaced, for the three consecutive months ending with the employee's termination by a qualifying event. Continuation coverage is not available if:

(1) the employee or eligible dependent is eligible for coverage under Medicare;

(2) the employee or eligible dependent fails to verify that he is ineligible for employer-based group health insurance as an eligible dependent;

or

(3) the employee or eligible dependent is or could be covered by any other insured or uninsured arrangements that provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to the termination of the employee's group coverage (excluding Medicaid, CHIP – the Children's Health Insurance Program, and adultBasic).

Coverage may be continued for up to nine (9) months. However, if any of these three events happens after continuation coverage has begun, eligibility for coverage ends, and the employee or eligible dependent is required to provide written notice to the administrator within fourteen (14) days that coverage should not occur.

In addition, continuation coverage will end:

(1) if the employee or eligible dependent fails to make timely payment of a required premium contribution;

or

(2) if the group coverage is terminated.

How can you elect continuation coverage?

To elect continuation coverage, each covered employee or eligible dependent must complete the Continuation Coverage Election Form and furnish it according to the directions on the Form. Unless an eligible dependent's election otherwise specifies, election of continuation coverage by an eligible dependent will be deemed an election of continuation coverage on behalf of any other eligible dependent who would lose coverage by reason of the qualifying event.

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 and state 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; 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, if you have a right to a conversion policy under section 621.2 of the Insurance Company Law of 1921 (40 P.S. §756.2), you will lose the right to a conversion policy if you do not elect continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

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 – not more than 105% of the group rate of the insurance being continued on the due date of each payment*]. You do not have to send any payment with the Continuation Coverage Election Form.

The federal 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 July 10, 2009 and ending December 31, 2009. If you qualify for the premium reduction, you need only pay 35% of the continuation coverage premium otherwise due. This premium reduction is available for up to nine months. 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, your rights to coverage you should contact [*enter name of party responsible for continuation coverage administration, with telephone number and address*].

For more information about your rights under state law, contact:

Pennsylvania Insurance Department
Toll-free, Automated Consumer Hotline: 1-877-881-6388
Harrisburg Regional Office: (717) 787-2317
Philadelphia Regional Office: (215) 560-2630
Pittsburgh Regional Office: (412) 565-5020
ra-in-consumer@state.pa.us

Keep Your Administrator 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*] 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*].

Summary of the Continuation Coverage Premium Reduction Provisions under ARRA*

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. For a limited period of time, the law gives "Assistance Eligible Individuals" the right to pay reduced continuation coverage premiums. Applying ARRA to Pennsylvania's Mini-COBRA Law, to be considered an Assistance Eligible Individual and get reduced premiums you:

- Ø MUST be eligible for continuation coverage at any time during the period from July 10, 2009 through December 31, 2009 and elect the coverage;
- Ø MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time on or after July 10, 2009 through December 31, 2009;
- Ø MUST NOT be eligible for Medicare; AND
- Ø 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 Mini-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 continuation coverage you may contact [*enter name of party responsible for continuation coverage administration, with telephone number and address*].

For specific information related to your insurer's administration of the ARRA Premium Reduction or to notify the Administrator of your ineligibility to continue paying reduced premiums, contact [*enter name of party responsible for ARRA Premium Reduction administration, 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

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* Modified to be consistent with Pennsylvania's Mini-COBRA Law, Act 2 of 2009.

** Must provide hospital, surgical or major medical coverage for individuals in a group; 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.	£ Yes £ No
2. The loss of employment occurred at some point on or after July 10, 2009 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 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.	£
2. The involuntary loss did not occur between July 10, 2009 and December 31, 2009.	£
3. Individual did not elect continuation coverage.	£
4. Other (please explain):	£

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.	£ 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) 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) 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 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:

_____ _____

_____ _____