



Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. ARRA has been amended three times: on December 19, 2009 by the Department of Defense Appropriations Act of 2010; on March 2, 2010 by the Temporary Extension Act of 2010; and on April 15, 2010 by the Continuing Extension Act of 2010. These laws give “Assistance Eligible Individuals” the right to pay reduced COBRA 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 have a COBRA continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through May 31, 2010*; and
- MUST elect the coverage; and
- 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.¹

* The involuntary termination must occur on or after March 2, 2010 if it is preceded by a qualifying event that was a reduction of hours occurring at any time from September 1, 2008 through May 31, 2010.

◆ IMPORTANT ◆

- ◇ If, after you elect 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 your plan’s COBRA coverage or the ARRA Premium Reduction contact your former employer. To notify the plan of your ineligibility to continue paying reduced premiums, contact your former employer and the plan.

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, call 866-400-6689 (TTY: 866-631-5610) or send an email to: continuationcoverage@maximus.com.

¹ 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.

COBRA Continuation Conversion Supplemental Notice

This notice contains important information about your right to continue your health care coverage in the Plan(s) identified in the cover letter you received with this notice from your employer. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, reduces the COBRA premium in some cases. You are receiving this election notice because you experienced a qualifying event (e.g. involuntary termination of employment, reduction in hours, loss of benefit eligibility...) during the period that begins with September 1, 2008 and ends with May 31, 2010 that resulted in a loss of coverage and you may be eligible for the temporary COBRA premium reduction for up to fifteen 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 COBRA Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the *Request for Treatment as an Assistance Eligible Individual* form. **If you believe you meet the criteria for the premium reduction, complete the *Request for Treatment as an Assistance Eligible Individual* form and return it with your completed application form(s).**

To change the coverage option(s) for your COBRA continuation coverage to something different than what you had on the last day of employment you must complete a new application listing the new plan option or coverage level. The new plan option must cost the same or less than the coverage you had on the last day of employment.

Important Note applicable to the University of Wisconsin System:

Anyone who works in a Student Assistant or Employee-in-Training title who receives a STIPEND is NOT eligible for the COBRA premium reduction. There is no official employer/employee relationship – the payroll system is used to pay the stipend and to allow payroll deduction of benefits. Ineligible appointment titles include:

- Advanced Opportunity Fellow
- Fellow
- Research assistant
- Scholar
- Trainee
- Graduate Intern/Trainee
- Postdoctoral Fellow
- Postdoctoral Trainee



REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

To apply for ARRA Premium Reduction, complete this form and return it to your former employer along with your completed continuation election form(s). If you are changing coverage type or plan options, you will also need to submit a completed application form.

If you are electing continuation coverage for any of the optional plans, such as dental, you must complete and submit a separate continuation election form for each plan you wish to continue.

Section A: PERSONAL INFORMATION FOR EMPLOYEE - List dependent information on back.

Name of Employee (First Name, Middle Initial, Last Name)	Employee's Social Security Number
Mailing Address	Telephone Number
Email Address	

Section B: QUALIFICATION - 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 May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. If the loss of employment was preceded by a qualifying event that was a reduction of hours, the reduction of hours took place at some point between September 1, 2008 and May 31, 2010 AND the loss of employment occurred on or after March 2, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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
6. 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

Section C: SIGNATURE OF APPLICANT

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 EMPLOYER USE ONLY – Return copy of completed form to the applicant

Date Employment Terminated _____
 Coverage(s) in effect at time of termination: Health Anthem DentalBlue Vision Insurance EPIC
 Other _____
 This application is: Approved Denied Approved for some/denied for others (explain in #4 below)

IF DENIED, 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 May 31, 2010.	<input type="checkbox"/>
3. The qualifying event was a reduction of hours and was not followed by a termination of employment (or the termination occurred prior to March 2, 2010 or after May 31, 2010).	<input type="checkbox"/>
4. Individual did not elect COBRA coverage.	<input type="checkbox"/>
5. Other (please explain)	<input type="checkbox"/>

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

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



Section D: DEPENDENT INFORMATION – If applying for family coverage, complete the information for each eligible dependent. Attach additional copies of this form if you have more than 4 eligible dependents. (Parent or guardian should sign for minor children.)

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
1. I elected (or am electing) COBRA 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 _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
1. I elected (or am electing) COBRA 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 _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
1. I elected (or am electing) COBRA 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 _____	

Dependent Name (First, MI, Last)	Date of Birth	Social Security Number	Relationship to Employee
1. I elected (or am electing) COBRA 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 _____	

Enrollment Information for COBRA and/or Premium Assistance

The COBRA premium assistance program may provide a number of different options to you. The following describes what steps you must take for each scenario. You have 60-days from the date of the cover letter to provide all of needed forms to your previous employer.

Enclosed you will find the COBRA election form for each benefit plan in which you are/were enrolled. Applications are not included because you do not need to complete and submit an application unless you elect to switch to a plan option that costs the same or less than plan you had on your last day of employment, you are changing your level of coverage (e.g., family to single) from what you had on your last day of employment or any of your dependents are making an individual election to continue coverage. The links to the on-line applications are provided in the cover letter. If you prefer a paper copy, please contact us. Any change you (or a dependent if electing individual coverage) elect will be effective on or after the first of the month in which we receive the application.

If you are enrolling in COBRA and Eligible for Premium Assistance: If, after reviewing the attached information, you wish to enroll in COBRA continuation coverage and you believe you are eligible for the premium assistance, you must:

1. Complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue.
2. You must also complete the *Request for Treatment as an Assistance Eligible Individual* form.
3. Return the completed forms to us at the address shown on the cover letter.

We will complete the employer section of the *Request for Treatment as an Assistance Eligible Individual* form letting you know whether you are approved or denied for the premium assistance. If you are approved, you will also receive important information on making your premium payment.

If you are Enrolling in COBRA and you are NOT Eligible for Premium Assistance: If this is your initial enrollment opportunity for COBRA continuation coverage and you wish to enroll but are not eligible for the premium assistance as explained in the attached information, you must:

1. Complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue.
2. Submit the completed forms to continue your health insurance coverage to the Department of Employee Trust Funds.
3. Submit all other (e.g., dental and vision) continuation election forms and applications, if required, to the address listed on the form.

If you are Enrolling in COBRA after Losing Eligibility for Coverage Due to a Reduction in Hours and you have NOT terminated all UW System Employment: If you experienced a reduction in hours that occurred at any point from September 1, 2008 through May 31, 2010 that caused you to lose eligibility for insurance, you are eligible to enroll in COBRA continuation coverage but you are **NOT** eligible for COBRA Premium Assistance. You must involuntarily terminate **ALL** UW System employment at any time from March 2, 2010 through May 31, 2010 before eligibility for Premium Assistance begins. Your eligibility for assistance begins on the first COBRA coverage month following your involuntary termination.

1. Complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue. Return health insurance forms to ETF and all other forms to the applicable vendor(s).
2. Complete the *Request for Treatment as an Assistance Eligible Individual* form only if/when you involuntarily terminate employment at any time from March 2, 2010 through May 31, 2010. Return the completed form to us at the address shown on the cover letter.

If you are Enrolling in COBRA after Losing Eligibility for Coverage Due to a Reduction in Hours and you have terminated ALL UW System Employment: If you experienced a reduction in hours that occurred at any point from September 1, 2008 through May 31, 2010 that caused you to lose eligibility for insurance and you did not elect COBRA at that time (or you elected COBRA but it has since lapsed) **and** you are involuntarily terminated from **all** UW System employment at any time from March 2, 2010 through May 31, 2010, you are eligible to elect COBRA coverage within 60 days of your termination date and you may be eligible for COBRA premium assistance effective the first COBRA coverage month following your involuntary termination.

If, after reviewing the attached information, you wish to enroll in COBRA continuation coverage and you believe you **are eligible for the premium assistance**, you must:

1. Complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue.
2. You must also complete the *Request for Treatment as an Assistance Eligible Individual* form.
3. Return the completed forms to us at the address shown on the cover letter.

We will complete the employer section of the *Request for Treatment as an Assistance Eligible Individual* form letting you know whether you are approved or denied for the premium assistance. If you are approved, you will also receive important information on making your premium payment.

If, after reviewing the attached information, you wish to enroll in COBRA continuation coverage and you believe you **are NOT eligible for the premium assistance**, you must:

1. Complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue.
2. Submit the completed forms to continue your health insurance coverage to the Department of Employee Trust Funds.
3. Submit all other (e.g., dental and vision) continuation election forms and applications, if required, to the address listed on the form.

If you are Currently Enrolled in COBRA and Eligible for Premium Assistance: If, after reviewing the attached information, you believe you are eligible for the premium assistance and you are already enrolled in COBRA continuation coverage, you must:

1. Complete the *Request for Treatment as an Assistance Eligible Individual* form. Note on the top of the form that you are currently enrolled in COBRA.
2. Submit the completed form to us at the address on the cover letter.

We will complete the employer section of the *Request for Treatment as an Assistance Eligible Individual* form letting you know whether you are approved or denied for the premium assistance. If you are approved, you will also receive important information on making your premium payment.

Note: If you are approved for the premium assistance and you paid the full COBRA premiums for any period of COBRA continuation coverage in which you were eligible for COBRA Premium Assistance, contact us for reimbursement for the overpaid premiums. If you elected COBRA when coverage was first lost due to a reduction in hours, your eligibility for assistance begins on the first COBRA coverage month following your involuntary termination

If you are Declining COBRA: If, after reviewing the attached information, you do not wish to enroll in COBRA continuation coverage, you do not need to take any further action.

For Employees Who Terminate Employment Due to Involuntary Layoff ONLY:

Once you are no longer eligible for the employer contribution towards your health insurance, you have the option to either begin using your sick leave credits to pay for your health insurance **OR** elect COBRA coverage.

Your fifteen month COBRA premium assistance eligibility period begins after your health insurance coverage as an active employee ends. Health insurance premiums are paid two months in advance so coverage as an active employee ends approximately two months after termination. You are eligible for an additional three months of employer contribution towards your health insurance because of layoff but these coverage months are not considered “active employee coverage” and these three additional months of coverage count towards the fifteen month COBRA premium assistance eligibility period.

If you elect COBRA coverage AFTER you use your sick leave credits, the credits must be fully exhausted before eligibility for COBRA premium assistance begins. Once the credits are exhausted, you are eligible to elect COBRA coverage. If you only have enough sick leave credits to pay for a partial month of health insurance before you are eligible to enroll in COBRA, you will be required to personally pay the difference between the total premium and the value of sick leave credits during the final month of sick leave credit usage.

If your sick leave credits are exhausted prior to the end of your fifteen month COBRA premium assistance eligibility period, you are eligible to receive COBRA premium assistance for the remainder of the eligibility period, provided you elect COBRA coverage when the sick leave credits are exhausted.

After your eligibility for COBRA premium assistance ends, you will be required to pay the entire monthly premium out-of-pocket if you want to maintain coverage.

If you elect COBRA coverage INSTEAD OF using your sick leave credits to pay for health insurance, you are immediately eligible for COBRA premium assistance, but you are not eligible to use your sick leave credits to pay for health insurance after COBRA premium assistance ends. After the 15 month COBRA premium assistance eligibility period, you will be required to pay the entire monthly premium out-of-pocket if you want to maintain coverage.

Lay-off is defined in the WI Human Resources Handbook, Chapter 232, as: *The termination of the services of an employee with permanent status in class from a position in a layoff group approved by the DMRS administrator, or agency head if delegated, in which a reduction in force is to be accomplished.*

Questions and Answers about Involuntary Terminations

What is an Involuntary Termination?

For purposes of determining whether there is an involuntary termination under section 3001 of ARRA (including new Code sections added by section 3001 of ARRA), the following questions and answers are excerpted from IRS Notice 2009-27. To view the entire IRS document, please visit <http://www.irs.gov/pub/irs-drop/n-09-27.pdf>.

Q-1. What circumstances constitute an involuntary termination for purposes of the definition of an assistance eligible individual?

A-1 Involuntary termination is the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services. An involuntary termination may include the employer's failure to renew a contract at the time the contract expires, if the employee was willing and able to execute a new contract providing terms and conditions similar to those in the expiring contract and to continue providing the services. In addition, an employee-initiated termination from employment constitutes an involuntary termination from employment for purposes of the premium reduction if the termination from employment constitutes a termination for good reason due to employer action that causes a material negative change in the employment relationship for the employee.

Involuntary termination is the involuntary termination of employment, not the involuntary termination of health coverage. Thus, qualifying events other than an involuntary termination, such as divorce or a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan (such as loss of dependent status due to aging out of eligibility), are not involuntary terminations qualifying an individual for the premium reduction. In addition, involuntary termination does not include the death of an employee or absence from work due to illness or disability.

The determination of whether a termination is involuntary is based on all the facts and circumstances. For example, if a termination is designated as voluntary or as a resignation, but the facts and circumstances indicate that, absent such voluntary termination, the employer would have terminated the employee's services, and that the employee had knowledge that the employee would be terminated, the termination is involuntary.

Q-2. Does an involuntary termination include a lay-off period with a right of recall or a temporary furlough period?

A-2. Yes. An involuntary reduction to zero hours, such as a lay-off, furlough, or other suspension of employment, resulting in a loss of health coverage is an involuntary termination for purposes of the premium reduction.

Q-3. Does an involuntary termination include a reduction in hours?

A-3. Generally no. If the reduction in hours is not a reduction to zero, the mere reduction in hours is not an involuntary termination. However, an employee's voluntary termination in response to an employer-imposed reduction in hours may be an involuntary termination if the reduction in hours is a material negative change in the employment relationship for the employee.

- Q-4. Does involuntary termination include an employer's action to end an individual's employment while the individual is absent from work due to illness or disability?
- A-4: Involuntary termination occurs when the employer takes action to end the individual's employment status (but mere absence from work due to illness or disability before the employer has taken action to end the individual's employment status is not an involuntary termination).
- Q-5. Does an involuntary termination include retirement?
- A-5. If the facts and circumstances indicate that, absent retirement, the employer would have terminated the employee's services, and the employee had knowledge that the employee would be terminated, the retirement is an involuntary termination.
- Q-6. Does involuntary termination include involuntary termination for cause?
- A-6. Yes. However, for purposes of Federal COBRA, if the termination of employment is due to gross misconduct of the employee, the termination is not a qualifying event and the employee and other family members losing health coverage by reason of the employee's termination of employment are not eligible for COBRA.
- Q-7. Does an involuntary termination include a resignation as the result of a material change in the geographic location of employment for the employee?
- A-7. Yes.
- Q-8. Does an involuntary termination include a work stoppage as the result of a strike initiated by employees or their representatives?
- A-8. No. However, a lockout initiated by the employer is an involuntary termination.
- Q-9. Does an involuntary termination include a termination elected by the employee in return for a severance package (a "buy-out") where the employer indicates that after the offer period for the severance package, a certain number of remaining employees in the employee's group will be terminated?
- A-9. Yes.

If you have any questions about this information or your rights to COBRA continuation coverage, you should contact us.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care 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” under Federal law 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. State law and plan contracts may allow you to cover other dependents who are not qualified beneficiaries under Federal law. These other dependents are eligible to continue coverage under COBRA, but they are not eligible for COBRA premium assistance. Dependents who are not qualified beneficiaries under Federal law are non-Assistance Eligible Individuals (non-AEI). Contact the office listed on the front page of this letter for more information about how continuing coverage for a non-AEI(s) affects the amount of COBRA premium assistance available to you.

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?

Health insurance and EPIC coverage generally may be continued for up to a total of 36 months. Under VSP Vision and Anthem DentalBlue, the continuation period is 18 months. Continuation coverage will be terminated 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 (you lose eligibility for the COBRA premium assistance when you become eligible for another group health plan even if you do not enroll in that plan),
- 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 elect COBRA continuation coverage?

To elect continuation coverage, you must complete the continuation election form(s) and submit 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 or domestic partner 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 or domestic partner 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 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 COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of 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), as amended, reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to COBRA continuation coverage that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with May 31, 2010 or a reduction of hours during a period beginning with September 1, 2008 and ending with May 1, 2010 that is followed by a termination of employment on or after March 2, 2010 and by May 31, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan (and your former employer will pay 65 percent). If you continue coverage that includes a Non-Assistance Eligible Individual on the plan, you may not qualify for the full 65% premium subsidy. This premium reduction is available for up to fifteen months. If your COBRA continuation coverage lasts for more than fifteen months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with your 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 your employer who provided you with this notice 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 when indicated on the billing statement 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 send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown on the billing statements from the Plan, you will be given a grace period of 30 days after the first day of the coverage period or the due date indicated on the premium bill, whichever is later, 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 will 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 submitted directly to the Plan. If you are eligible for the ARRA premium reduction, your employer will provide you with information on submitting your premium. You and the former employer must both make payment to the health plan within the grace period. As such, you should submit your 35% of the premium to the employer as much prior to the due date as possible.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact your employer.

State and local government employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or by email at NewCobraRights@cms.hhs.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan 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 submit to the Plan and your employer.

Intentionally blank

PARTICIPANT NOTIFICATION

Keep this form. If you are approved for COBRA premium assistance, you must notify your former employer and your plan if you become eligible for other group health plan coverage or Medicare and therefore become ineligible for reduced premiums under ARRA. To notify your former employer and plan, complete and submit this form.

Failure to provide this notice may subject you to a tax penalty.

Section A: PERSONAL INFORMATION

Name (First Name, Middle Initial, Last Name)	Employee's Social Security Number
Mailing Address	Telephone Number

Section B: PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one.

I am eligible for coverage under another group health plan. If any dependents are also eligible, list their names below. Insert date you become eligible _____	<input type="checkbox"/>
I am eligible for Medicare. Insert date you become eligible _____	<input type="checkbox"/>

IMPORTANT

If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA 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.

Section C: SIGNATURE

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 _____

Section D: DEPENDENT INFORMATION

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____	_____
_____	_____
_____	_____

**Return to Your Employer's Benefits Office
AND
To Your Health Plan (and Dental or Vision Plan, if applicable)**

HOW TO CONTACT BENEFIT PLANS

Anthem BCBS
P.O. Box 34210
Louisville, KY 40233-4210
Tele: (800) 490-6201

Anthem DentalBlue
P.O. Box 9274
Oxnard, CA 93031-9274
Tele: (866) 589-0582

Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625
Tele: (920) 490-6900
(888) 711-1444
Fax: (920) 490-6942

Dean Health Plan
1277 Deming Way
Madison, WI 53717
Tele: (608) 828-1301
(800) 279-1301
Fax: (608) 827-4212

The EPIC Life Insurance Company
P.O. Box 8430
Madison, Wisconsin, 53708-8430
Tele: (800) 520-5750
Fax: (608) 223-2159

Group Health Cooperative of
Eau Claire (GHC-EC)
P.O. Box 3217
Eau Claire, WI 54702
Tele: (715) 552-4300
(888) 203-7770
Fax: (715) 552-3500

Group Health Cooperative of South
Central Wisconsin (GHC-SCW)
1265 John Q. Hammons Dr.
P.O. Box 44971
Madison, WI 53744-4971
Tele: (608) 828-4853
(800) 605-4327
Fax: (608) 662-4186

Gundersen Lutheran Health Plan
1836 South Ave.
LaCrosse, WI 54601
Tele: (608) 775-8007
(800) 897-1923
Fax: (608) 775-804

HealthPartners Health Plan
P.O. Box Box 1309
Minneapolis, MN 55440-1309
Tele: (952) 883-5000
(800) 883-2177
Fax: (952) 883-5666

Health Tradition Health Plan
P.O. Box 188
La Crosse, WI 54602-0188
Tele: (608) 781-9692
(888) 459-3020
Fax: (608) 781-9653

Humana
N19 W24133 Riverwood Dr. #300
Waukesha, WI 53188
Tele: (800) 448-6262

Medical Associates Health Plan
1605 Associates Dr., Suite 101
P.O. Box 5002
Dubuque, IA 52004-5002
Tele: (563) 556-8070
(800) 747-8900
Fax: (563) 556-5134

MercyCare Health Plan
3430 Palmer Dr.
P.O. Box 2770
Janesville, WI 53547-2770
Tele: (608) 752-3431
(800) 752-3431
Fax: (608) 752-3751

Navitus Health Solutions
5 Innovation Court Ste B
Appleton, WI 54914
Tele: (866) 333-2757
Fax: (920) 831-1930

Network Health Plan
1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Tele: (920) 720-1300
(800) 826-0940
Fax: (920) 720-1900

OptumHealth Vision Insurance
Tele: (800) 638-3120

Physician Plus Insurance Corp.
P.O. Box 2078
Madison, WI 53701-2078
Tele: (608) 282-8900
(800) 545-5015
Fax: (608) 258-1902

Security Health Plan of Wisconsin
1515 Saint Joseph Ave.
P.O. Box 8000
Marshfield, WI 54449-8000
Tele: (800) 472-2363
(715) 221-9555
Fax: (715) 221-9500

Standard Plans and SMP
WPS Health Insurance
1717 W. Broadway
P.O. Box 8190
Madison, WI 53707-8190
Tele: (800) 634-6448
Fax: (608) 243-6139

UnitedHealthcare of Wisconsin, Inc.
P.O. Box 13187
3100 AMS Blvd.
Green Bay, WI 54307-3187
Tele: (800) 357-0974
Fax: (920) 662-8349

Unity Health Insurance
840 Carolina Street
Sauk City, WI 53583-1374
Tele: (800) 362-3310
Fax: (608) 643-2564

VSP Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100
Tele: (800) 400-4569
Fax: (916) 463-9031

WPS Metro Choice
1717 W Broadway
PO Box 8190
Madison, WI 53707-8190
Tele: (800) 634-6448
Fax: (608) 243-6139