



ARRA Subsidy Election Notice

[Enter date of notice]

[Member first name][member last name]

[member address]

[city, state, zip]

Dear Terminated Plan Member:

This notice contains important information about your right to receive a premium subsidy for your state continuation benefits <Employer Name>.

Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended, reduces the amount you will owe for continuation coverage premium in some cases. Individuals who are receiving this subsidy election notice in connection with a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with February 28th, 2010 may be eligible for the temporary premium reduction for up to 15 months for qualifying states. 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 “Application for Treatment as an Assistance Eligible Individual.” **If you believe you meet the criteria for the premium reduction, complete the “Request for Treatment as an Assistance Eligible Individual” and return it to your employer.**

You must separately elect continuation coverage through NHP within the state mandated timeframes. If you have not elected continuation coverage, your coverage under the Plan will end based on your plan’s eligibility guidelines and you will not be eligible for the subsidy.

NHP will track and monitor participants through a possible 15 months of subsidy eligibility. State continuation durations may differ from the maximum subsidy assistance timeframes allow by ARRA. Please refer to your certificate of Coverage for durational limits of state continuation.

Refer to your Certificate of Coverage, or NHP, for more information on the following topics:

- Who under your plan is eligible to elect continuation coverage and for what period of time?
- What is continuation coverage?
- How can I elect continuation coverage?
- How much does continuation coverage cost?
- When and how must payment for continuation coverage be made?
- What is the correct amount of my first payment, and what are my payment options?

Where to Send Payment:

Once you are approved for the subsidy, you should continue to send payments to the same location you have always sent them.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep NHP 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 NHP.

How to initiate a Mini-COBRA policy

The former member should submit a letter of intent containing the following elements to Neighborhood Health Partnership within 63 days of the coverage termination date or qualifying event date (whichever is later):

- Member's Name
- Social Security Number
- Group Policy Number
- Date of Qualifying Event
- The Member's Return Mailing Address
- Contact Phone Number

Send this letter of intent requesting Mini-COBRA coverage to the following address:

Neighborhood Health Partnership
ATTN: Premium Services
P.O. Box 025680
Miami, Florida 33102-5680
Fax: 1-800-743-5087

Within 14 days of receipt Neighborhood Health Partnership will respond to the letter of intent. A Florida Election and Premium Notice Form detailing the rates and length of coverage are returned to the member by certified mail. This information will also include the information for the next steps the member should take.

Summary of the Continuation Coverage 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, 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 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 and continue to qualify for state continuation, 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 continuation coverage 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 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 NHP.

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 NewCobraRights@cms.hhs.gov
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, send the completed "Request for Treatment as an Assistance Eligible Individual" form to NHP within 60 days of this notice being provided to you.

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"

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

Employee SSN #

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

Name and Address of Former Employer

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 NHP USE ONLY

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.	<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 → _____

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 → _____

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 issuer that you are eligible for other group health plan coverage or Medicare.

NHP

Participant Notification

Attention:
Miami, FL 33126

PERSONAL INFORMATION

Name and mailing address

Telephone number

Participant SSN#

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 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:
