

**Continuation Coverage Premium Reduction Election Notice
For Those Employed by Employers with Fewer than Twenty Total Employees**

This notice contains important information about additional rights you may have related to your Vermont continuation coverage under your previous employer's 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, reduces health insurance 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 March 31, 2010 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 Continuation Coverage Premium Reduction Provisions under ARRA, as Amended" with details regarding eligibility, restrictions, and obligations and the "Request for Treatment as an Assistance Eligible Individual."

To be considered an Assistance Eligible Individual and get reduced premiums you:

- **MUST** elect the coverage (YOU MUST CONTACT YOUR FORMER EMPLOYER TO ELECT HEALTH INSURANCE CONTINUATION 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 March 31, 2010;
- **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.*

If you believe you meet the criteria for the premium reduction, complete the attached "Request for Treatment as an Assistance Eligible Individual".

For general information your Plan's COBRA coverage, you should contact your previous employer. If you have questions about the premium subsidy reduction, you may contact Blue Cross and Blue Shield of Vermont at (888) 445-5805.

* 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.

Important Information about Your Continuation Coverage Rights

What is continuation coverage?

State law requires that most group health insurance coverage give employees and their families the opportunity to continue their 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 or civil union partner, 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.

How long will continuation coverage last?

Coverage may last up to 18 months. Coverage will terminate 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).

Note: Eligibility for the ARRA premium reduction subsidy will end when you become eligible for group coverage or Medicare, whether or not you actually enroll in that coverage. You must notify us if you lose eligibility for these reasons or you may be subject to a penalty.

How can you elect continuation coverage?

To elect continuation coverage, you must follow the instructions provided to you by your former employer (usually completion of an Election Form and payment of amounts required to keep coverage in force).

How can you apply for the premium reduction subsidy?

Once you have elected continuation coverage through your employer, you must complete the attached Request for Treatment as an Assistance Eligible Individual form and return it to:

Subsidy Service Area
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601

How much does 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 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. If your coverage lasts more than 15 months, you will have to pay the full amount to continue your 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 American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act 2010, 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 March 31, 2010. 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 15 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.

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?

When you notify your employer that you are electing continuation coverage, you must pay the initial contribution, which must include payment for the period from the qualifying event through the end of the month in which the election is made. If you do not make payment of the initial contribution when you elect continuation coverage, you will lose all continuation rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact your previous employer to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Other than the amount, which may now include a fee charged by your employer of up to 2 % of your total payment, nothing else about the payment has changed. All periodic payments for continuation coverage should be sent to the address detailed in the continuation coverage election notice sent to you by your employer.

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from your employer or your employer’s Plan Administrator.

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. 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 elect the coverage (YOU MUST CONTACT YOUR FORMER EMPLOYER TO ELECT HEALTH INSURANCE CONTINUATION 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 March 31, 2010;
- 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 9 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 February 17, 2010 or, if later, within 30 days from receipt of notice regarding the ARRA amendment that extended the premium to 15 months.

◆ 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.
- ◇ **Special note about Vermont’s Catamount premium assistance program:** You may be eligible for state premium assistance for coverage under Vermont’s Catamount health insurance. In some situations, the available state assistance may be more valuable than the premium reduction under federal law. You should contact Green Mountain Care at www.greenmountaincare.org or toll free at 1-800-250-8427 for assistance. You may also obtain more information about Catamount Blue at www.bcbsvt.com or by calling us at **(888) 445 – 5805**.

For general information regarding continuation coverage, you should contact your previous employer.

* 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 notify the issuer of your ineligibility to continue paying reduced premiums, contact Blue Cross and Blue Shield of Vermont at (888) 445-5805.

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:

- visit www.cms.hhs.gov/COBRAContinuationofCov or
- email NewCobraRights@cms.hhs.gov.

To apply for ARRA Premium Reduction, complete this form and return it to:

Subsidy Service Area
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601

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."

**REQUEST FOR TREATMENT AS AN ASSISTANCE
ELIGIBLE INDIVIDUAL**

EMPLOYEE PERSONAL INFORMATION

| | |
|--|---------------------------|
| Name | Telephone number |
| Mailing Address (list any dependents on the back of this form) | 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 March 31, 2010. | <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 |
| 6. I was covered by the employer's group health plan preceding termination from employment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Termination from employment was NOT for gross misconduct. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Date of termination from employment _____ (mm/dd/yy) | |

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 X _____ Date _____ (mm/dd/yy)
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 March 31, 2010. | <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

X _____ Date _____ (mm/dd/yy)

Type or print name _____
Telephone number _____ E-mail address _____

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

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

| | |
|--|--|
| 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 _____ (mm/dd/yy)

Type or print name _____ Signees relationship to employee _____

DEPENDENT B

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

| | |
|--|--|
| 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 _____ (mm/dd/yy)

Type or print name _____ Signees relationship to employee _____

DEPENDENT C

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

| | |
|--|--|
| 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 _____ (mm/dd/yy)

Type or print name _____ Signees relationship to employee _____