

[Client Name]
WageWorks, Inc
[Address 1]
[City, State & Zip]

[Date]

[Participant Name] & Eligible Covered Dependents (if applicable)
[Address 1]
[Address 2]
[City, State & Zip]

Recently you were provided with a COBRA Election Notice from WageWorks due to termination of employment with [Company Name]. This notice is provided to you as an update of the COBRA Election Notice as it relates to the recent changes of the American Recovery and Reinvestment Act of 2009 (ARRA).

The American Recovery and Reinvestment Act of 2009 (ARRA) was amended on December 19, 2009 under the Department of Defense Appropriations Act (H.R. 3326) and provides an extension of the original ARRA regulations. ARRA allows for a 65% premium reduction assistance of the group health benefits for an Assistance Eligible Individual (AEI). This notice outlines the extension under ARRA.

First, the original ARRA regulations required that in order to be considered an AEI under ARRA, you must have been involuntarily terminated from your former employer on or before December 31, 2009 and must have incurred a loss of coverage on or before December 31, 2009. The newly expanded ARRA regulations allows for you to be eligible for the premium reduction assistance under ARRA if you have been involuntarily terminated by your former employer on or before February 28, 2010. The loss of coverage date no longer impacts your eligibility for the premium subsidy assistance.

Second, the original ARRA regulations provided the premium reduction assistance for a total of nine (9) months for each AEI. The newly amended ARRA regulations extend the premium assistance for each AEI for a total of fifteen (15) months.

Enclosed is a Request for Treatment as an Assistance Eligible Individual and COBRA Continuation Coverage Enrollment Form which will need to be completed and returned to WageWorks in order for your COBRA continuation coverage and ARRA premium reduction assistance to be processed. You will have sixty (60) days from the date of this letter to return these forms for your COBRA and ARRA enrollment to be processed.

Failure to provide these forms within the sixty (60) days will waive your right for the enrollment onto COBRA continuation coverage and for the newly amended provisions of the ARRA premium reduction assistance.

If you have any questions, please contact WageWorks, Inc at [Phone number].

Below is a revised section of your COBRA Election Notice as it relates to ARRA.

SPECIAL INFORMATION - COBRA ARRA Premium Reduction Information

This section contains important information about additional rights you may have related to your COBRA continuation coverage as it relates to the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA was amended on December 19, 2009 by the Department of Defense Appropriations Act, 2010 (H.R 3326) and provides for an extension of the original ARRA regulations. Please read the information contained in this section very carefully.

What is ARRA?

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. You may be eligible for the premium reduction if you experienced a Qualifying Event at some time on or after September 1, 2008 and before February 28, 2010 and are being offered the opportunity to elect COBRA continuation coverage. If your loss of group health coverage was due to an involuntary termination of employment you may be eligible for the temporary premium reduction for up to fifteen months. To help determine whether you are eligible for the ARRA premium reduction, you should read the below information and the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" carefully.

How much does COBRA continuation coverage cost under ARRA?

Generally, each Qualified Beneficiary may be required to pay the entire cost of continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

ARRA reduces the COBRA premium in some cases. The premium reduction is available to certain Assistance Eligible Individuals (AEIs) who experience a Qualifying Event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with February 28, 2010. If you qualify for the premium reduction, you need only pay 35% of the COBRA premium otherwise due to the Plan. This premium reduction is available for up to fifteen months, but may end sooner if you lose eligibility for the premium reduction. If your COBRA continuation coverage lasts for more than fifteen months, or if you lose eligibility for the premium reduction, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

How long does the premium assistance last?

AEIs are entitled to the premium reduction assistance for up to fifteen months; however, entitlement ends if you:

- i. Become eligible for other group health coverage (even if you do not elect such coverage) or for benefits under Medicare;
- ii. When your COBRA coverage period expires; or
- iii. If COBRA coverage terminates early for some other reason (such as failure to pay the required premium payment).

If you become eligible for other coverage, you must provide notice to the plan within 30 days or face a penalty equal to 110% of the subsidy received after becoming eligible for such other coverage.

Are my dependents eligible for the ARRA premium reduction assistance?

Yes, your eligible dependents that are covered under the group health plan on the day before the involuntary termination (except in the case of a child born or adopted by covered employee during a period of COBRA continuation coverage) are eligible for premium reduction assistance. The exceptions to this rule (and the types of individuals NOT eligible for premium reduction assistance under ARRA) would be:

- i. Dependents who are entitled to or currently covered under another group health plan or Medicare, and
- ii. Domestic Partners

Is the premium reduction assistance mandatory or voluntary?

The premium reduction assistance is a voluntary program. You can either elect to receive premium reduction assistance or waive your right to it. Please note: If you elect to waive the premium reduction assistance, you may not elect to receive it at a later time.

When and how will I get information on my reduced premium amount?

If you believe you are eligible and return the completed form "Request for Treatment as an Assistance Eligible Individual", and after WageWorks verifies with your former employer that you are eligible to receive the ARRA premium reduction assistance, you will receive an eligibility confirmation notice and updated payment information.

When and how must payment for COBRA continuation coverage be made?

Other than the amount, nothing else about the payment has changed. Payments are due the 1st of each month for that month's COBRA coverage. There is, however, a grace period for late payments, which expires on the 30th day after the 1st of the month. *Failure to pay the full premium by premium due dates, or within the 30-day grace period, will result in cancellation of your COBRA coverage retroactively to the 1st of the month* You may contact WageWorks to confirm the correct amount of your first payment or to discuss payment questions related to the ARRA premium reduction.

For More Information

This notice does not fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA continuation coverage and your rights under the Plan is available in your original COBRA election notice, the Summary Plan Description, or from the Plan Administrator.



Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended



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 COBRA 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** have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at any time from September 1, 2008 through February 28, 2010;
- **MUST** elect the coverage;
- **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 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 COBRA 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 general information regarding your plan's COBRA coverage, you can contact the name of the administrator listed on the COBRA Election Notice.

For specific information related to your plan's administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact the name of the administrator listed on the COBRA Election Notice.

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.dol.gov/COBRA or call 1-866-444-EBSA (3272)

* 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.

Plan Name [Client Name]	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	Plan Mailing Address WageWorks, Inc [Address 1] [City, State & Zip]
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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.	<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) COBRA 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

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 ☐ 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 COBRA coverage.*	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

Signature of employer, plan administrator, or other party responsible for COBRA 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) COBRA 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) COBRA 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) COBRA 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 → _____

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare.

Plan Name
[Client Name]

Participant Notification

Plan Mailing Address
WageWorks, Inc
[Address 1]
[City, State & Zip]

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.
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 plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA 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:

_____	_____
_____	_____

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COBRA CONTINUATION COVERAGE ENROLLMENT FORM

PQB Name: [Participant Name] & Eligible Covered Dependents (if applicable)
Address: [Address 1]
[Address 2]
[City, State & Zip]
Employer: [Client Name]

PLEASE NOTE: If you return this form, your COBRA coverage will begin retroactively to when you first lost COBRA coverage. Payments for prior months coverage will be required for full reinstatement of your COBRA coverage.

ACTION REQUIRED: To receive COBRA continuation coverage, you must complete and return this form to:

WageWorks
[Address 1] Fax
[City, State & Zip] Email

This Enrollment Form must be completed and returned by [Due Date]. If mailed, it must be post-marked no later than [Due Date].

Instructions: Under the American Recovery and Reinvestment Act you are only entitled to elect COBRA continuation coverage at this time if you lost group health plan coverage due to an involuntary termination of employment during the period that begins with September 1, 2008 and ends with February 28, 2010. To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Certification of Eligibility for COBRA Coverage

To qualify, you must be able to check "Yes" to all below statements.

- | | |
|--|--|
| • The loss of employment was involuntary. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • 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 |
| • 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 |
| • I am NOT eligible for Medicare coverage (or I was not eligible for Medicare coverage during the period for which I am claiming a reduced premium.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you do not submit a completed Enrollment Form by the due date shown above, you will lose your right to re-elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Enrollment Form before the due date. COBRA continuation coverage will be reinstated retroactively two when you first lost your COBRA coverage.

IMPORTANT: Please cross off any plan(s) that you do not wish to continue, adjust coverage levels as necessary.

<u>Plan Description</u>	<u>Coverage Level</u>	<u>Premium Rate</u>

Please Note – The above plans are a reflection of the benefits and rates you had in place at the time of your loss of COBRA coverage. If you elect to continue COBRA, the benefits and/or rates may have change based off your employer benefit's plan year. If this is the case, updated benefits and/or rates will be provided to you upon enrollment.

COBRA CONTINUATION COVERAGE ENROLLMENT FORM – cont.

If you are eligible for the ARRA premium reduction, the premium due will be 35% of the Premium Rates displayed above. You will receive the applicable premium rate information after your enrollment is processed.

List eligible Persons to be covered (INCLUDING YOURSELF) - Persons Previously Covered Only

Name, Last, First M

Relationship

Birth Date

Gender

Soc Sec #

PLEASE NOTE – Domestic Partners are not eligible for ARRA Premium Reduction.

I hereby request enrollment in the Health Benefits Continuation Plan (COBRA) for myself and eligible qualified dependents listed on this form and agree to pay the premiums as required. I understand that COBRA Continuation Coverage will terminate under several circumstances, including: the date I or a continued dependent became covered under another group health/dental plan, become entitled to Medicare or on the date in which the group health/dental plan ends. I also understand that if I was disabled within 60 days of the COBRA Qualifying Event, I am be eligible for the extended continuation converge, and that any break in continued coverage of more than sixty-three days may cause loss of coverage "portability".

Additionally, I understand that my eligibility for up to fifteen months of premium assistance requiring payments of the total monthly premiums shown above will be determined by my plan administrator after receipt of this completed Enrollment Form and Request for Treatment as an Assistance Eligible Individual form. I believe that I qualify for this assistance because (a) I was involuntarily terminated between September 1, 2008 and February, 28, 2010, (b) I have not become eligible for any other group health plan or Medicare since my termination and (c) I fall below the income limits required by the law.

Signature

Date