Kaiser Permanente Health Plan of Georgia, Inc.
P.O. Box 921012
Fort Worth, TX 76121-0012

Date:

[Section reserved for member contact information]

Regarding: **State Continuation Coverage Premium Subsidy**

Dear subscriber and any covered dependents:

This notice contains important information about your and your dependents' right to continue health care coverage under [Group Name:] (the Plan). Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the State 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. To help determine whether you and/or your dependents can get the ARRA premium reduction, you and your dependents 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 "Request for Treatment as an Assistance Eligible Individual." **If you and/or your dependents meet the criteria for the premium reduction, please complete the "Request for Treatment as an Assistance Eligible Individual" and forward it to the former employer (see contact information below).** The former employer should complete section 2 of the form and send it to us for processing. After we process your request, we will let you and any dependents know whether you and they are approved for the subsidy.

For general information regarding State Continuation Coverage and the ARRA Premium Reduction, please contact the former employer:

[Section reserved for Employer Group contact information]

Sincerely,

Kaiser Permanente

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.*

Note: Certain individuals who previously declined Georgia State Continuation Coverage (or who elected Georgia State Continuation Coverage and then later disenrolled) may be eligible for an additional opportunity to enroll in Georgia State Continuation Coverage with the nine-month premium reduction. To see if you are eligible to enroll during this special election period, please contact the former employer. If you believe you meet the requirements for both the special election and the premium reduction, you must apply for "State Continuation Coverage" with the former employer AND complete the "Request for Treatment as an Assistance Eligible Individual" form and send it to the employer.

♦ IMPORTANT ♦

- ◊ If, after you elect state 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.
- ◊ If the former employer offers more than one plan to its employees, and if the former employer permits, you may be able to enroll in a different plan than the one you were enrolled in at the time of termination, if the premium for the other plan is not more than the premium for the plan in which you were enrolled. For questions about enrolling in another plan, please contact the former employer listed below.

* 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.

State Continuation Coverage Subsidy

For general information regarding State Continuation Coverage and the ARRA Premium Reduction, please contact the former employer

[Section reserved for Employer Group contact information]

If you are denied treatment as an Assistance Eligible Individual, you may have the right to have the denial reviewed. If you would like more information about the premium subsidy or the appeal process, you should contact the premium assistance continuation coverage help desk sponsored by the federal Centers for Medicare & Medicaid Services at (866) 400-6689 or by e-mail at continuationcoverage@maximus.com.

State Continuation Coverage Subsidy

To apply for ARRA Premium Reduction, complete this form and send it to the former employer (please do not send this form directly to Kaiser Permanente as that will delay the processing of the request).

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."

Kaiser Permanente

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Section 1 (To be completed by requestor)

PERSONAL INFORMATION

Subscriber HRN # (GA Region):	
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.	☐ Yes ☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	☐ Yes ☐ No
3. I elected (or am electing) continuation coverage.	☐ Yes ☐ 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).	☐ Yes ☐ 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).	☐ Yes ☐ 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 → _____

Requestor: Please send this form to the former employer.

Note: After Kaiser Permanente has received this completed from the employer, you and the employer will be notified of the decision regarding this request.

Section 2 (To be completed by Employer)

Please select the applicable checkbox(es):

☐ Loss of employment was involuntary AND took place between September 1, 2008 and December 31, 2009
OR
☐ Loss of employment was voluntary
☐ The involuntary loss of employment did not occur between September 1, 2008 and December 31, 2009.

☐ Requestor has been (will be) enrolled in State Continuation Coverage as of:_____(mm/dd/yy)
☐ Enrollment in State Continuation Coverage was (will be) done through 'second chance'

Employer Plan Administrator Signature

→ _____ Date → _____

Print Name → _____

Telephone number → _____ E-mail address → _____

Employer: Please fax or mail this form to
Kaiser Permanente Consolidated Service Center
P.O. Box 921012
Fort Worth, TX, 76121-0012
Fax: 1-866-311-5974

State Continuation Coverage Subsidy

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 in the process of electing with the former employer) continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ 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 in the process of electing with the former employer) continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ 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 in the process of electing with the former employer) continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

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

Kaiser Permanente	**Participant Notification**	Kaiser Permanente Consolidated Service Center P.O. Box 921012 Fort Worth, TX, 76121-0012

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 Kaiser Permanente 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 means that you are eligible to enroll in other group health plan coverage or Medicare, even if you do not actually enroll. **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:

_____ _____

_____ _____