Dear

We are required by Federal law to provide you with this information. It explains premium assistance for COBRA continuation coverage under the American Recovery and Reinvestment Act of 2009 (ARRA). **We are required to provide you this information, even though you may not be eligible for the premium assistance.**

Enclosed you will find the following information:

- *COBRA Continuation Conversion Supplemental Notice* that describes your rights under ARRA.
- *Request for Treatment as an Assistance Eligible Individual* (form ET-2314) that you must complete if you believe you are eligible for the premium assistance under ARRA. You must return the completed form to us within 60 days of the date of this notice along with the completed application(s) for the coverage(s) that you wish to continue.
- *Important Information about Your COBRA Continuation Coverage Rights* that provides general information about COBRA continuation coverage.
- *Summary of the COBRA Premium Reduction Provisions Under ARRA* regarding eligibility, restrictions and obligations.
- *Participant Notification* form for you to keep. If you are approved for premium assistance but later become eligible for other group health insurance coverage (including eligibility through a spouse) or Medicare, you must then complete and submit the form to us.
- Continuation election form(s) and application form(s), if required, for the coverage(s) that you are eligible to continue and indicated below:

  ☐ Health Insurance (plan _____)

  ☐ Dental Insurance (plan _____)

  ☐ Vision Insurance (plan _____)

  ☐ Other (plan _____)

  ☐ Other (plan _____)

If you wish to enroll in COBRA continuation coverage, you must do so within 60 days of the date of this notice, following the instructions given below.

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 (that is, the COBRA offering is due to an involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009), you must complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue. You must also complete the *Request for Treatment as an Assistance Eligible Individual* form. Return these completed forms to us at the address shown on the next page.

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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.

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

Initially Declined Enrollment in COBRA and Eligible for Premium Assistance: If you experienced a loss of coverage at some time from September 1, 2008 through February 16, 2009 and either chose not to elect COBRA continuation coverage at that time OR elected COBRA but subsequently discontinued that coverage, you may have an extended election period. COBRA continuation coverage, if elected, begins retroactively on March 1, 2009. If, after reviewing the attached information, you wish to enroll in COBRA continuation coverage and you believe you are eligible for the premium assistance (that is, the COBRA offering is due to an involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009), you must complete the continuation election form and application form, if required, for the coverage(s) that you wish to continue. You must also complete the *Request for Treatment as an Assistance Eligible Individual* form. Return these completed forms to us at the address listed below. 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.

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 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. Submit the completed form to us at the address listed below. You do not need to complete and submit an application unless you elect to switch to a lower-cost plan option. 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 that if you are approved for the premium assistance and you paid premium for COBRA continuation coverage for periods of coverage after ARRA was enacted (March 2009 and/or April 2009); contact us for information on a credit or reimbursement for the overpaid premiums.

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.

If you have questions about this notice or your rights to COBRA continuation coverage, please contact us at:

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) reduces the COBRA premium in some cases. You are receiving this election notice because:

- You experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 and you may be eligible for the temporary premium reduction for up to nine months.

  OR

- You experienced a loss of coverage at some time from September 1, 2008 through February 16, 2009. If your loss of coverage was due to an involuntary termination of employment, you may be eligible for a second COBRA election opportunity and the temporary premium reduction for up to nine months. If elected, COBRA continuation coverage begins retroactively on March 1, 2009.

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 "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 application Form.**

To elect COBRA continuation coverage, follow the instructions in the cover letter and this notice. Refer to the continuation election form(s) that you received from your employer for any Plan(s) for which you are eligible for COBRA continuation coverage. The form(s) list(s) the qualifying event that makes you eligible for COBRA continuation coverage, the date your coverage under the Plan(s) will end if you do not elect COBRA continuation coverage, and the qualified beneficiary(ies) eligible to elect COBRA continuation coverage.

If elected, COBRA continuation coverage begins on the date following the coverage end date indicated on your continuation election form(s), unless otherwise noted above, and can last up to 36 months.

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

COBRA continuation coverage will cost:

Plan	**Total Monthly Premium**
Health Insurance (plan _____)	$
Dental Insurance (plan _____)	$
Vision Insurance (plan _____)	$
Other (plan _____)	$
Other (plan _____)	$

If you qualify as an "Assistance Eligible Individual" the monthly cost will be:
(for up to nine months)

Plan	**Your Portion (35%)**
Health Insurance (plan _____)	$
Dental Insurance (plan _____)	$
Vision Insurance (plan _____)	$
Other (plan _____)	$
Other (plan _____)	$

You do not have to send any payment with the application. Important additional information about payment for COBRA continuation coverage is included in this notice.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact us at:

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 the continuation election form for that plan.

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 ( ) _____ - _____

Section B: QUALIFICATION - 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) COBRA 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

***If you checked NO for statement 3, you may still be eligible if you qualify for an ADDITIONAL ELECTION PERIOD.** If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 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. You should receive a new election notice with an election form that you MUST complete and return. If you believe you should have received this additional notice but have not, contact your former employer at the phone number listed on the letter that was sent with this form.

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 ☐ Dental ☐ Vision ☐ 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.	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual did not elect COBRA coverage.*	☐
4. Other (please explain)	☐

***If you checked number 3, was individual eligible for, and given, the Additional Election Period described above?**

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.	☐ 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 ____________________

Dependent Name (First, MI, Last)	**Date of Birth**	**Social Security Number**	**Relationship to Employee**

1. I elected (or am electing) COBRA 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 ____________________

Dependent Name (First, MI, Last)	**Date of Birth**	**Social Security Number**	**Relationship to Employee**

1. I elected (or am electing) COBRA 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 ____________________

Dependent Name (First, MI, Last)	**Date of Birth**	**Social Security Number**	**Relationship to Employee**

1. I elected (or am electing) COBRA 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 ____________________

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" 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 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?

Coverage generally may be continued only for up to a total of 36 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,
- 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 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 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) reduces the COBRA 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 COBRA premium otherwise due to the plan (and your former employer will pay 65 percent). 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 COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

If you have questions about this provision, 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.

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 above, 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.

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 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.

Summary of the COBRA 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 COBRA 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.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

♦ 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, the ARRA Premium Reduction, or to notify the plan of your ineligibility to continue paying reduced premiums, contact:

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.dol.gov/COBRA or call 1-866-444-EBSA (3272)

*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.

PARTICIPANT NOTIFICATION

Keep this form. *If you are approved for the 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 not eligible 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_____	☐
I am eligible for Medicare. Insert date you become eligible_____	☐

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:

_____ _____

_____ _____

_____ _____