



Utah mini-COBRA Continuation Coverage Election Notice

_____ *date of notice*

Dear: _____
qualified beneficiary(ies) identified by name or status

This notice contains important information about your right to continue your health care coverage in the _____ (the Plan). Please read the information contained in this notice very carefully.
name of group health plan

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, reduces the amount you will owe for continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a qualifying event that occurred during the period that begins with September 1, 2008 and ends with February 28, 2010 may be eligible for the temporary premium reduction for up to 15 months. ***Utah mini-COBRA, however, is only available for a maximum of 12 months, so that would be the maximum period of premium reduction available to the Plan.*** 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 “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 _____ due to:

date

- 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
- Sabbatical
- Disability
- Leave of absence

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 12 months

- 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 _____ and can last until _____.

date

date

Continuation coverage will cost:

_____.

monthly amount(s) each qualified beneficiary will be required to pay for each option

If you qualify as an “Assistance Eligible Individual” this cost can be reduced to

_____.

35% of the amount above for each option

for up to 12 months. 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

_____.

name of party at the group 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 the Utah mini-COBRA law (Utah Code §31A-22-722), you generally have 60 days after your loss of coverage to decide whether you want to elect continuation coverage.

Send completed Election Form to: _____
Name and address

This Election Form must be completed and returned by mail, postmarked no later than _____
Date

[or describe any other means of submission and due 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 _____ (the Plan) as indicated below:

Name of plan

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

Relationship to individual(s) listed above

Print Address

Telephone number

Important Information about Your Continuation Coverage Rights

What is continuation coverage?

Utah law requires that most group health insurance coverage (including this 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, 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 special enrollment rights.

How long will continuation coverage last?

Coverage may be continued without interruption for 12 months. Coverage will be terminated before the 12 months if:

- Residence is established outside this state;
- Insured moves out of the insurer’s service area;
- Insured fails to pay premiums or contributions in accordance with the terms of the policy, including any timeliness requirements;
- Insured performs an act or practice that constitutes fraud in connection with the coverage;
- Insured makes an intentional misrepresentation of material fact under the terms of the coverage;
- Insured becomes eligible for similar coverage under another group health plan; or
- The employer’s coverage is terminated.

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?

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 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 relating to continuation coverage that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with February 28, 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 12 months. . 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). 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?

Under normal circumstances, your payments of premiums for continuation coverage are due to

by **group name**

requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods

The Department of Defense Appropriations Act, 2010 provides an extended period of time for certain periods of coverage. If you already have exhausted the former maximum reduced premium period and have additional months of continuation coverage available, you can make a retroactive payment of the reduced premium(s) for the period(s) of coverage immediately following what would have been the last period subject to the premium reduction. This payment must be made by the later of February 17, 2010, 30 days from the date this notice was provided to you, or the end of the otherwise applicable payment grace period.

Contact _____ at

Group name 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:

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

contact information for the party at the group 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

name of party at the group responsible for continuation coverage administration for the Plan, with telephone number and address

For more information about your rights under state law, contact the Utah Insurance Department at (801) 538-3800, toll-free in Utah at (800) 439-3805, or visit the department's website at www.insurance.utah.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep

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. *group name and contact information*

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. Utah mini-COBRA makes continuation coverage available for up to 12 months, so that is the maximum period that reduced premiums would be available under plans subject to that Utah law.

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 February 28, 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 who exhausted the nine month premium reduction available under prior law also have an opportunity to make a payment to continue coverage at the reduced rates for up to three more months. 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 your plan’s continuation coverage you can contact _____

name of party at the group responsible for continuation coverage administration for the Plan, with telephone number and address

* 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.

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 _____

name of party at the group 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.ContinuationCoverage.net or call **(866) 400-6689**

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, as Amended."

[Insert Plan Name]

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

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 February 28, 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

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 February 28, 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

→ _____ 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:
