

Model Wisconsin Premium Reduction Notice

(For use by group health plans subject solely to Wisconsin continuation insurance coverage requirements under s. 632.897, Wis. Stat.)

[Enter date of notice]

Dear: [Identify the terminated insured by name or status]

[Add the paragraphs below when an Assistance Eligible Individual is to be given a continuation coverage election opportunity pursuant to s. Ins 3.75, Wis. Adm. Code, because the group health insurance policy providing the coverage was terminated or will terminate on or after June 30, 2009 and prior to February 28, 2010.]

[You are receiving this notice because you either lost your group health insurance coverage when your former employer ceased business operations or otherwise discontinued, without replacing, the group health insurance policy that provided you coverage on or after June 30, 2009, or your employer plans to cease business operations or otherwise discontinue, without replacing, its group health insurance policy on [enter date of termination]. Wisconsin continuation insurance coverage requirements under s. Ins 3.75, Wis. Adm. Code provide you the right to continue your group health insurance coverage as long as you are eligible for a premium subsidy as an Assistance Eligible Individual as explained elsewhere in this notice.

You may elect continuation coverage by [enter procedure]. The premium amount required for continuation coverage is [enter amount] and should be paid to [enter manner, place, and time in which payments shall be paid].

You will no longer be eligible for group continuation coverage if: 1) you establish residence outside of Wisconsin 2) you fail to make timely payment of premium 3) you become eligible for Medicare or similar coverage under another employer's group policy 4) you cease to be eligible for premium assistance as an Assistance Eligible Individual 5) your eligibility for continued coverage would have otherwise ceased under Wisconsin continuation requirements, if the group policy had not been discontinued.

This notice contains important information about your right to apply for a reduction of your continuation premium an Assistance Eligible Individual under the American Recovery and Reinvestment Act of 2009 (ARRA), as amended. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA, as amended by the Department of Defense Appropriations Act, 2010), reduces the state continuation coverage premium you are required to pay in some cases. Individuals who are receiving this election notice in connection with a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with February 28, 2010, may be eligible for the 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 Premium Reduction Provisions under ARRA, as Amended" 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 and return the "Application for Treatment as an Assistance Eligible Individual."**

Summary of the Premium Reduction Provisions under ARRA

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. On December 19, 2009, the President signed the Department of Defense Appropriations Act of 2010. These laws give “Assistance Eligible Individuals” the right to pay reduced premiums for periods of COBRA or state continuation coverage beginning on or after February 17, 2009, and can last up to 15 months. **Please note, you may be eligible for Wisconsin continuation coverage but not qualify as an assistance eligible individual due to ARRA qualifying requirements for premium reduction.**

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 February 28, 2010, 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 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 9 month premium reduction ended also have an opportunity to make a payment to continue coverage of the reduced rates. These payments must be made by February 27, 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 continuation and while you are paying the reduced premium, you become eligible for other group health plan coverage 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 continuation coverage you can contact [*enter appropriate contact information with telephone number and address*].

For specific information related to your plan’s administration of the ARRA Premium Reduction or to notify the issuer of your ineligibility to continue paying reduced premiums, contact [*enter appropriate contact information with telephone number and address*].

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 or call (866) 400-6689

*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.

To apply for ARRA Premium Reduction, complete this form and send the completed "Request for Treatment as an Assistance Eligible Individual" to: [Enter Name and Address].

You may also want to read the important information about your rights included in the "Summary of the Premium Reduction Provisions Under ARRA."

[Insert Plan Name]

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

[Insert Plan Mailing Address]

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 02/28/2010 ^{02/28/2010} . | <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 ISSUER USE ONLY
 This application is: Approved Denied
 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. | <input type="checkbox"/> |
| 4. Other (please explain) | <input type="checkbox"/> |

Signature of party responsible for continuation coverage administration for the Plan
 → _____ Date → _____
 Type or print name → _____
 Telephone number → _____ E-mail address → _____

This form is designed for issuers to distribute to terminated insureds 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 issuer that you are eligible for other group health plan coverage or Medicare.

| | | |
|-----------|---------------------------------|----------------------|
| Plan Name | Participant Notification | Plan Mailing Address |
|-----------|---------------------------------|----------------------|

| | |
|-----------------------------|---------------------------|
| 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 _____ | <input type="checkbox"/> |
| I am eligible for Medicare. Insert date you became eligible _____ | <input type="checkbox"/> |

IMPORTANT

If you fail to notify your issuer 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.