



Model Georgia State Continuation Coverage Election Notice

For use where coverage is subject to Georgia State Group Health Insurance Continuation requirements during the period that begins with September 1, 2008 and ends with December 31, 2009.

Date of Notice: _____

Dear _____
[Name of qualified beneficiary(ies)]

This notice contains important information about your right to continue your group health insurance coverage in the _____ (the Plan).
(Name of employer group health insurance plan)

Please read the information contained in this notice very carefully.

Georgia State Continuation Coverage under O.C.G.A. Section 33-24-21.1(c) requires group health insurance coverage, including this coverage, to give individuals and their families the opportunity to continue their coverage when there is a qualifying event that results in a loss of coverage. Individuals electing continuation coverage may not be charged more than 100% of the combined employer/employee premium applicable to other group members.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. Individuals who are receiving this election notice in connection with a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 may be eligible for the temporary premium reduction for up to nine months. Not all individuals who elect continuation coverage are eligible for the premium reduction. 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 Continuation Coverage Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual."

HOW TO APPLY FOR CONTINUATION COVERAGE AND THE PREMIUM REDUCTION

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Form A, entitled "Continuation Coverage Election Form" and submit it to [insert applicable name and address]. If you previously declined continuation coverage and your employment was involuntarily terminated between September 1, 2008 and February 17, 2009, then you now have a second opportunity to elect group health insurance continuation coverage.

If you elect continuation coverage AND believe that you meet the criteria for the premium reduction, then complete the enclosed Form B entitled "Request for Treatment as an Assistance Eligible Individual" and return it with your completed Continuation Coverage Election Form (Form A).

If you currently have continuation coverage AND believe that you meet the criteria for the premium reduction, then complete the enclosed Form B entitled “Request for Treatment as an Assistance Eligible Individual.”

If you do not elect continuation coverage, your Georgia group health insurance coverage from your employer will end on _____ *[insert date]*_____.

If elected, Georgia group health insurance continuation coverage will begin on _____ *[insert date]* _____ and can last until *[insert date]*_____.

Second Election Assistance Eligible Individuals are those persons who previously declined state group health insurance continuation coverage and whose employment was involuntarily terminated between September 1, 2008 and February 17, 2009. Second Election Assistance Eligible Individuals have options available to them about when their continuation coverage begins.

Option One is to elect to have continuation coverage begin when a potential premium subsidy is available under ARRA, March 1, 2009. Under this first option, subsidized continuation coverage, if elected by those eligible for subsidy, will be retroactive to March 1, 2009 and Insurers are authorized to calculate and collect retroactive subsidized monthly premiums to match the continuation coverage period back to March 1, 2009. For these second election assistance eligible individuals, any gap in coverage between September 1, 2008 and February 17, 2009 will be disregarded for the purpose of determining whether a pre-existing condition limitation applies.

Option Two for Second Election Assistance Eligible Individuals would be an election by the individual for the continuation coverage to begin on a first day of a month no later than 60 days after the individual’s receipt of notice of the second election. Insurers may collect retroactive premiums back to the elected date the continuation coverage begins.

For all other Assistance Eligible individuals, continuation coverage, if elected, must commence on the date that group health insurance coverage otherwise would have been lost due to a qualifying event.

Under Georgia Code Section 33-24-21.1(c)(3), you may change the coverage option for your continuation coverage to something different than what you had on the last day of employment, if your former employer offers the option of a High Deductible Health Plan (“HDHP”) eligible for use with a Health Savings Account (“HSA”) under Section 223 of the Internal Revenue Code. To change to this HDHP coverage option, complete the enclosed Form C, entitled “Form for Switching Continuation Coverage Benefit Options” and return it to *[insert applicable name and address]*. You must still complete Form A to secure your continuation coverage. Contact your former employer or group health insurer to obtain information on available HDHP coverage options, if any.

WHAT DOES CONTINUATION COVERAGE COST?

The regular monthly premium for State Health Insurance Continuation Coverage under your current group health insurance plan will cost \$ *[Enter monthly premium amount representing the combined employer/employee cost per month of coverage]*. This amount is the combined employer/employee contribution toward the monthly cost of health insurance coverage.

If you qualify as an “Assistance Eligible Individual,” this monthly cost can be reduced to \$ [include the amount that is 35 percent of the amount above] , which is 35% of the combined employer/employee premium, for up to nine months. The first premium payment must be given to [enter name of party responsible for continuation coverage administration for the issuer] to establish payment not more frequently than on a monthly basis in advance. [Important additional information about payment for continuation coverage is included in the pages following the Continuation Coverage Election Form.]

If you have any questions about this notice or your rights to Georgia group health insurance continuation coverage, you should contact [enter name of party responsible for continuation coverage administration for the issuer, with telephone number and address].

Summary of the Continuation Coverage Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced continuation coverage premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an Assistance Eligible Individual and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- 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.*

◆ IMPORTANT ◆

- ◇ If, after you elect continuation coverage and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the 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 continuation coverage you can contact [enter name of party responsible for continuation coverage 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 issuer 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:

www.cms.hhs.gov/COBRAContinuationofCov or NewCobraRights@cms.hhs.gov

* 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.



Important Information about Your Georgia Group Health Insurance Continuation Coverage Rights

What is Georgia Group Health Insurance Continuation Coverage?

Georgia's group health insurance continuation coverage law gives covered employees and their family dependents the opportunity to continue their coverage when there is a qualifying event that results in a loss of coverage under an employer's plan.

Continuation coverage is the same coverage that the employer provides through its group health insurance plan to other participants or beneficiaries under the plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the employer's group health insurance plan as other covered employee participants and their dependents under the plan.

How long does Georgia Group Health Insurance Continuation Coverage last?

For Assistance Eligible Individuals as defined under ARRA, Georgia law now provides that if an employee is involuntarily terminated and loses Georgia Group Health Insurance coverage, then group health insurance coverage generally may be continued during the fractional month of termination plus up to 9 months from the date coverage would otherwise terminate.

How can you elect Georgia Group Health Insurance Continuation coverage?

To elect continuation coverage, you must complete the Continuation Coverage Election Form and furnish it according to the directions on the form.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under federal and state law. For example, if you have a pre-existing condition, then having a gap in coverage greater than 63 days may cause you to have a pre-existing condition waiting period when you obtain other group or individual coverage.

You should take into account that you may have other coverage options, such as another group health plan for which you may be otherwise eligible, if you enroll within 30 days after your group health coverage ends because of the qualifying event listed above. An example is a group health plan sponsored by your spouse's employer. You may also have the opportunity to enroll in another group health plan for which you are otherwise eligible at the end of continuation coverage if you elect and exhaust continuation coverage for the maximum time available to you. You may also preserve future rights you may have to convert the continued group health insurance coverage to an individual health conversion policy on a guaranteed issue basis, without recognition or penalty for any pre-existing conditions you may have at that time.

How much does Georgia Group Health Insurance Continuation Coverage cost?

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. The premium reduction is available to certain Assistance Eligible Individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35

percent of the continuation coverage premium otherwise due to the issuer. This premium reduction is available for up to nine months. If you are not eligible for the premium assistance, then you will have to pay the full amount to continue your state continuation coverage. See the attached “Summary of the Continuation Coverage Premium Reduction Provisions under ARRA” for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

[If employees might be eligible for trade adjustment assistance, the following information must be added: 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 state 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.]

What if I was involuntarily terminated between September 1, 2008 and February 17, 2009 and previously declined state group health insurance continuation coverage, did not elect continuation coverage when it was first offered to me, or elected continuation coverage and let it lapse?

Georgia law creates a new, special second election period for individuals whose employment was involuntarily terminated between September 1, 2008 and February 17, 2009 who did not elect state group health insurance continuation coverage, who elected continuation coverage and let it lapse, or who received a notice of the right to continue coverage and did not respond to the notice. These individuals have a second opportunity to elect Georgia group health insurance continuation coverage, this time with a premium reduction for the period beginning March 1, 2009, if they are Assistance Eligible Individuals. Individuals must elect continuation coverage within 60 days of receiving notice.

Note that Georgia state continuation coverage is limited to a period of a combined total of nine months. The period beginning on the date that you were involuntarily terminated and ending when the continuation coverage starts will be disregarded for the purpose of determining whether a condition is pre-existing.

What if I already paid the full continuation coverage premium and am later determined to be eligible for the premium reduction?

The [enter name of party responsible for continuation coverage administration for the insurer] will apply the overpayment as a credit toward subsequent premium payments as long as it is reasonable to believe that the credit can be used within 180 days of the overpayment. Otherwise, the overpayment must be reimbursed to the individual within 60 days of receipt. Premium credit or reimbursement of overpayment is available for Assistance Eligible Individuals starting with the first coverage period beginning on or after February 17, 2009.

When and how must payment for Georgia State Group Health Insurance Continuation Coverage be made?

The first premium payment must be given to [enter name of party responsible for continuation coverage administration for the insurer] to establish payment not more frequently than on a monthly basis in advance. [Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.]

You may contact [enter appropriate contact information for the party responsible for continuation coverage administration under the Plan] to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Your payment(s) for continuation coverage should be sent to:

[enter appropriate payment address]

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from [enter appropriate contact information for the party responsible for continuation coverage administration under the Plan].

If you have any questions concerning the information in this notice, your rights to coverage you should contact [enter name of party responsible for continuation coverage administration for the Plan, with telephone number and address].

For more information about your rights under Georgia Group Health Insurance Continuation law, contact the Georgia Office of Commissioner of Insurance, Consumer Services Division at 1-800-656-2298, 1-404-656-2070 or visit the Commissioner of Insurance web site at www.gainsurance.org

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep [enter name and contact information for the appropriate party responsible for continuation coverage administration under the Plan] 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 [enter the name of the party responsible for continuation coverage administration under the Plan].

FORM A
Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under Georgia law, you have 60 after the date of this notice or after the date of termination, whichever is longer, to decide whether you want to elect continuation coverage.

Send completed Election Form to: [Enter Name and Address]

This Election Form must be completed and returned by mail [or describe other means of submission and due date]. If mailed, it must be post-marked no later than 60 after the date of this notice or after the date of termination, whichever is longer.

If you do not submit a completed Election Form by the due date, you will lose your right to elect continuation coverage.

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

I (We) elect continuation coverage in the [enter name of plan] (the Plan) as indicated below:

| Name | Date of Birth | Relationship to Employee | SSN (or other identifier) |
|------|---------------|--------------------------|---------------------------|
|------|---------------|--------------------------|---------------------------|

a. _____

[Add if appropriate: Coverage option(s): _____]

b. _____

[Add if appropriate: Coverage option(s): _____]

c. _____

[Add if appropriate: Coverage option(s): _____]

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

FORM B

To apply for ARRA Premium Reduction, complete this form and return it to us with FORM A, the "Continuation Coverage Election Form." You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: [Enter Name and Address]

You may also want to read the important information about your rights included in the "Summary of the Continuation Coverage Premium Reduction Provisions Under ARRA."

[Insert Plan Name]

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

[Insert Plan Mailing Address]

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 December 31, 2009. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I elected (or am electing) 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 ISSUER 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 December 31, 2009. | <input type="checkbox"/> |
| 3. Individual did not elect continuation coverage. | <input type="checkbox"/> |
| 4. Other (please explain) | <input type="checkbox"/> |

Signature of party responsible for continuation coverage 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) 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) 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) 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 issuers to distribute to qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the issuer if they become eligible for other group health plan coverage or Medicare.

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

Plan Name

Plan Mailing Address

Participant Notification

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

FORM C

[Only use this model form if the plan permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred.]

Form for Switching Continuation Coverage Benefit Options

Instructions: To change the benefit option(s) for your continuation coverage to something different than what you had on the last day of employment, complete this Form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.

Only Assistance Eligible Individuals may change continuation coverage benefit options. If you are not an Assistance Eligible Individual but want to elect continuation coverage, then you must keep the same coverage that you presently have.

Send completed Form to: [Enter Name and Address]

This Form must be completed and returned by mail [or describe other means of submission and due date]. If mailed, it must be post-marked no later than 90 days after the date of this notice.

THIS IS NOT YOUR ELECTION NOTICE

YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE (FORM A) TO SECURE YOUR CONTINUATION COVERAGE.

I (We) would like to change the continuation coverage option(s) in the [enter name of plan] (the Plan) as indicated below:

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

a. _____

Old Coverage Option: _____

New Coverage Option: _____

b. _____

Old Coverage Option: _____

New Coverage Option: _____

c. _____

Old Coverage Option: _____

New Coverage Option: _____

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number