

## IMPORTANT NOTICE FOR EMPLOYEES AND FORMER EMPLOYEES

### **Important Information About Your COBRA Continuation Coverage Rights Under The American Recovery and Reinvestment Act of 2009**

#### The COBRA Subsidy For Assistance Eligible Individuals

Under the American Recovery and Reinvestment Act of 2009 (“ARRA”), Employers will subsidize 65% of the COBRA premium payments for “assistance eligible individuals.” Consequently, an “assistance eligible individual” need only pay 35% of the COBRA premium. You are an “assistance eligible individual” if you are a qualified beneficiary under COBRA who (1) becomes eligible for COBRA between September 1, 2008 and December 31, 2009 due to an involuntary termination of employment and, (2) elected COBRA coverage during the original election period or a special election period required by ARRA. A qualified beneficiary of a formerly covered employee may elect and claim the subsidy even if the formerly covered employee does not so elect. The 65% subsidy is phased out if your adjusted gross income is between \$125,000 and \$145,000 (\$250,000 to \$290,000 for joint filers) because you must repay the subsidy as an additional tax in the year the subsidy is received.

The subsidy begins the next COBRA coverage period after the date of the Act, February 17, 2009. For plans using calendar months, this will be March 1, 2009. The subsidy ends upon the earliest of the following: (1) nine months after the subsidy began (even if COBRA coverage extends beyond the end of the subsidy), (2) the date you become eligible for Medicare or other group health insurance, or (3) the end of the maximum COBRA coverage period. The subsidy will also end if you fail to pay your required 35% of the COBRA premium. You are required to notify the group health plan if your right to the subsidy ends due to eligibility for other group health insurance coverage or Medicare. A penalty of 110% of any subsidy improperly paid by the employer will be assessed against you if you do not promptly notify the health plan if you are eligible for other coverage or Medicare.

#### Second Chance To Elect COBRA

If you lost health insurance coverage due to an involuntary employment termination on or after September 1, 2008, and either did not elect COBRA coverage or elected and then dropped such coverage or were terminated from COBRA for not paying premiums, you may now elect COBRA coverage during a 60-day special election period commencing after you receive notice of your right to this election. If you elect COBRA coverage during this 60-day period you will also qualify for the 65% subsidy. Nevertheless, your new election of COBRA coverage does not extend the 18/36 month COBRA coverage period that has always applied. In other words, if you were involuntarily terminated on September 1, 2008 under circumstances that entitled you to 18 months of COBRA coverage, but did not elect this second chance coverage until March 1, 2009, COBRA coverage still runs out on March 1, 2010, the 18 month anniversary of your separation.

*[The Next Paragraph May Be Omitted If The Employer Does Not Offer a Less Expensive Option]*

#### Option to “Opt Down” To Less Expensive Coverage

If offered by the employer, you have the right to elect coverage under a health insurance option other than the option by which you were covered at the time of termination, provided the option (1) is made available to active employees, (2) has the same or lower cost (pre-subsidy) as the option which previously covered, and (3) is other than a flexible spending account as defined in section 106(c)(2) of the Internal Revenue Code of 1986 or coverage consisting only of dental, vision, or certain other limited services. If offered by the employer, you may elect this option within 90 days following receipt of the required notice. This replacement coverage will run for the full duration of your COBRA coverage, even after the expiration of the nine-month COBRA subsidy.

#### Enrollment And Questions

The form necessary to establish your eligibility for the 65% subsidy is attached to the COBRA Coverage Election Notice form provided with this Notice. If you have any questions about this Notice or your rights to COBRA continuation coverage, you should contact *[enter name, address, and telephone number of the person responsible for COBRA administration for the plan]*

STIMULUS ACT  
COBRA ELECTION FORM

Name: \_\_\_\_\_  
(Printed)

Date of Involuntary Termination: \_\_\_\_\_

Check here if you are eligible for health care under another health insurance plan (i.e.: spouse's plan) \_\_\_ or Medicare \_\_\_. (Federal penalties apply for false answers)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you elect to participate in the subsidy, please return this form with your COBRA Continuation Coverage Election Form to *(Name and address of person responsible for COBRA administration for the plan.)*