Attachment B

Model Wisconsin Continuation Coverage Second Election Notice
(For use by employers to provide notice of a second election period to terminated insureds who are or would be Assistance Eligible Individuals who had a qualifying event at any time from September 1, 2008 through May 18, 2009 and either did not elect continuation coverage or who elected it but subsequently discontinued coverage.

[*Enter date of notice*]

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

This notice contains important information about additional rights to continue your health care coverage in the [*enter name of group health plan*] (the Plan). Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation premium in some cases. You are receiving this notice because you are or would be considered an Assistance Eligible Individual who due to an involuntary termination of coverage at some time from September 1, 2008 through May 18, 2009, you either chose not to elect continuation coverage at that time OR elected continuation but subsequently discontinued that coverage. This notice provides you a second state continuation election opportunity and the temporary premium reduction for up to nine months. To learn more about 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" 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 Continuation Election Form.**

If elected, state continuation coverage will begin retroactively on [enter the date of the first day of the first coverage period beginning on or after February 17, 2009, and can last until [enter the date that is 18 months after the date of involuntary termination].

State continuation coverage will cost: [*enter amount each terminated insured will be required to pay per month of coverage.*] As an Assistance Eligible Individual this cost can be reduced to [*include the amount that is 35 percent of the amount above for each option*] for up to nine months. Important additional information about payment for state continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to state continuation coverage, you should contact [*enter appropriate contact information, with telephone number and address*].

State Continuation Coverage Election Form

Instructions: Under the American Recovery and Reinvestment Act you are only entitled to elect state continuation coverage at this time if you lost group health plan coverage due to an involuntary termination of employment during the period from September 1, 2008 through May 18, 2009. To elect state continuation coverage, complete this Election Form and return it to us. Under state law, you have 60 days after the date of this notice to decide whether you want to elect state continuation coverage under the Plan and pay appropriate premium.

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect state continuation coverage. If you reject state continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

Instructions: You are only entitled to elect state continuation coverage at this time if you lost group health plan coverage due to an involuntary termination of employment during the period from September 1, 2008 through May 18, 2009. To elect state continuation coverage, complete this Election Form and return it to us. Under state law, you have 60 days after the date of this notice to decide whether you want to elect state continuation coverage under the Plan and pay the appropriate premium.

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect state continuation coverage during this second continuation election period.

I elect state continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

Name Date of Birth SSN (or other identifier)

_____

_____ _____

Signature Date

_____

Print Name

_____

_____

_____ _____

Print Address Telephone number

Summary of the 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 premiums for periods of COBRA or state continuation coverage beginning on or after February 17, 2009 and can last up to 9 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 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.*

♦ 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.cms.hhs.gov/COBRAContinuationofCov or NewCobraRights@cms.hhs.gov

* 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 return it to us along with your Election Form.

You may also send this form in separately. If you choose to do so, 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.	☐ 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. See below for more information.**

ADDITIONAL ELECTION PERIOD

If your state continuation coverage relates to an involuntary loss of employment from September 1, 2008 through May 18, 2009 and you were eligible for, but did not elect, state continuation coverage **OR** you elected but subsequently discontinued state continuation, you may have the right to an additional 60-day election period. You should receive a new election notice with an Election Form which you MUST complete and return. If you believe you should have received this additional notice but have not, contact [*enter name of party responsible for state continuation coverage administration for the Plan, with telephone number and address*].

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 OR PLAN USE ONLY

This application is: ☐ Approved ☐ Denied (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.	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual did not elect state continuation 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 state continuation coverage administration for the Plan

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

This form is designed for plans to distribute to state continuation terminated insureds who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

Use this form to notify your plan 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. Insert date you became eligible_____	☐
I am eligible for Medicare. Insert date you became 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 state continuation 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 ➔ _____