

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. ARRA has been amended twice by the Department of Defense Appropriations Act, 2010 and the Temporary Extension Act of 2010. These laws give “Assistance Eligible Individuals” the right to pay reduced continuation coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 15 months.

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 March 31, 2010;*
- Must elect the coverage;
- **MUST NOT** be eligible for Medicare; AND
- **MUST NOT** be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.**

* 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 March 31, 2010.

Individuals whose premium reduction ended also have an opportunity to make a payment to continue coverage at the reduced rates.

◆ 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 March 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 March 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) 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

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 March 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 March 31, 2010).	<input type="checkbox"/>
4. Individual did not elect continuation coverage within the allowable timeframe.	<input type="checkbox"/>
5. Other (please explain)	<input type="checkbox"/>
6. Are you paying any portion of this individual's premium? If yes, please explain in the space provided below.	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

