



[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 after 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 between April 28, 2009 and May 31, 2010, you may be able to enroll in the group plan at almost one-third of the normal cost.

The American Recovery and Reinvestment Act of 2009, as amended (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 (19 or fewer employees) Group Health Plan

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

### Step 2: ARRA Qualification Requirements for an Assistance Eligible Individual

- You must have been eligible for continuation coverage (see above) sometime between April 28, 2009 and May 31, 2010;
- 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 be eligible for continuation coverage related to a qualifying event relating to continuation coverage that is an involuntary termination of employment occurring between April 28, 2009 and May 31, 2010\*; 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.

*\* An involuntary termination of employment that occurs between March 2, 2010 and May 31, 2010 that follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through May 31, 2010 is also a qualifying event for purposes of ARRA.*

### Step 3: Electing Continuation Coverage

- If you qualify as an Assistance Eligible Individual, you must complete a Continuation Special Election Form.
  - 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 **within 31 days** from the date you received this notice, along with the applicable premium. *PacificSource will not be able to accept an Election Form that does not have Section 6 properly completed.*
- If you do NOT qualify as an Assistance Eligible Individual, you must complete a Group Coverage Continuation Election Form, see your former employer for this election form.
  - You must return the form and initial premium payment to your employer within 31 days after your last day of coverage under the Plan.
- 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.)

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

- Continuation coverage and premium subsidy is available for up to 15 months as follows:
  - If your employment was involuntarily terminated between April 28, 2009 and May 31, 2010, your continuation of coverage will begin on the first day of the month after which you would have lost coverage and continues for up to 15 months.
  - If you had a reduction in hours between September 1, 2008 and May 31, 2010, followed by an involuntary termination of employment that occurred between March 2, 2010 and May 31, 2010, your continuation of coverage will begin on the first day of the month after which you experienced an involuntary termination of employment and continues for up to 15 months from the date you lost coverage due to a reduction in hours.

*Note: If you are NOT an Assistance Eligible Individual under the provisions of ARRA, the maximum length of continuation coverage available to you is nine months.*

- 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.
  - Your initial premium payment, which is due 31 days from the date you received this notice, must be sent to PacificSource along with your Continuation Special Election Form.
  - 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.
- If you are NOT an Assistance Eligible Individual under the provisions of ARRA, you pay 100% of what is currently charged for coverage.
  - Your initial premium payment must be to your former employer within 31 days after your last day of coverage under the Plan.
  - All subsequent premium payments must be to the former 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.
- You may also call your former employer to determine the current premium.

### **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 employer has two different medical plans that are available to actively covered 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 offered by the employer (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](http://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](http://www.cms.hhs.gov/COBRAContinuationofCov) or e-mail [NewCobraRights@cms.hhs.gov](mailto: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 MAY 31, 2010**

- 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 May 31, 2010 or I lost group health coverage because of a reduction in hours which occurred between September 1, 2008 and May 31, 2010 then experienced an involuntary termination of employment that occurred between March 2, 2010 and May 31, 2010.  
Date my hours were reduced: \_\_\_\_\_ Date my 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, as amended.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Title\_\_\_\_\_  
Date**ADDITIONAL INFORMATION ON CONTINUATION COVERAGE****Continuation and Subsidy Period**

Continuation of coverage and premium subsidy is available for up to 15 months as follows:

<b><i>Employment &amp; Coverage Termination Dates</i></b>	<b><i>Continuation and Subsidy Period</i></b>
Loss of coverage due to an involuntary termination of employment that occurred between March 1, 2009 and May 31, 2010	15 months from the first day you lost coverage
Loss of coverage due to a reduction in hours that occurred between September 1, 2008 and May 31, 2010 followed by an involuntary termination of employment that occurred between March 2, 2010 and May 31, 2010	Begins first of the month following involuntary termination of employment and expires 15 months from the first day you lost coverage due to a reduction in hours.

**When Coverage Ends**

Your continuation coverage will end before the end of the 15-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.