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HR/Benefits 2010-03
Supplement #2

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and Supplements

To: Human Resources Directors
Benefits Representatives

From: Evelyn Nazario 
Assistant Vice Chancellor
Human Resources Management

Subject: Expansion of Consolidated Omnibus Budget Reconciliation Act (COBRA) Premium Reduction Subsidy Provisions under HR 4851

Overview

Audience: Human Resources Directors, Benefits Representatives, and/or campus designee(s) responsible for benefits and/or COBRA administration

Action Item(s): Campuses are required to distribute revised COBRA notice(s) based on information in this technical letter

Affected Employee Group(s)/Units(s): All employees eligible for COBRA Continuation between April 1 – May 31, 2010, and all employees eligible for COBRA Continuation due to reduction of hours that occurs between September 1, 2008 and May 31, 2010.

Summary

On April 15, 2010, President Obama signed the Continuing Extension Act of 2010 (HR 4851), which amended previous COBRA Subsidy regulations under the American Recovery and Reinvestment Act (ARRA) and extended the COBRA subsidy provisions, effective immediately. The legislation:

- Extends eligibility for the subsidy to workers who are involuntarily terminated April 1 - May 31, 2010, as well as their qualified beneficiaries;
- Extends new COBRA premium assistance eligibility to individuals and their qualified beneficiaries who were eligible for COBRA due to reduced hours of employment between September 1, 2008, through May 31, 2010, and experience a subsequent involuntary termination on or after March 2, 2010, through May 31, 2010; and
- Requires employers to provide current and future COBRA beneficiaries with notice of the extension.

Campus designees responsible for COBRA administration should read the technical letter in its entirety.

COBRA Subsidy Extension Background

On April 15, 2010, President Obama signed the Continuing Extension Act of 2010 (HR 4851) (Attachment A), which amended previous COBRA Subsidy regulations under the American Recovery and Reinvestment Act (ARRA), and extended the COBRA Subsidy provisions. Under the previous amendment, which was signed into law on March 2, 2010, the COBRA Subsidy eligibility period ended on March 31, 2010. Effective immediately, the

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CSU Presidents
Executive Vice Chancellor and CFO
Vice Chancellor, Human Resources
Vice Presidents, Administration

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Continuing Extension Act of 2010 provides a new, 61-day extension of the COBRA premium reduction eligibility period and now includes employees who experience an involuntary termination between September 1, 2008, and May 31, 2010. The new provisions also allow individuals who have lost health coverage due to reduction in hours between September 1, 2008, and May 31, 2010, to qualify for COBRA premium reduction assistance if subsequently involuntarily terminated on or after March 2, 2010, through May 31, 2010.

COBRA premium reduction assistance applies to periods of coverage beginning March 1, 2009, (with the exception of individuals that are involuntarily terminated after experiencing a COBRA qualifying event due to reduction in hours, per the Continuing Extension Act) and lasts for fifteen (15) months. Individuals already receiving the COBRA Subsidy will continue to receive premium assistance (65% employer portion) for up to fifteen (15) months from the initial enrollment date, provided he/she continues to meet the COBRA Subsidy's eligibility requirements.

Based on the amendment, an individual will be deemed eligible for COBRA Subsidy up to 15 months if the involuntary termination of employment occurs no later than May 31, 2010, even if COBRA coverage does not start until after this date.

The federally mandated lengths of COBRA continuation periods (18, 29, or 36 months) based on specific qualifying events remain unchanged.

COBRA Premium Reduction Eligibility Criteria

As a result of the Continuing Extension Act, an Assistance Eligible Individual is a qualified beneficiary who is deemed eligible for COBRA Premium Reduction under the following criteria:

- Experiences a qualifying event for continuation coverage under COBRA resulting from the employee's involuntary termination of employment during the period beginning on or after September 1, 2008, through May 31, 2010; or
- Is the spouse or qualified dependent of an Assistance Eligible Individual who experiences a qualifying event for continuation coverage under COBRA resulting from an involuntary termination of employment during the period beginning on or after September 1, 2008, through May 31, 2010; or
- Experiences a loss of health coverage due to reduction of hours between September 1, 2008, and May 31, 2010, and is subsequently involuntarily terminated on or after March 2, 2010, through May 31, 2010; or
- Is the spouse or qualified dependent of an employee who experiences a loss of health coverage due to reduction of hours between September 1, 2008, and May 31, 2010, and is subsequently involuntarily terminated on or after March 2, 2010, through May 31, 2010; and
- Elects COBRA continuation coverage timely.

Please note, individuals that experience a qualifying event due to reduction in hours but do not choose or discontinue COBRA coverage, and are subsequently involuntarily terminated, receive a new COBRA election period under the Continuing Extension Act, and are not mandated to pay COBRA premiums back to original loss of coverage date. The COBRA premiums are payable based on the involuntary termination qualifying event date (typically, first of the month following the involuntary termination), and the COBRA continuation period is still based on the first qualifying event date due to reduction in hours. If qualified, COBRA Premium Assistance for these individuals will begin with payments due after March 2, 2010, and will continue for up to 15 months, based on the original COBRA continuation period. Individuals that are currently enrolled in COBRA due to reduction in hours and subsequently experience a voluntary termination can continue paying COBRA premiums at the reduced rate of 35%, up to 15 months. The new law does not change the length of the COBRA maximum coverage period.

Additional Notice Requirements and Continuation of COBRA Subsidy

The Department of Labor "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended," the "Request for Treatment as an Assistance Eligible Individual" form, and the following COBRA notices have been revised by HRM to include information pertaining to the Continuing Extension Act:

- Qualifying Event (QE) General COBRA Election Notice; and
- Premium Assistance Extension Notice.

For qualifying events occurring on or after April 1, 2010, an updated General Election Notice must be provided within the normal timeframe for providing a COBRA election notice. These individuals must receive a full 60-day election period from the date that the revised notice has been provided by the Benefits Office.

For individuals who were previously offered COBRA due to reduction in hours that occurred between September 1, 2008, and May 31, 2010, but declined or dropped COBRA, should not be provided a revised COBRA notice unless a subsequent involuntary termination occurs on or after March 2, 2010, through May 31, 2010. However, those who now qualify for COBRA premium assistance due to an involuntary termination that followed reduction in hours should be provided a revised COBRA General Election Notice within 60 days of the involuntary termination.

Please note: if an individual has already received a COBRA Election Notice for a termination that occurred in March but without the ARRA extension provisions, the campus is required to provide ARRA extension information, but only if the individual was terminated from employment (voluntarily or not). If so, the campus can choose to either reissue a revised COBRA Election Notice or can provide a copy of the Premium Assistance Extension Notice.

To further assist campuses, please note the following information regarding COBRA notice requirements:

Who Must Receive Notice	Which Notice to Send	When to Send Notice
Individual with <u>any</u> qualifying event after March 31, 2010, who lost (or loses) health coverage.	Revised (QE) General Election Notice (Attachment B), along with ARRA Summary (Attachment C)	Within the normal COBRA notice deadlines
Individual terminated from employment April 1, 2010, through May 31, 2010, who lost health coverage but received a COBRA election without extension information.	Premium Assistance Extension Notice (Attachment D) with ARRA Summary (Attachment C), or revised General Election Notice (Attachment B), with ARRA Summary (Attachment C) (if campus chooses) <u>if the qualifying event was based on termination of employment</u> . Otherwise, no new notice is required.	Within the normal COBRA notice deadlines
Individual who lost health coverage due to reduction in hours between September 1, 2008, and May 31, 2010, <u>and</u> was subsequently involuntarily terminated March 2, 2010, through May 31, 2010, and is still within the original COBRA continuation period.	Revised (QE) General Election Notice (Attachment B), with ARRA Summary (Attachment C)	Within 60 days of the involuntary termination
Assistance Eligible Individual who has not received any COBRA notice.	Revised (QE) General Election Notice (Attachment B), with ARRA Summary (Attachment C)	Within the normal COBRA notice deadlines
Assistance Eligible Individual who previously received a COBRA election notice without extension information.	Premium Assistance Extension Notice (Attachment D) with ARRA Summary (Attachment C)	Within the normal COBRA notice deadlines

The revised COBRA General Election Notice (Attachment B) should be distributed with the revised "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended," (Attachment C) and the "Request for Treatment as an Assistance Eligible Individual" (Attachment C). The "Premium Assistance Extension Notice," (Attachment D) also should be distributed with the revised "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended," (Attachment C) and the "Request for Treatment as an Assistance Eligible Individual" (Attachment C).

CMS Processing Instructions

Currently, CSU COBRA processing is not managed in CMS Baseline; therefore, there is no impact to the Base Benefits or Benefits Administration (Ben Admin) Oracle/PeopleSoft modules.

Questions regarding this Technical Letter may be directed to Human Resources Management at (562) 951-4411.

This Technical Letter is also available on the Human Resources Management Web site at:

<http://www.calstate.edu/HRAdm/memos.shtml>.

EN/mh

H. R. 4851

One Hundred Eleventh Congress of the United States of America

AT THE SECOND SESSION

*Begun and held at the City of Washington on Tuesday,
the fifth day of January, two thousand and ten*

An Act

To provide a temporary extension of certain programs, and for other purposes.

*Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE.

This Act may be cited as the “Continuing Extension Act of 2010”.

SEC. 2. EXTENSION OF UNEMPLOYMENT INSURANCE PROVISIONS.

(a) IN GENERAL.—(1) Section 4007 of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note) is amended—

(A) by striking “April 5, 2010” each place it appears and inserting “June 2, 2010”;

(B) in the heading for subsection (b)(2), by striking “APRIL 5, 2010” and inserting “JUNE 2, 2010”; and

(C) in subsection (b)(3), by striking “September 4, 2010” and inserting “November 6, 2010”.

(2) Section 2002(e) of the Assistance for Unemployed Workers and Struggling Families Act, as contained in Public Law 111–5 (26 U.S.C. 3304 note; 123 Stat. 438), is amended—

(A) in paragraph (1)(B), by striking “April 5, 2010” and inserting “June 2, 2010”;

(B) in the heading for paragraph (2), by striking “APRIL 5, 2010” and inserting “JUNE 2, 2010”; and

(C) in paragraph (3), by striking “October 5, 2010” and inserting “December 7, 2010”.

(3) Section 2005 of the Assistance for Unemployed Workers and Struggling Families Act, as contained in Public Law 111–5 (26 U.S.C. 3304 note; 123 Stat. 444), is amended—

(A) by striking “April 5, 2010” each place it appears and inserting “June 2, 2010”; and

(B) in subsection (c), by striking “September 4, 2010” and inserting “November 6, 2010”.

(4) Section 5 of the Unemployment Compensation Extension Act of 2008 (Public Law 110–449; 26 U.S.C. 3304 note) is amended by striking “September 4, 2010” and inserting “November 6, 2010”.

(b) FUNDING.—Section 4004(e)(1) of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note) is amended—

(1) in subparagraph (C), by striking “and” at the end;

(2) by inserting after subparagraph (D) the following new subparagraph:

“(E) the amendments made by section 2(a)(1) of the Continuing Extension Act of 2010; and”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect as if included in the enactment of the Temporary Extension Act of 2010 (Public Law 111–144).

SEC. 3. EXTENSION AND IMPROVEMENT OF PREMIUM ASSISTANCE FOR COBRA BENEFITS.

(a) **EXTENSION OF ELIGIBILITY PERIOD.**—Subsection (a)(3)(A) of section 3001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), as amended by section 3(a) of the Temporary Extension Act of 2010 (Public Law 111–144), is amended by striking “March 31, 2010” and inserting “May 31, 2010”.

(b) **RULES RELATING TO 2010 EXTENSION.**—Subsection (a) of section 3001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), as amended by section 3(b) of the Temporary Extension Act of 2010 (Public Law 111–144), is amended by adding at the end the following:

“(18) **RULES RELATED TO APRIL AND MAY 2010 EXTENSION.**—

In the case of an individual who, with regard to coverage described in paragraph (10)(B), experiences a qualifying event related to a termination of employment on or after April 1, 2010 and prior to the date of the enactment of this paragraph, rules similar to those in paragraphs (4)(A) and (7)(C) shall apply with respect to all continuation coverage, including State continuation coverage programs.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect as if included in the provisions of section 3001 of division B of the American Recovery and Reinvestment Act of 2009.

SEC. 4. INCREASE IN THE MEDICARE PHYSICIAN PAYMENT UPDATE.

Paragraph (10) of section 1848(d) of the Social Security Act, as added by section 1011(a) of the Department of Defense Appropriations Act, 2010 (Public Law 111–118) and as amended by section 5 of the Temporary Extension Act of 2010 (Public Law 111–144), is amended—

(1) in subparagraph (A), by striking “March 31, 2010” and inserting “May 31, 2010”; and

(2) in subparagraph (B), by striking “April 1, 2010” and inserting “June 1, 2010”.

SEC. 5. EHR CLARIFICATION.

(a) **QUALIFICATION FOR CLINIC-BASED PHYSICIANS.**—

(1) **MEDICARE.**—Section 1848(o)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(o)(1)(C)(ii)) is amended by striking “setting (whether inpatient or outpatient)” and inserting “inpatient or emergency room setting”.

(2) **MEDICAID.**—Section 1903(t)(3)(D) of the Social Security Act (42 U.S.C. 1396b(t)(3)(D)) is amended by striking “setting (whether inpatient or outpatient)” and inserting “inpatient or emergency room setting”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be effective as if included in the enactment of the HITECH Act (included in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5)).

(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section by program instruction or otherwise.

SEC. 6. EXTENSION OF USE OF 2009 POVERTY GUIDELINES.

Section 1012 of the Department of Defense Appropriations Act, 2010 (Public Law 111–118), as amended by section 7 of the Temporary Extension Act of 2010 (Public Law 111–144), is amended by striking “March 31, 2010” and inserting “May 31, 2010”.

SEC. 7. EXTENSION OF NATIONAL FLOOD INSURANCE PROGRAM.

(a) EXTENSION.—Section 129 of the Continuing Appropriations Resolution, 2010 (Public Law 111–68), as amended by section 8 of Public Law 111–144, is amended by striking “by substituting” and all that follows through the period at the end and inserting “by substituting May 31, 2010, for the date specified in each such section.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be considered to have taken effect on February 28, 2010.

SEC. 8. COMPENSATION AND RATIFICATION OF AUTHORITY RELATED TO LAPSE IN HIGHWAY PROGRAMS.

(a) COMPENSATION FOR FEDERAL EMPLOYEES.—Any Federal employees furloughed as a result of the lapse in expenditure authority from the Highway Trust Fund after 11:59 p.m. on February 28, 2010, through March 2, 2010, shall be compensated for the period of that lapse at their standard rates of compensation, as determined under policies established by the Secretary of Transportation.

(b) RATIFICATION OF ESSENTIAL ACTIONS.—All actions taken by Federal employees, contractors, and grantees for the purposes of maintaining the essential level of Government operations, services, and activities to protect life and property and to bring about orderly termination of Government functions during the lapse in expenditure authority from the Highway Trust Fund after 11:59 p.m. on February 28, 2010, through March 2, 2010, are hereby ratified and approved if otherwise in accord with the provisions of the Continuing Appropriations Resolution, 2010 (division B of Public Law 111–68).

(c) FUNDING.—Funds used by the Secretary to compensate employees described in subsection (a) shall be derived from funds previously authorized out of the Highway Trust Fund and made available or limited to the Department of Transportation by the Consolidated Appropriations Act, 2010 (Public Law 111–117) and shall be subject to the obligation limitations established in such Act.

(d) EXPENDITURES FROM HIGHWAY TRUST FUND.—To permit expenditures from the Highway Trust Fund to effectuate the purposes of this section, this section shall be deemed to be a section of the Continuing Appropriations Resolution, 2010 (division B of Public Law 111–68), as in effect on the date of the enactment of the last amendment to such Resolution.

SEC. 9. SATELLITE TELEVISION EXTENSION.

(a) AMENDMENTS TO SECTION 119 OF TITLE 17, UNITED STATES CODE.—

(1) IN GENERAL.—Section 119 of title 17, United States Code, is amended—

(A) in subsection (c)(1)(E), by striking “April 30, 2010” and inserting “May 31, 2010”; and

(B) in subsection (e), by striking “April 30, 2010” and inserting “May 31, 2010”.

(2) TERMINATION OF LICENSE.—Section 1003(a)(2)(A) of Public Law 111–118 is amended by striking “April 30, 2010”, and inserting “May 31, 2010”.

(b) AMENDMENTS TO COMMUNICATIONS ACT OF 1934.—Section 325(b) of the Communications Act of 1934 (47 U.S.C. 325(b)) is amended—

(1) in paragraph (2)(C), by striking “April 30, 2010” and inserting “May 31, 2010”; and

(2) in paragraph (3)(C), by striking “May 1, 2010” each place it appears in clauses (ii) and (iii) and inserting “June 1, 2010”.

SEC. 10. EXTENSION OF SMALL BUSINESS LOAN GUARANTEE PROGRAM.

(a) APPROPRIATION.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, \$80,000,000, for an additional amount for “Small Business Administration—Business Loans Program Account”, to remain available until expended, for the cost of fee reductions and eliminations under section 501 of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat. 151) and loan guarantees under section 502 of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat. 152), as amended by this section: *Provided*, That such costs shall be as defined in section 502 of the Congressional Budget Act of 1974.

(b) EXTENSION OF SUNSET DATE.—Section 502(f) of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat. 153) is amended by striking “April 30, 2010” and inserting “May 31, 2010”.

SEC. 11. SENSE OF THE SENATE REGARDING A VALUE ADDED TAX.

It is the sense of the Senate that the Value Added Tax is a massive tax increase that will cripple families on fixed income and only further push back America’s economic recovery and the Senate opposes a Value Added Tax.

SEC. 12. DETERMINATION OF BUDGETARY EFFECTS.

(a) IN GENERAL.—The budgetary effects of this Act, for the purpose of complying with the Statutory Pay-As-You-Go Act of 2010, shall be determined by reference to the latest statement titled “Budgetary Effects of PAYGO Legislation” for this Act, submitted for printing in the Congressional Record by the Chairman of the Senate Budget Committee, provided that such statement has been submitted prior to the vote on passage.

(b) EMERGENCY DESIGNATION FOR CONGRESSIONAL ENFORCEMENT.—This Act, with the exception of section 4, is designated as an emergency for purposes of pay-as-you-go principles. In the Senate, this Act is designated as an emergency requirement pursuant to section 403(a) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

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(c) EMERGENCY DESIGNATION FOR STATUTORY PAYGO.—This Act, with the exception of section 4, is designated as an emergency requirement pursuant to section 4(g) of the Statutory Pay-As-You-Go Act of 2010 (Public Law 111–139; 2 U.S.C. 933(g)).

Speaker of the House of Representatives.

*Vice President of the United States and
President of the Senate.*

COBRA QUALIFYING EVENT GENERAL ELECTION NOTICE

To: Covered Employee, [*INSERT ADDITIONAL QUALIFIED BENEFICIARY CATEGORIES – Spouse/Registered Domestic Partner and Dependent Children*]
Fr: [*EMPLOYER NAME*]
Date: [*DATE*]

This notice contains important information about your right to continue your group health care coverage in the [*ENTER NAMES OF APPLICABLE GROUP HEALTH PLANS, e.g., medical, dental, vision, health care reimbursement account (HCRA) plans*] (collectively, the “Plan”). Please read the information contained in this notice very carefully. We use the pronoun “you” in this notice (including the enclosed Election Form) to refer to each of the individual addressees named above.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010 (TEA), and the Continuing Extension Act of 2010 (CEA), reduces the COBRA premium in some cases. You are receiving this election notice because you either experienced a qualifying event that occurred during the period that begins with September 1, 2008, and ends with May 31, 2010, or you lost health coverage due to a reduction in hours between September 1, 2008, and May 31, 2010, and were subsequently involuntarily terminated on or after March 2, 2010, and may be eligible for the temporary premium reduction for up to 15 months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the “Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended” 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 Election Form.**

Please note, if you qualify, the COBRA Premium Reduction will apply only to group health, dental and vision plans. As a result, you will be responsible for paying 35% of the monthly premium. You also have the right to waive the COBRA Premium Reduction. The decision to waive is irrevocable.

HCRA Continuation is not eligible for COBRA Premium Reduction. In addition, COBRA Premium Reduction does not apply to Registered Domestic Partners and same sex spouses.

Based on your COBRA qualifying event (see below), you [*CHECK ONE*] ___ are eligible ___ are not eligible for COBRA Premium Reduction. **If you want to appeal this decision, and feel you meet the criteria for the premium reduction due to an involuntary termination, complete the “Application for Treatment as an Assistance Eligible Individual” and return it to the campus Benefits Office. You can download appeal forms at the Centers for Medicare and Medicaid Services (CMS) at www.continuationcoverage.net or by contacting them at 866-400-6689.**

To elect COBRA coverage, follow the instructions on the enclosed Election Form and submit the completed form to your [*INSERT CORRECT LOCATION - Campus Benefits Office*].

If you do not (did not) elect COBRA coverage, your coverage under the Plan will end (or ended) on [*ENTER DATE*] due to [*CHECK APPROPRIATE BOX*]:

- | | |
|---|--|
| <input type="checkbox"/> End of employment on [<i>INSERT DATE</i>] | <input type="checkbox"/> Loss of dependent child status [<i>INSERT DATE</i>] |
| <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary | <input type="checkbox"/> Death of employee [<i>INSERT DATE</i>] |
| <i>Prior to involuntary termination, a previous loss of health coverage due to reduction in hours occurred between 09/01/08 – 05/31/10 on [<i>INSERT DATE, IF APPLICABLE</i>]</i> | <input type="checkbox"/> Divorce or legal separation [<i>INSERT DATE</i>] |
| <input type="checkbox"/> Reduction in hours of employment [<i>INSERT DATE</i>] | <input type="checkbox"/> Dissolution of Registered Domestic Partnership [<i>INSERT DATE</i>] |

The event designated above that caused you to lose coverage under the Plan(s) is called your “qualifying event” in this notice, and the date of that event shown above is the date of your qualifying event. Each person (“qualified beneficiary”) in the category(ies) checked below is entitled to elect COBRA coverage under one or more group health coverages under the Plan specified below and can continue group health care coverage under the Plan for up to ___ months **[ENTER 18 or 36, as appropriate]** ***[Check appropriate box or boxes below; names may be added]:***

- Employee or former employee **[INSERT NAME]**
- Spouse or former spouse **[INSERT NAME]**
- Registered Domestic Partner **[INSERT NAME]**
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage **[INSERT NAMES]**
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan **[INSERT NAME]**

If elected, COBRA coverage will begin on **[ENTER DATE]** and can last until **[ENTER DATE]** (except that coverage under the HCRA can last only until December 31, _____ **[INSERT YEAR]**). *You may elect COBRA continuation coverage for any of the following coverage options in which you are already enrolled: [LIST AVAILABLE COVERAGE OPTIONS]*

COBRA continuation coverage will cost: **[ENTER AMOUNT EACH QUALIFIED BENEFICIARY WILL BE REQUIRED TO PAY FOR EACH OPTION PER MONTH OF COVERAGE AND ANY OTHER PERMITTED COVERAGE PERIODS.]**. If you qualify as an “Assistance Eligible Individual,” this cost will be: **[INCLUDE THE AMOUNT THAT THE ASSISTANCE ELIGIBLE INDIVIDUAL IS REQUIRED TO PAY FOR EACH OPTION] for up to 15 months.**

You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA coverage, you should contact **[ENTER CONTACT INFORMATION INCLUDING ADDRESS AND PHONE NUMBERS FOR CAMPUS BENEFITS OFFICE]**.

INSTRUCTIONS: To elect COBRA coverage, complete this Election Form and return it to CSU. Under federal law, you must have 60 days after the date of this qualifying event (election) notice to decide whether you want to elect COBRA coverage under the Plan.

Mail or hand deliver the completed Election Form to: *[Enter Name and Address of campus benefits office contact person]*

This Election Form must be completed in writing and returned by mail or hand delivered to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail. If mailed, it must be post-marked no later than *[enter date]*. If hand delivered, it must be received 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 COBRA coverage. If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA coverage in the *[medical, dental and vision plan and the HCRA plan]* (collectively, the Plan) as indicated below (you may elect one or more group health coverages listed after your name):

a. Name _____ Date of Birth _____ Relationship to Employee _____ SSN (or other identifier) _____

b. Coverage options elected: _____ **[INSERT AVAILABLE**

COVERAGES]

All qualified beneficiaries who were covered under the HCRA will be covered together for HCRA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate HCRA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact your **[INSERT CORRECT CONTACT INFORMATION]**.

Is the covered employee, spouse, domestic partner, or any dependent child entitled to Medicare Part A, Part B or both?
 Yes No

If yes, name and date of entitlement (shown on Medicare card): _____.

If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting this Election Form, immediately notify the **[CAMPUS BENEFITS OFFICE]** and the applicable dental and vision carriers/COBRA administrators of the date of your Medicare entitlement at the addresses shown below.

I (we) have received and read this entire COBRA Qualifying Event (Election) Notice, including the paragraph entitled "Electing COBRA under the HCRA." I (we) understand that the use-it-or-lose-it rule will continue to apply to the HCRA coverage, if elected, so any unused amounts will be forfeited at the end of the Plan year (December 31). I (we) also understand that no HCRA coverage will be available for subsequent years.

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone Number

Important information about your COBRA coverage rights

What is COBRA continuation coverage?

Federal law requires that most group health plans (including CSU's medical, dental, vision and HCRA plans) give employees and their families the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan and the covered employee's spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under QMSCOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Although not required by law, CSU offers COBRA coverage to registered domestic partners of CSU employees covered under CSU's group health plans.

COBRA continuation coverage is the same coverage that the medical, dental, vision and HCRA plans (collectively, the "Plan") give to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to group health coverage offered by CSU under the Plan (i.e., medical, dental, vision and HCRA) and not to any other benefits offered by CSU (such as life insurance, disability, or accidental death and dismemberment). The Plan provides no greater COBRA rights than what COBRA requires (except for COBRA coverage for registered domestic partners) – nothing in this notice is intended to expand your rights beyond COBRA's requirements. You may be eligible for additional continuation rights under California State law – see the "California Continuation Rights for Certain Qualified Beneficiaries" section below.

How long will COBRA coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 36 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours. In the case of a loss of coverage due to an employee's death, divorce or legal separation, or dissolution of a registered domestic partnership, or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months. Regardless of the qualifying event, HCRA COBRA coverage may only be continued to the end of the plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries. COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan (but only after any preexisting condition exclusions of that other plan that applies to the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage; or
- CSU ceases to provide any group health plan for its employees; or

- during a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the [**CAMPUS BENEFITS OFFICE**] and the applicable dental and vision carriers/COBRA administrators (see “For More Information” section below) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The insurance carriers/HMOs may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

How can you extend the length of COBRA continuation coverage?

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the [**CAMPUS BENEFITS OFFICE**] and applicable dental and vision carriers/COBRA administrators (see “For More Information” section below) of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend the period of COBRA coverage. (The period of COBRA coverage under the HCRA cannot be extended under any circumstances.)

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee’s termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day after the covered employee’s termination of employment or reduction of hours with CSU and must last until the end of the 18-month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the [**CAMPUS BENEFITS OFFICE**] and applicable dental and vision carriers/COBRA administrators (see “For More Information” section below) in writing of the Social Security Administration’s determination of disability within 60 days after the latest of:

- the date of the Social Security Administration’s disability determination;
- the date of the covered employee’s termination of employment or reduction of hours; or
- the date of which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan(s) as a result of the covered employee’s termination or reduction of hours.

You must also provide this notice within 18 months after the covered employee’s termination of employment or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- the name(s) of the group health coverage(s);
- the name of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the initial qualifying event giving rise to COBRA coverage;
- the date of the initial qualifying event;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary become disabled;
- the date that the Social Security Administration made its determination of disability;

- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the [**CAMPUS BENEFITS OFFICE**] and applicable dental and vision carriers/COBRA administrators at the addresses indicated below (see "For More Information" section).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the [**CAMPUS BENEFITS OFFICE**] and applicable dental and vision carriers/COBRA administrators (see "For More Information" section below) of that fact within 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event. An extension of coverage will be available to spouses, registered domestic partners and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, dissolution of the employee's registered domestic partnership, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the [**CAMPUS BENEFITS OFFICE**] and applicable dental and vision carriers/COBRA administrators (see "For More Information" section below) in writing of the second qualifying event within 60 days after the later of:

- the date of the second qualifying event; or
- the date on which the qualified beneficiary would lose coverage under the terms of the Plan(s) as a result of the second qualifying event.

The notice must include the following information:

- the names of the group health coverage(s) under the Plan;
- the name of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the initial qualifying event giving rise to COBRA coverage;
- the date of the initial qualifying event;
- the second qualifying event;
- the date of the second qualifying event; and
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the [**CAMPUS BENEFITS OFFICE**] and/or applicable dental and vision carriers/COBRA administrators request it. Acceptable documentation includes a copy of the divorce decree, domestic partnership dissolution documents, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to the [**CAMPUS BENEFITS OFFICE**] and applicable dental and vision carriers/COBRA administrators at the addresses indicated below (see “For More Information” section).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

How can you elect COBRA coverage?

To elect COBRA coverage, you must complete the Election Form according to the directions on the Election Form and mail or hand deliver it by the date specified on the Election Form. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the employee’s spouse or registered domestic partner may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under any or all of the group health coverages (medical, dental, vision and HCRA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary’s COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

Electing COBRA under the HCRA

COBRA coverage under the HCRA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the HCRA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for HCRA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the HCRA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. All qualified beneficiaries who were covered under the HCRA will be covered together for HCRA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate HCRA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact [**INSERT CONTACT INFORMATION**] for more information.

Special Considerations in deciding whether to elect COBRA

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage under the Plan ends because of the qualifying event listed above. You also will have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How much does COBRA coverage cost?

Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) 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 COBRA coverage. The required monthly payment for each group health benefit provided under the Plan(s) under which you are entitled to elect COBRA is described in this notice.

The American Recovery and Reinvestment Act of 2009, as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010, and the Continuing Extension Act of 2010 (CEA), reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who either: 1) experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008, and ending with May 31, 2010, or 2) lost health coverage between September 1, 2008, and May 31, 2010, and subsequently experienced an involuntary termination on or after March 2, 2010, through May 31, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months, and will not extend the length of your actual COBRA continuation period. If your COBRA continuation coverage lasts for more than 15 months, 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, as Amended" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011, and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a non-forfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

When and how must payment for COBRA coverage be made?

Special payment provision for individuals qualifying for COBRA Subsidy due to reduction of hours that was followed by an involuntary termination

Please note, as a result of the Continuing Extension Act, individuals that experience a qualifying event due to reduction in hours between September 1, 2008, and May 31, 2010, but do not choose or discontinue COBRA coverage, and are subsequently involuntarily terminated on or after March 2, 2010, through May 31, 2010, receive a new COBRA election period as the result of the involuntary termination. In addition, these individuals and qualified beneficiaries are not mandated to pay COBRA premiums back to original loss of coverage date. Instead, the COBRA premiums are payable based on the involuntary termination qualifying event date (typically, first of the month following the involuntary termination), and the COBRA continuation period is based on the first qualifying event date due to reduction in hours. If qualified, COBRA Premium Assistance for these individuals will begin with payments due after March 2, 2010, and will continue for up to 15 months, based on the COBRA continuation period.

First payment for COBRA coverage

With the exception of individuals that are described above, your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan(s) would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure

that the amount of your first payment is correct. You may contact [**ENTER APPROPRIATE CONTACT INFORMATION**] to confirm the correct amount of your first payment.

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date the Qualifying Event (Election) Notice is post-marked, if mailed, or the date your Election Form is received by the individual as the address specified for delivery on the Election Form, if hand delivered.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan(s).

Monthly payments for COBRA coverage

To maintain COBRA coverage for you and/or qualified dependents, you will be required to make monthly payments for each month of COBRA coverage, beginning with your COBRA effective date. The amount due for each coverage period for each month for each qualified beneficiary is shown in this notice. Under the Plan(s), each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan(s) will continue for that month without any break. It is your responsibility to pay your COBRA premiums on time.

Grace periods for monthly payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan(s) will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan(s).

All COBRA premiums must be paid by check or money order.

If mailed, your payment is considered to have been made on the date that it is postmarked. [If hand delivered, your payment is considered to have been made when it is received.] You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

Please note the following information regarding your Medical coverage: Your health plan will bill you directly for the first payment of COBRA. If you do not receive a monthly invoice or payment booklet within three (3) weeks after choosing COBRA coverage continuation, please contact CalPERS at (888) 225-7377, or your health plan:

Medical

_____ [*enter appropriate payment addresses for medical*]

After you make your first COBRA payment for dental, vision and/or the Flexible Spending Account, a payment booklet will be mailed to you by the Plan. All COBRA payments should be sent to the address(es) specified below.

Dental

For Delta Dental PPO:

Wolfpack Insurance Services
P.O. Box 156
Belmont, California 94002
(800) 296-0192

For DeltaCare USA:

Wolfpack Insurance Services
P.O. Box 156
Belmont, California 94002
(800) 296-0192

Vision

VSP/COBRA Administration
P.O. Box 997100
Sacramento, California 95899-7100
(800) 852-7600 extension 4637

HCRA

ASI
P. O. Box 6044
Columbia, MO 65205-6044
Telephone: (800) 659-3035

More information about individuals who may be qualified beneficiaries

Children born to or placed for adoption with the covered employee during COBRA enrollment

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption. The child's COBRA coverage begins when the child is enrolled in the Plan(s), whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan(s), the child must satisfy the otherwise applicable Plan(s) eligibility requirements (for example, regarding age).

Alternative recipients under QMSCOs

A child of the covered employee who is receiving benefits under the Plan(s) pursuant to a Qualified Medical Child Support Order (QMSCO) received by CSU during the covered employee's period of employment with CSU is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

For more information

This notice does not fully describe COBRA coverage or other rights under the Plan(s). More information about COBRA coverage and your rights under the Plan is available from the [**CAMPUS BENEFITS OFFICE**].

If you have any questions concerning the information in this notice, or your rights to COBRA coverage, or if you want a copy of your summary plan description, you should contact the following:

For general COBRA questions and questions regarding medical COBRA coverage:

[ENTER CAMPUS BENEFITS OFFICE CONTACT INFORMATION INCLUDING ADDRESS AND PHONE NUMBER]

Questions regarding dental COBRA coverage

For Delta Dental PPO:
Wolfpack Ins. Services
P.O. Box 156
Belmont, California 94002
(800) 296-0192

For DeltaCare USA:
Wolfpack Ins. Services
P.O. Box 156
Belmont, California 94002
(800) 296-0192

Questions regarding vision COBRA coverage

VSP/COBRA Administration
P.O. Box 997100
Sacramento, California 95899-7100
(800) 852-7600 extension 4637

Questions regarding HCRA COBRA coverage

ASI
P. O. Box 6044
Columbia, MO 65205-6044
(800) 659-3035

Information about COBRA provisions for governmental employees is available from the:
Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

You may call (866) 400-6689 for assistance, or contact CMS via e-mail at continuationcoverage@maximus.com. The CMS website is www.cms.hhs.gov.

Keep your plan informed of address changes

In order to protect your and your family's rights, you should keep the [***CAMPUS BENEFITS OFFICE***] and applicable dental and vision carriers/COBRA administrators informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to these entities.

Special COBRA Rights for California Employees

If you are enrolled in an HMO or insured group medical coverage in California at the time of your initial qualifying event, you and your eligible dependents may be eligible to extend COBRA coverage from 18 or 29 months to a total of 36 months measured from the date of the original qualifying event. The HMO or insurance company may charge up to 110% of the cost (disabled individuals may be charged up to 150% of the cost).

This special California continuation benefit is provided by the HMO and insurance company and is not CSU's responsibility. Contact your HMO or insurance company to find out whether you are eligible for continuation benefits and how to obtain them.

Conversion Privilege after COBRA Terminates

You and your enrolled dependents may be entitled to a conversion policy upon the expiration of COBRA coverage. In the event you do not elect COBRA coverage, you may still apply for conversion to an individual medical policy. If you wish to convert your medical coverage to an individual conversion policy, you must make your application within 30 days from the date your coverage terminates to ensure continuous coverage. If you elect COBRA coverage, you will have the option to convert your medical coverage to an individual policy during the last 180 days of the maximum 18, 29, or 36 month COBRA coverage period.



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. ARRA has been amended thrice: on December 19, 2009, the President signed the Department of Defense Appropriations Act, 2010; on March 2, 2010, the President signed the Temporary Extension Act of 2010; and on April 15, 2010, the President signed the Continuing Extension Act of 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 either: *1) an involuntary termination of employment that occurred at any time from September 1, 2008, through May 31, 2010, or 2) loss of health coverage due to reduction in hours between September 1, 2008, and May 31, 2010, and subsequently experience an involuntary termination on or after March 2, 2010, through May 31, 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.*

Please note, individuals that experience a qualifying event due to reduction in hours but do not choose or discontinue COBRA coverage, and are subsequently involuntarily terminated per the Continuing Extension Act of 2010, receive a new COBRA election period, and are not mandated to pay COBRA premiums back to original loss of coverage date.

◆ 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 [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

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 [*enter name of party responsible for ARRA Premium Reduction administration for the Plan, 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 the websites listed below or **call (866) 400-6689**.

<http://www.dol.gov/ebsa/COBRA.html> or <http://www.cms.hhs.gov/COBRAContinuationofCov/>

* 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: [Enter Name and Address]

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended."

Campus Name and Address:

California State University
Campus Address Here

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Attn: Health Plan Carrier
Mail Employer Invoices to:
CSU, Chancellor's Office
Human Resources Management
401 Golden Shore
Long Beach, CA 90802
562.951.4411

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 statements #1-5. See special note for #6.

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 May 31, 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
6. Prior to involuntary termination that occurred on or after March 2, 2010, through May 31, 2010, I experienced loss of health coverage due to reduction in hours between September 1, 2008, and May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Please note: if your involuntary termination occurred after you experienced loss of health coverage due to reduction in hours, you must be able to answer 'Yes' for statements 1-6.

THIS SECTION WAS INTENTIONALLY LEFT BLANK

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 termination did not occur between September 1, 2008 and May 31, 2010.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.	<input type="checkbox"/>
4. The qualifying event was a reduction of hours and was not followed by a termination of employment (or the termination occurred prior to March 2, 2010, or after May 31, 2010).	<input type="checkbox"/>
5. 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 → _____

This form is designed for plans to distribute to COBRA qualified beneficiaries 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.
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:

_____	_____
_____	_____

PREMIUM ASSISTANCE EXTENSION NOTICE

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice contains important information about additional rights you may have related to your COBRA continuation 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), as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010, and the Continuing Extension Act of 2010 (CEA), reduces the COBRA premium in some cases. You are receiving this notice because you either:

- 1. *Became an Assistance Eligible Individual or experience(d) a qualifying event that was related to the termination of a covered employee's employment on or after April 1, 2010, but were not provided a notice that included the information required by ARRA, as amended; or***
- 2. *Experience(d) a loss of health coverage due to reduction of hours between September 1, 2008, and May 31, 2010, followed by a subsequent involuntary termination that occurred on or after March 2, 2010, through May 31, 2010.***

If you experience(d) an involuntary termination of employment you may be eligible for the temporary premium reduction for up to 15 months. **To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" with details regarding eligibility, restrictions, and obligations.**

Important Information about Your COBRA Continuation Coverage Rights

How much does COBRA continuation coverage cost?

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 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) 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.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by Continuing Extension Act, reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who either experience a qualifying event relating to COBRA continuation coverage that is either: 1) an involuntary termination of employment during the period beginning September 1, 2008, and ending May 31, 2010, or 2) loss of health coverage due to reduction in hours on or after September 1, 2008, through May 31, 2010, and is followed by a subsequent involuntary termination that occurs on or after March 2, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, 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, as Amended" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get

advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011, and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a non-forfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

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

Under normal circumstances, you have a grace period of at least 30 days after the first day of the coverage period to make each periodic payment. If you fail to make a periodic payment before the end of the grace period for that coverage period, you would lose all rights to continuation coverage under the Plan.

Please note, individuals that experience a qualifying event due to reduction in hours but do not choose or discontinue COBRA coverage, and are subsequently involuntarily terminated per the Continuing Extension Act, receive a new COBRA election period, and are not mandated to pay COBRA premiums back to original loss of coverage date. Instead, the COBRA premiums are payable based on the involuntary termination qualifying event date (typically, first of the month following the involuntary termination), and the COBRA continuation period is based on the first qualifying event date due to reduction in hours. COBRA Premium Assistance for these individuals will continue for up to 15 months, based on the COBRA continuation period.

All periodic payments for continuation coverage should be sent to: *[enter appropriate payment address]*

You may contact *[enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan]* to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about 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.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact *[enter name of party responsible for COBRA administration for the Plan, with telephone number and address]*.

State and local government employees may also access the website for the Centers for Medicare and Medicaid Services (CMS) at www.cms.hhs.gov/COBRAContinuationofCov/, or contact them at (866) 400-6689.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.