

COBRA PREMIUM ASSISTANCE NOTICE AND ELECTION FORM American Reinvestment and Recovery Act of 2009 (ARRA)

The American Recovery and Reinvestment Act provides COBRA health premium assistance (subsidy) for qualified beneficiaries (known as assistance eligible individuals). The act requires that employers pay 65% of the monthly COBRA health premium and the qualified beneficiary pays 35% of the monthly COBRA health premium. This provision includes medical, dental, and vision coverage.

An Assistance Eligible Individual (AEI) is a COBRA qualified beneficiary whose employment is involuntarily terminated between September 1, 2008 and May 31, 2010 and loses coverage during this period. Eligible dependents are also considered an AEI based on their enrollment under the former employee's plan.

As a COBRA qualified beneficiary you may be eligible to receive premium assistance to pay monthly dental and vision COBRA premiums, if you meet the eligibility requirements listed in this notice under "Requirements for Premium Assistance."

The purpose of this notice and application is to allow an AEI the opportunity to elect the premium assistance for dental and vision coverage. In order to request the premium assistance, please complete this form and return to the address on page 4.

Requirements for Premium Assistance

To qualify for the subsidy, you must be able to check 'Yes' for all statements below*

1. The loss of employment was involuntary. Yes No
2. The loss of employment occurred on or after September 1, 2008 and on or before May 31, 2010. Yes No
3. I elected (or I am now electing) COBRA continuation coverage.* Yes No
4. I am NOT enrolled in 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

***New Election Period**

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through the date of this notice and you were eligible for, but did not elect COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. If you believe this applies to you, and would like to elect COBRA Continuation coverage, complete the enclosed ARRA Election form.

High Income Individual

High Income Individuals (HIE) who take the subsidy will be subject to increased tax liability for any subsidy taken in the tax year they receive the subsidy.

Tax liability is increased, to achieve repayment of a portion of the subsidy, for those taxpayers whose modified adjusted gross income is between \$125,000 and \$145,000, or \$250,000 and \$290,000 for those filing joint returns. If a taxpayer's modified adjusted gross income exceeds \$145,000, \$290,000 for those filing joint returns, the full amount of the subsidy must be repaid as an additional tax. There is no additional tax for individuals with modified adjusted gross income less than these income levels.

COBRA Premium Payments

Payment of monthly COBRA premiums must be paid to the plan timely. Failure to pay COBRA premiums timely will result in the termination of your continuation coverage.

COBRA premium assistance ends under the following eligibility conditions

1. You are covered under another group dental and/or vision plan;
2. You have received subsidy for 15 months;
3. Your maximum 18-month COBRA continuation period ends during the 15 months;
4. You become eligible for Medicare.

You must notify the plan(s) if eligibility for the subsidy ends based on the conditions reflected above. Failure to notify the plan of an event that will result in a loss of the subsidy, will subject the AEI to penalties of 110% of the subsidy after termination of eligibility.

Waive Your Rights to Elect Premium Subsidy

If you choose not to elect COBRA on page 3 of this form or this form is not received or postmarked within 60 days from the "Date Notice Sent" on page 4, it will be considered a waiver of the premium assistance and is irrevocable. All election rights will end. No late elections will be accepted.

Appeal Right

Assistance eligible individuals who are denied premium assistance may appeal through the U.S. Department of Health and Human Services – Centers for Medicare and Medicaid Services. If you were denied premium assistance, you may appeal this decision by completing and submitting the CMS Request for Review If You Have Been Denied Premium Assistance form located at <http://www.cms.hhs.gov/COBRAContinuationofCov/>.

Please note: The COBRA Premium assistance does not extend nor shorten the COBRA eligibility period for qualified beneficiaries. You are still required to pay 102% (full premium amount) until you are approved for subsidy) and to pay the full premium when the subsidy expires.

After your dental and/or vision plan receives your 35% of the monthly premium amount, then the plan will bill your former department for the 65% subsidy amount. Timelines to pay your portion of the monthly COBRA premium do not change.

Should you qualify for this premium assistance, there may be retroactive subsidy payments paid to the plan depending on your COBRA enrollment date. However, no subsidy payments will be applicable prior to March 1, 2009.

COBRA Premium Assistance Election Form

I choose to make an election to exercise my right to the ARRA COBRA Premium Assistance (subsidy). To the best of my knowledge and belief, all of the information I have provided on this form is true and correct.

I wish to elect the maximum 15 months of premium assistance for my dental coverage Yes No

Name of dental plan: _____

Yes No

I wish to elect the maximum 15 months of premium assistance for my vision coverage

Name of vision plan: _____

AEI Personal Information (please print)

Date: _____

Name: _____

Signature: _____

Social Security Number: _____

Home Address: _____

Phone Number: _____

If you are an AEI dependent and not the involuntarily terminated employee, please provide the employee's name and your relationship to the employee.

Employee Name: _____

Relationship to Employee: _____

Return Completed Form to the following address:

[Insert Department Name and Address here]

Questions

If you have questions regarding this notice, please contact the Personnel Office staff person listed below. It is important that you keep us informed if you have a change of address.

Name: _____ Phone Number: _____

Date Notice Sent: _____

FOR PERSONNEL OFFICE USE ONLY

THIS ELECTION FORM HAS BEEN REVIEWED FOR COBRA SUBSIDY ELIGIBILITY

This application is: Approved Denied

If denied, specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL:

- Loss of employment was voluntary.
- The involuntary loss of coverage did not occur between September 1, 2008 and May 31, 2010.
- Individual did not elect COBRA coverage.*
- Other (please explain).

Department Authorized Signature:

_____ Date _____
Type or Print Name