



IMPORTANT INFORMATION ABOUT YOUR RIGHT TO CONTINUATION COVERAGE WITH HEALTHPARTNERS

In February 2009, the American Recovery and Reinvestment Act (ARRA) of 2009 was signed into law by President Obama. The law includes a 65 percent federal premium reduction for COBRA premiums for individuals who were involuntarily terminated from employment. In December 2009, the Department of Defense Appropriations Act extended the availability of the premium reduction as explained below.

The premium reduction reduces the amount you would pay for continuation coverage by 65 percent. It is available for employees (and their eligible dependents) who were involuntarily terminated from employment from September 1, 2008 to February 28, 2010. The premium reduction is available for up to 15 months beginning on or after March 1, 2009.

In order to meet our legal obligation to notify our members about this premium reduction, we are sending the enclosed notice to all individuals that were covered by HealthPartners through an employer with fewer than 20 employees and terminated coverage from September 1, 2008 to February 28, 2010.

Please note that you are only eligible for the premium reduction if you were involuntarily terminated from employment during the times specified above. You may be eligible for continuation coverage, but not the premium reduction.

- If you were involuntarily terminated from employment between September 1, 2008 and February 28, 2010 and you would like to elect continuation coverage, please reference both the enclosed Continuation Coverage Election Notice and the Attestation for ARRA Premium Reduction.
- If you had a COBRA-qualifying event other than involuntary termination from employment between September 1, 2008 and February 28, 2010 and you would like to elect continuation coverage, please reference the Continuation Coverage Election Notice. You are not eligible for the premium reduction.
- It is also possible that this information does not apply to you.

Depending on the location of the employer, you have different rights for continuation coverage:

- **Minnesota-based employers**
 - If your employer is located in Minnesota and you're eligible for continuation coverage, you can elect coverage for both medical and dental coverage as long as you had coverage on the day before your employment ended.
- **Wisconsin-based employers**
 - If your employer is located in Wisconsin and you're eligible for continuation coverage, you can only elect continuation coverage for your medical coverage as long as you had coverage on the day before your employment ended.

Note: *If you were covered on a health plan of someone other than yourself, "the employer" refers to the employer for the policy holder.*

Please note that you are no longer eligible for the premium reduction on the date you become eligible for other health plan coverage. You must notify your employer of this eligibility or you could face tax penalties. You may also receive similar information from your employer. If you're not sure what information you need to complete, please contact your employer or their COBRA administrator. For more information about the premium reduction, please visit www.dol.gov/COBRA.



Continuation Coverage Election Notice

Dear qualified beneficiary,

This notice contains important information about your right to continue your healthcare coverage with HealthPartners. Please read the information in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriation Act, 2010, reduces the premium for continuation coverage in some cases. You are receiving this election notice because you experienced a qualifying event from September 1, 2008 through February 28, 2010 and you may be eligible for a temporary premium reduction for up to 15 months.

To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA, as Amended” with details regarding eligibility, restrictions and obligations and the “Request for Treatment as an Assistance Eligible Individual.”

If you believe you meet the criteria for the premium reduction, please also complete, the “Attestation for ARRA Premium Reduction” and return it with your completed Election Form to your employer or their COBRA administrator.

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to your employer or their COBRA administrator.

If you do not elect continuation coverage, your coverage under HealthPartners will end on the last day of the month in which your termination event occurred due to:

Check the appropriate box(es)

- 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

Each person in one or more of the categories checked below is entitled to elect continuation coverage, which will usually continue group healthcare coverage under the plan for the noted time period.

Check the appropriate box

- Employee or former employee – 18 months
- Spouse or former spouse – varies depending on the qualifying event
- Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage – varies depending on the qualifying event
- Child who is losing coverage under the plan because he or she is no longer a covered dependent – 36 months



Continuation Coverage Election Notice

If you are eligible and coverage is elected, your continuation coverage will begin on the date you lost your coverage due to a qualifying event.

You may elect the following options for continuation coverage if you were enrolled in the coverage on the day prior to your qualifying event:

- HealthPartners Medical Plan
- HealthPartners Dental Plan (not available if your employer is based in Wisconsin)

To find out how much your continuation coverage will cost, please contact your employer or their COBRA administrator.

If you qualify as an “Assistance Eligible Individual” this cost can be reduced by 65 percent for up to 15 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, please contact your employer or their COBRA administrator.



Continuation Coverage Election Notice

Instructions: To elect continuation coverage, complete this Election Form and return it to your employer or their COBRA administrator. By law, you have 60 days after the date of your first continuation notice to decide whether you want to elect continuation coverage.

Send completed Election Form to your employer or their COBRA administrator. This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than 60 days after the date of your first continuation notice.

If you do not submit a completed Election Form by the due date, 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.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage as indicated below:

Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options:	<input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan		
Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options:	<input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan		
Qualified Beneficiary Name	Date of Birth	Relationship to Employee	Social Security Number (or other identifier)
Coverage Options:	<input type="checkbox"/> HealthPartners Medical Plan <input type="checkbox"/> HealthPartners Dental Plan		

If you have additional qualified beneficiaries, please attach a separate sheet of paper with the information requested above.

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number



Continuation Coverage Election Notice

Important information about your continuation coverage rights

What is continuation coverage?

State law requires that most employers 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 you had with your employer on the day before the qualifying event. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

How long will continuation coverage last?

The length of continuation coverage varies depending on the qualifying event. Please contact your employer or their COBRA administrator for specific information about your coverage.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it to your employer or their COBRA administrator.

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 pre-existing 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 pre-existing condition exclusion if you do not elect continuation coverage for the maximum time available to you. 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?

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 February 28, 2010. If you qualify for the premium reduction, you only need to pay 35 percent of the continuation coverage premium otherwise due to your employer. This premium reduction is available for up to 15 months. See the attached “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA” for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When and how must payment for continuation coverage be made?

Please contact your employer or their COBRA administrator to confirm the correct amount of your first payment and/or to discuss payment issues related to the ARRA premium reduction. Your payment(s) for continuation coverage should be sent to your employer or their COBRA administrator.

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from your employer or their COBRA administrator

Keep your plan informed of address changes

In order to protect your and your family’s rights, you should keep your employer or their COBRA administrator 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 your employer or their COBRA administrator.

Summary of the Continuation Coverage Premium Reduction Provisions under ARRA, as Amended



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. 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 15 months.

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 some time from September 1, 2008 through February 28, 2010;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.*

Individuals whose nine-month premium reduction ended also have an opportunity to make a payment to continue coverage at the reduced rates. These payments must be made by February 17, 2010 or, if later, within 30 days from receipt of the notice regarding the ARRA amendment that extended the premium reduction to 15 months.

◆ 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 your employer or their COBRA administrator in writing immediately. 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 information related to your plan’s administration of continuation coverage, the ARRA Premium Reduction or to notify the issuer of your ineligibility to continue paying reduced premiums, contact your employer or their COBRA administrator.

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- www.dol.gov/COBRA.

* 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.

Attestation for ARRA Premium Reduction, as Amended

To apply for ARRA Premium Reduction, complete this form and return it to your employer or their COBRA administrator along with your Election Form.

If you already have continuation coverage, you may send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to your employer or their COBRA administrator.

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."

Employer Name

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

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 EMPLOYER USE ONLY

To be completed before sending to HealthPartners

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 within the allowable timeframe. | <input type="checkbox"/> |
| 4. Other (please explain) | <input type="checkbox"/> |
5. Are you paying any portion of this individual's premium? If yes, please explain in the space provided below. Yes No

Signature of party responsible for continuation coverage administration for the Plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

Attestation for ARRA Premium Reduction, as Amended

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 → _____

Attestation for ARRA Premium Reduction

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 employer or their COBRA administrator that you are eligible for other group health plan coverage or Medicare.

Employer Name

Participant Notification

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 employer or their COBRA administrator 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:

