Connecticut Continuation Coverage Additional Election Notice
For use by group health plans subject to Connecticut Continuation requirements for qualified beneficiaries who are or would be an Assistance Eligible Individual but are not enrolled in Connecticut Continuation coverage (including those who never elected AND those who elected but subsequently discontinued coverage) with qualifying events that occurred during the period from September 1, 2008 through February 16, 2009.

Date of Notice: _____

Dear: _____
(Name of Qualified Beneficiary(ies)

This notice contains important information about your right to continue your health care coverage in the _____ (the Plan).
(Name of Group Health 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. You are receiving this notice because you experienced a loss of coverage at some time from September 1, 2008 through February 16, 2009 and either chose not to elect continuation coverage at that time OR elected continuation coverage but subsequently discontinued the coverage. If your loss of health coverage was due to an involuntary termination of employment you may be eligible for a second continuation coverage election opportunity and 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.

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 the Maximum Period shown below.

Check One	Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
☐	Termination (for reasons other than gross misconduct) or reduction in hours of employment	☐ Employee ☐ Spouse ☐ Dependent Child	18 months
☐	Employee enrollment in Medicare	☐ Spouse ☐ Dependent Child	36 months
☐	Divorce or legal separation	☐ Spouse ☐ Dependent Child	36 months
☐	Death of employee	☐ Spouse ☐ Dependent Child	36 months
☐	Loss of "dependent child" status under the plan	☐ Dependent Child	36 months

If elected, continuation coverage will begin retroactively on March 1, 2009 and can last until _____.

You may elect any of the following options for medical coverage under Connecticut Continuation coverage:

☐ Medical - $ _____ per month
Option A

If you qualify as an "Assistance Eligible Individual" the rate is $ _____ per month for up to 9 months.

Rate quoted is for:

☐ Employee

☐ Employee + Spouse

☐ Employee + 1

☐ Employee + Child(ren)

☐ Family

This section should be completed 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. The different coverage must cost the same or less than the coverage they had at the time of the qualifying event and be offered to active employees.

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:

☐ Medical - $ _____ per month
Option B
Plan Name: _____

If you qualify as an "Assistance Eligible Individual" the rate is $ _____ per month for up to 9 months.

Rate quoted is for:

☐ Employee

☐ Employee + Spouse

☐ Employee + 1

☐ Employee + Child(ren)

☐ Family

☐ Medical - $ _____ per month
Option C
Plan Name: _____

If you qualify as an "Assistance Eligible Individual" the rate is $ _____ per month for up to 9 months.

Rate quoted is for:

☐ Employee

☐ Employee + Spouse

☐ Employee + 1

☐ Employee + Child(ren)

☐ Family

If you qualify as an "Assistance Eligible Individual" your cost can be reduced to 35 percent of the full cost as shown above for up to nine 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 Continuation Coverage Administrator: _____

Address; _____

Telephone #: _____

Continuation Coverage Election Form

Instructions: Under the American Recovery and Reinvestment Act you are only entitled to elect continuation coverage at this time if you lost group health plan coverage due to an involuntary termination of employment during the period that begins with September 1, 2008 and ends with December 31, 2009. To elect continuation coverage, complete this Election Form and return it to us. You have 60 days after the date of this notice to decide whether you want to elect continuation coverage under the Plan.

Send completed Election Form to: Name: _____

Address: _____

_____

This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than _____ (60 days from the date of the Election Notice).

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)

a. _____

Coverage option(s): _____

b. _____

Coverage option(s): _____

c. _____

Coverage option(s): _____

_____ Signature

_____ Date

_____ Print Name

_____ Relationship to individual(s) listed above

_____

_____

_____ Print Address

_____ Telephone number

For use with plans that permit 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. You have 90 days after the date of this notice to decide whether you want to switch benefit options.

Send completed Form to: **Name:** _____

Address: _____

_____

This Form must be completed and returned by mail. If mailed, it must be post-marked no later than _____ (90 days from the date of the Election Notice).

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 _____ the Plan) as indicated below:
Name of Plan

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

Address: _____

_____ Telephone #: _____

Important Information About Your Continuation Coverage Rights

Am I eligible to elect Continuation Coverage at this time?

Only individuals who lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period, and who did not elect continuation coverage during their first election period OR who elected but subsequently discontinued continuation coverage (for reasons other than becoming eligible for another group health plan or Medicare), are entitled to elect coverage at this time. If you lost group health coverage for any other reason between these dates and did not elect continuation coverage when it was first offered, you are not entitled to this second election period.

Am I eligible for the premium reduction?

If you lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below under the question, "How much does continuation coverage cost?"

How long will continuation coverage last?

Your coverage will begin retroactively on March 1, 2009 and can generally continue for up to 18 months from the date of your involuntary termination of employment. The duration of the premium reduction is determined separately and may not last for the entire length of your continuation coverage. See the question below entitled *"How much does continuation coverage cost?"*

Continuation coverage will be terminated before the end of the 18 month 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).

How can you extend the length of Continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administer of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must provide written proof from the Social Security Administration (SSA) to be considered disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must provide written proof of the Social Security Administration's determination of approval for disability within 60 days after the latest of: (1) the date on which SSA issues the disability determination; (2) the date on which the qualifying event occurs; or (3) the date on which the qualified beneficiary receives the COBRA general notice.

You must provide this notice to the individual shown in the "For more information" section at the end of this notice. This proof must be provided prior to the end of the first 18 months of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

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. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

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 state and 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 150-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 (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) 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. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA 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?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator or the issuer to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

The Plan ☐ **will or** ☐ **will not** send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan may be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

_____

_____

_____

You may contact the Plan Administrator or the issuer 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 with respect to your coverage. More information about continuation coverage or other rights under the Plan is available in your group health insurance certificate or from the Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage you should contact:

Continuation Coverage Administrator: _____

Address: _____

Telephone Number: _____

For more information about your rights under state law, contact the Connecticut Insurance Department, Division of Consumer Affairs at 1-800-203-3447.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator and the issuer 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 or the issuer.

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 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

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* 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.	☐ Yes ☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 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 September 1, 2008 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:

_____ _____

_____ _____