



[Date]

[name]
[address]
[address]

Dear [name]

Re: Continuation of your healthcare coverage

Enclosed is an important notice about your right to continue your healthcare coverage in your former employer's group health plan. Please read this letter and the enclosed notice carefully.

You are receiving this letter and notice because our records indicate that your group health plan coverage, and your dependents' coverage (if any), terminated sometime between September 1, 2008, and April 28, 2009. As such, you may be eligible to continue that coverage at a reduced cost.

The enclosed notice provides complete information about the eligibility requirements for continuation coverage. If you believe you are eligible to continue coverage on your former employer's group health plan at this time and/or at a reduced cost, please complete the following items and return them to PacificSource Health Plans at PO Box 7068, Eugene, OR 97401, **within 31 days of the receipt of this notice:**

- Continuation Coverage Special Election Form;
 - **Please note:** *You must have your former employer complete Section 6 of this form before returning the form to PacificSource Health Plans. We will not be able to enroll you for continuation coverage with the subsidized premium without that information.*
- Your initial premium payment. (You'll send subsequent payments to your employer.)

If you have any questions regarding this letter or the enclosed notice, please contact our Membership Department at 684-5583 or (866) 999-5583.

Sincerely,

Louise Reffstrup
Membership Manager

541.686.1242 Local
800.624.6052 Toll Free

110 International Way
Springfield, OR 97477

PacificSource.com



Important Information About Your Continuation Coverage Rights

[Date]

This notice contains important information about your right to continue your healthcare coverage in the employer's group health plan (the Plan). If you involuntarily lost employment anytime between September 1, 2008 and April 28, 2009, you may be able to enroll in the group plan at almost one-third of the normal cost during a special election period. This special election period is available to those individuals who either chose not to elect state continuation coverage at the time they were initially eligible or who elected state continuation but whose coverage subsequently ended for any reason other than becoming eligible for Medicare or another group health plan.

The American Recovery and Reinvestment Act of 2009 (ARRA) will reduce the continuation of coverage premium to 35% of its normal cost for individuals that qualify under ARRA. To qualify for a 65% federal subsidy of your premium, you must have met the qualification requirements for continued coverage under your plan, and you must meet the requirements for an Assistance Eligible Individual under the provisions of ARRA.

Step 1: Qualification Requirements for Continuation under a Small Employer (typically 19 or fewer employees) Group Health Plan During the Special Election Period

- You must have been enrolled in the Plan continuously for three months;
- You must have lost coverage due to the involuntary termination of employment; and
- The Plan must still be in force.

Step 2: ARRA Qualification Requirements for an Assistance Eligible Individual During the Special Election Period

- You must have been eligible for continuation coverage (see above) sometime between September 1, 2008 and April 28, 2009;
- Your eligibility for continuation coverage must be based on the **involuntary** termination of your employment;
- You must elect continuation of coverage within the required timelines (see Step 3 - Electing Continuation Coverage below); and
- You **MUST NOT** be eligible for Medicare or any other group health plan coverage, such as a new employer's plan or a spouse's employer plan. This is true even if you do not enroll in the other group health plan for which you became eligible.

Step 3: Electing Continuation Coverage

- You must complete a Continuation Special Election Form (attached).
- Your continuation of coverage election may include your spouse, domestic partner, or any dependent children who were covered prior to the involuntary termination of your employment. (Note that domestic partners are not eligible for premium subsidy.)
- You must make sure that your former employer completes Section 6 of the Continuation Special Election Form and that the form is returned to PacificSource Health Plans within 31 days from the date you received this notice, along with the applicable premium. *PacificSource Health Plans will not be able to accept an Election Form that does not have Section 6 properly completed.*

When does continuation of coverage begin and how long will it last?

- If your employment was involuntarily terminated between September 1, 2008 and February 28, 2009, your continuation of coverage will begin on March 1, 2009 and continue for up to nine months. If your employment was involuntarily terminated between March 1, 2009 and April 28, 2009, your continuation of coverage will begin on the first day you lost coverage as a result of that termination and continue for up to nine months from that date.

- If the Plan is terminated by the employer, your coverage under the Plan will end as of the last date the Plan is active.
- If you fail to pay your portion of the premium owed, your coverage under the Plan will end as of the last date for which premium was received by PacificSource. Your coverage cannot be reinstated for any reason.
- If a child no longer qualifies as an eligible dependent (due to age, marriage, loss of student status, etc.), his/her coverage will end as of the end of the month in which he/she became ineligible under the Plan.

Premium – how much, when, and how do I pay?

- If you are an Assistance Eligible Individual under the provisions of ARRA, you pay 35% of what is currently charged for coverage. The attached Continuation Special Election Form shows your share of the subsidized premium. You may also call your former employer to determine the current premium required for coverage.
- Except for the initial premium, which is due 31 days from the date you received this notice, your premium payment must be made to the employer by the first of the month for which you are to be covered.
- Premium rates are established annually and may be adjusted if the Plan's benefits or costs change.
- Note that while domestic partners are eligible for continuation coverage, the ARRA subsidy is not available for any premium that is attributed to your domestic partner.

What plan(s) may I elect to continue and can I change plans?

- You may elect to continue your medical coverage only. Dental or vision coverage is not included.
- If your former employer has two different medical plans that are available to active employees, then you may elect to switch to a different plan at the Plan's anniversary date under certain circumstances. The different coverage must cost the same or less than the coverage you had at the time your employment was lost. Contact your former employer if you want to change to a different medical plan (if any).

◆ IMPORTANT TAX INFORMATION ◆

- 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 federal 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 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 ARRA Web page at www.irs.gov.

Who should I contact with questions?

- For general information regarding continuation coverage, contact your former employer or PacificSource Health Plans Membership Department at (541) 684-5583 or toll-free (866) 999-5583.
- For specific information related to your plan's administration of the ARRA Premium Reduction, or to notify PacificSource of your ineligibility to continue paying reduced premiums, please contact your former employer.
- 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 general information about the ARRA Premium Reduction, go to: www.cms.hhs.gov/COBRAContinuationofCov or e-mail NewCobraRights@cms.hhs.gov.

**CONTINUATION
SPECIAL
ELECTION FORM**
(For Oregon groups with
19 or fewer employees)



Date form distributed: _____

Effective date: _____

Date election period expires: _____

IMPORTANT: THIS FORM SHOULD BE USED ONLY BY INDIVIDUALS THAT LOST COVERAGE DUE TO AN INVOLUNTARY TERMINATION OF EMPLOYMENT BETWEEN SEPTEMBER 1, 2008 AND DECEMBER 31, 2009

- All sections of this form must be completed if you are applying for continuation of coverage as an Assistance Eligible Individual (AEI).
- Return the completed form to PacificSource Health Plans before the election period expires (above).
- You may continue medical coverage only. Dental or vision coverage is not included.

Please type or print in ink.

SECTION 1 QUALIFYING INDIVIDUAL INFORMATION

Last Name		First		M.I.		Social Security No.		Group No.	
Street Address				City		State	Zip Code	Daytime Phone No.	
Date Of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed						

SECTION 2 QUALIFYING EVENT INFORMATION

I am eligible for continuation of medical coverage as an Assistance Eligible Individual because all the following conditions apply:

- I lost group health coverage because of the involuntary termination of my employment which occurred between September 1, 2008 and December 31, 2009. Date your employment ended: _____
- I was covered under the employer's group health plan continuously for the three months prior to termination of coverage.
- I am not currently enrolled or eligible to enroll in Medicare or other group coverage

Initial & date _____.

You must have Section 6 completed before submitting this form.

If this election is for a person(s) other than the previously covered employee, give name and Social Security number of the previously insured employee.

Name: _____ Social Security No.: _____

SECTION 3 CONTINUATION PREMIUM RATES

PacificSource will accept your initial premium payment whether directly from you or with your former employers premium payment. After the initial premium payment, all subsequent payments must be received by your former employer **before the first day of each month** for which you wish to continue coverage. Your coverage will be cancelled if the employer does not receive your premium on time.

Your share of the cost of continuation coverage (35% of the full premium) is:

	Employee Only	Employee + Spouse	Employee + Family	Employee + Children
Medical Coverage Premium:	\$ _____	\$ _____	\$ _____	\$ _____

SECTION 4 DEPENDENTS CONTINUING COVERAGE

Please list all dependent family members continuing coverage.

Last Name	First Name	M.I.	Birth Date	Sex	Relationship	Social Security number

SECTION 5**SIGNATURE OF QUALIFYING INDIVIDUAL**

ACCEPT: I have read and understand the notification of rights on the reverse side. I hereby **request** continued coverage as indicated above. I understand that failure to make timely payment of required premiums will result in permanent loss of this coverage. While under coverage I expressly authorize any licensed physician, hospital, insurance company, or person that has any record or knowledge of my health or the health of any listed family member to furnish to PacificSource Health Plans with any records concerning myself or any family member named on this application for the purpose of collecting information in connection with a claim for benefits. A photographic copy of the authorization will be as valid as the original.

Signature

Date

SECTION 6**EMPLOYER VERIFICATION**

As an authorized representative of the employer/policyholder, I confirm that this former employee lost coverage under the company's group health plan due to an involuntary termination of employee's employment. I understand that confirmation of an involuntary termination of employment may entitle the former employee, and covered dependents, to a premium subsidy under the American Recovery and Reinvestment Act.

Signature

Title

Date

ADDITIONAL INFORMATION ON CONTINUATION COVERAGE**Continuation and Subsidy Period**

Continuation of coverage and premium subsidy is available for nine months as follows:

<i>Employment & Coverage Termination Dates</i>	<i>Continuation and Subsidy Period</i>
Between September 1, 2008 and February 28, 2009	Nine months from March 1, 2009
Between March 1, 2009 and December 31, 2009	Nine months from the first day you lost coverage

When Coverage Ends

Your continuation coverage will end before the end of the nine-month maximum continuation period if:

- Your continuation premium is not paid on time;
- You become eligible for Medicare or other group health plan coverage;
- A child no longer qualifies as an eligible dependent (due to age, marriage, loss of student status, etc.);
- The group discontinues its health plan.

Plan Changes or Termination

While it does not currently intend to do so, your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage. If your employer terminates the health plan, your continuation coverage will also terminate.

Enrollment Deadline

To continue coverage, this form must be returned to your employer or PacificSource within 31 days after you receive notification of your right to premium subsidized coverage. The date your election period expires is noted on the reverse side of this form. If your continuation election form is not returned by the deadline, your coverage will end on the last day you were eligible under the group health policy. **Mail this election form and your initial premium to PacificSource Health Plans, Attn: Membership Department, PO Box 7068, Eugene, OR 97401-0068.**

Dependent Coverage

To continue coverage for your eligible dependents, you must list your family members in Section 4 on the reverse side of this form. If your dependents were not covered prior to the qualifying event, they may not enroll in the continuation coverage at this time. Only newborn children and newly adopted children may enroll and become eligible for premium subsidy after the termination of employment. A newly acquired spouse may enroll after the termination of employment but the spouse's portion of the premium is not eligible for the subsidy. Please note that dependent children who no longer qualify for coverage under the group policy (because of age, marriage, loss of student status, etc.) are not eligible for continuation coverage.

Premium Payments for Continued Coverage

The cost of continuation coverage is your responsibility. You must pay your premium to the employer before the first day of each month for which you want coverage. The employer will include your continuation premium with the group's monthly payment to PacificSource. **Except for the initial premium,** PacificSource will not accept premium directly from you. If your premium is not paid on time, your coverage will end. If your coverage is cancelled due to a missed payment, it will not be reinstated for any reason. Premium rates are established annually and may be adjusted if the plan's benefits or costs change.