

For Distribution to Brokers/General Producers/Full-Service Producers Only

June 26, 2009

Notification for Involuntarily Terminated Employees Eligible for State Continuation Coverage

MARKET: GROUPS WITH FEWER THAN 20 EMPLOYEES

This is an update to the [April 17, 2009 Sales Flash](#) and the [May 8, 2009 Sales Flash](#) regarding the American Recovery and Reinvestment Tax Act (ARRA) of 2009 as it relates to State Continuation Coverage for employers with fewer than 20 employees.

As you may know, ARRA dramatically affects employers whose group health plans are subject to COBRA. For those employer groups with less than 20 employees that are not eligible for Federal COBRA premium subsidies, State Continuation premium subsidies may be available. Please note that religious organizations are also eligible for State Continuation coverage.

As a result of this legislation, CareFirst BlueCross BlueShield (CareFirst) is required to send a notice to individuals (and their qualified beneficiaries) who experienced a qualifying event between February 17, 2009 and December 31, 2009 while employed by a group with less than 20 employees. The new law requires that the carrier notify involuntarily terminated individuals about their potential eligibility to obtain up to a 9-month subsidy of the continuation premium from March 1, 2009 forward.

CareFirst is unable to identify those who are involuntarily terminated from an employer group. In order to provide the required documents to those affected individuals, information must be provided by the employer. Please note that if your client is a small group with more than 20 employees this request for information does not apply to them.

To ensure that CareFirst remains compliant with this law, the attached letter will be mailed to all employer groups with 20 or fewer employees in Maryland, DC and Virginia on July 2, 2009. This letter includes instructions for submitting data to CareFirst when employees are involuntarily terminated. When CareFirst receives contact information for affected individuals, we will mail the attached State Continuation Premium Subsidy packet to those individuals.

For Full-Service/General Producers: We ask that you send contact information for affected individuals to CareFirst via e-mail to mandates.team@carefirst.com on behalf of your groups. We will need the group number, group name, employee name and employee address. Please send this information in a spreadsheet as you receive it from your groups.

Paperwork:

Please follow the processes below for members that meet the criteria for premium reduction for terminations occurring on or after February 17, 2009:

- **Direct Brokers:** Enrollees complete the **Application for Treatment as an Assistance Eligible Individual** as well as the **Election Form** that they received in the State Continuation Premium Subsidy packet obtained from CareFirst. Please send the completed enrollment forms to CareFirst

for processing through the regular e-mail address in the MD office at direct.broker.one@carefirst.com, or by Right fax at 410-505-2159 or in the UCP office by Right fax at 301-470-7604.

- **Brokers that use a Full-Service (FSP) /General Producer (GP):** Enrollees may complete either the Full-Service Producer approved State Continuation Election form (if available) or the ***Application for Treatment as an Assistance Eligible Individual*** and the ***Election Form*** that they received in the State Continuation Premium Subsidy packet obtained from CareFirst. **All brokers using either an FSP or GP must submit their enrollment forms to their Full-Service/General Producer for processing.**

Reminder: CareFirst Connect cannot be used to enroll eligible subsidy State Continuation members.

If an overpayment of premium has occurred, CareFirst will refund the difference between the amount paid and the amount due. Please note that if a refund is not received within 15 days, a refund request should be faxed to (410) 505-6791. Please be sure to include the following information in the request: Group Name/Telephone Number; Member Name/Address/Telephone Number; Member ID or SSN; the point of contact for the refund request; and the name of the payee.

Should you have any questions, please contact your Broker Sales Representative.



Shekar Subramaniam
Associate Vice President, Broker Sales

July 2, 2009



Dear Employer:

You may have recently received a letter from CareFirst BlueCross BlueShield (CareFirst) regarding the American Recovery and Reinvestment Tax Act of 2009 that was signed into law on February 17, 2009. This law dramatically affects employers whose group health plans are subject to COBRA, which includes virtually all employers with 20 or more employees. **However, the Act also impacts those plans which provide continuation coverage pursuant to State law to employers with less than 20 employees when that continuation coverage is deemed to be comparable to COBRA.** As you may know, the Act provides a 65% government premium subsidy to employees who are involuntarily terminated between September 1, 2008 and December 31, 2009.

As a result of this legislation, CareFirst is also required to send a notice to individuals (and their qualified beneficiaries) who experienced a qualifying event between February 17, 2009 and December 31, 2009 while employed by an employer with less than 20 employees.

This law requires CareFirst to notify those individuals, who are involuntarily terminated, about their potential eligibility to elect continuation coverage and obtain up to a 9-month subsidy of the continuation premium from March 1, 2009 forward. **Unfortunately, we do not have access to this information and must receive this information from you in order to provide the required notification to impacted individuals.**

Please note that if your business is not subject to state continuation coverage (for example, if you employ more than 20 employees) this letter and its request for information does not apply to you, your group or your employees.

Action Required

To ensure that CareFirst remains compliant with this law, please send the name, address and date of termination of any employee (or their qualified beneficiary) who meets the list of qualifying events to **mandates.team@carefirst.com**. Information should be sent as an Excel spreadsheet that contains your **group name, group number** and the list of **qualifying individuals** with the most current address you have on record for them. **Please password-protect the spreadsheet by using the password COBRA417** and add the word "confidential" within the subject line. You also have the option to fax this information to (410) 505-2619. Please keep this letter for future reference.

- **Qualifying Events** include involuntary loss of employment and eligibility for state continuation coverage between February 17, 2009 and December 31, 2009.
- **Qualifying Individuals** include Employees or Former Employees, Spouse or Former Spouse, and Dependent Children covered by the Plan the day before the qualifying event occurred.

As always, CareFirst appreciates the time it takes to assist us in informing your employees and their qualified beneficiaries of the benefits that may be available to them as the result of State and Federal legislation. We look forward to hearing from you.

Wishing you and your business continued success.

Sincerely,

A handwritten signature in black ink that reads "Michael J. Felber".

Michael J. Felber
Senior Vice President, Sales

ACC2018 (6/09)



[insert date]

RE: State Continuation Coverage Premium Subsidy Notice

Dear Beneficiary,

This notice contains important information about the right you might have to elect to continue your health care coverage in the group health plan (the Plan) from which you were involuntarily terminated. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium by 65%. Individuals who are receiving this election notice in connection with a loss of coverage that occurred between February 17, 2009 and December 31, 2009 may be eligible for the temporary premium reduction for up to nine months.

To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, you should review the *Summary of the Continuation Coverage Premium Reduction Provisions under ARRA* that contains details regarding eligibility, restrictions and obligations, as well as the *Application for Treatment as an Assistance Eligible Individual*.

If you believe that you meet the criteria for the premium reduction, please complete the *Application for Treatment as an Assistance Eligible Individual* and return it to your former employer, along with your completed Election Form. Please note that based on State laws, your application must be returned within 60 days from the date on this notice if you live in Virginia or 45 days from the date on this notice if you live in Maryland or Washington, DC.

To elect continuation coverage, read the instructions on the following pages, complete the enclosed form and submit to your former employer. If you do not elect continuation coverage, your coverage under the Plan will end on the date of your involuntary termination of employment after which premiums were no longer paid.

Each person in the category(ies) checked below is entitled to elect continuation coverage, which will continue group health care coverage under the Plan:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage

If you elect the COBRA subsidy and are determined to be an “Assistance Eligible Employee” by your former employer, your subsidy will begin with the first period of coverage beginning on or after the loss of coverage.

Contact your former employer to determine whether or not you can elect to enroll in coverage that is different than the coverage you were enrolled in at the time of your involuntary termination. To change the coverage option(s) for your continuation coverage to something different than what you had on the last day of employment, complete the *Switching Continuation Coverage Benefit Options Form* and return it with your application to your former employer.

To determine the cost of continuation coverage, check with your former employer. If you qualify as an "Assistance Eligible Individual" this cost can be reduced by 65% (you will need to pay 35% of the premium amount), for up to nine months. Additional important information about paying for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact the employer from which you were involuntarily terminated.

Continuation Coverage Election/Notification Form

To elect continuation coverage, complete this Election/Notification Form and return it to your former employer. Based on State laws, this Election/Notification Form must be completed and returned to your former employer within 60 days from the date on this notice if you live in Virginia or 45 days from the date on this notice if you live in Maryland or Washington, DC. If you do not submit a completed Election/Notification Form within the timeframes listed above, you will lose your right to continuation coverage.

I (We) elect continuation coverage in my former employer's health plan (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____			
Coverage option(s) - add if appropriate: _____			
b. _____			
Coverage option(s) - add if appropriate: _____			
c. _____			
Coverage option(s) - add if appropriate: _____			

Signature

Date

Print Name

Relationship to Individual(s) Listed Above

Print Address

Telephone Number

Switching Continuation Coverage Benefit Options Form

THIS IS NOT YOUR ELECTION NOTICE - YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR CONTINUATION COVERAGE.

To change the benefit option(s) for your continuation coverage to something different than what you had on the last day of employment, complete and return this form.

I (We) would like to change the continuation coverage option(s) in my former employer's health 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

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 you were enrolled at the time of your involuntary termination. Please confirm with your former employer.

Important Information about Your Continuation Coverage Rights

What is continuation coverage?

State law requires that most group health insurance coverage (including this coverage) give employees and their families the opportunity to continue their coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan (the Plan). Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives 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 Plan as other participants or beneficiaries covered under the Plan.

How long will continuation coverage last?

Continuation coverage varies by state. Please check with your former employer to determine what the length of continuation coverage is for your state.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes eligible for coverage under another group health plan,
- a qualified beneficiary accepts coverage under a non-group policy that provides hospital, medical, or surgical benefits written on an expense basis or under a Health Maintenance Organization contract,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both),
- for a qualified beneficiary who is covered as a divorced spouse, the date the qualified beneficiary remarries; or
- the former employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage - such as fraud or a child reaching a limiting age in the policy.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and submit 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 will affect your future rights under federal and state 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 a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a pre-existing condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal and state law.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. If the group coverage ends due to loss of job or death of the employee, the amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for a similarly situated plan participant or beneficiary who is not receiving continuation coverage. If the group coverage ends due to divorce, the amount a qualified beneficiary may be required to pay may not exceed 100% of the cost to the group health plan (including both employer and employee contributions) for a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. The premium reduction is available to certain 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 your continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your 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.

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 continuation coverage be made?

You may contact your former employer to confirm the correct amount of your payments 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 with respect to your coverage. More information is available from your former employer at the time of your involuntary termination.

For more information about your rights under state law, contact the Insurance Administration of your state. Attached is the contact information:

Maryland Insurance Administration

200 St. Paul Place - Suite 2700
Baltimore, Maryland 21202
www.mdinsurance.state.md.us
(800) 492-6116

Insurance Bureau of the Department of Insurance, Securities and Banking (DISB)

810 First Street, NE - Suite 701
Washington, DC 20002
www.disb.dc.gov
(202) 727-8000

Virginia Bureau of Insurance

PO Box 1157
Richmond, Virginia 23218
www.scc.virginia.gov/division/boi
(804) 371-9741

Keep Your Plan Informed of Address Changes:

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

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, which 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 succeeding employer or a spouse’s employer. (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:

- If, after you elect COBRA or State continuation of 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 your former employer.

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 your former employer.

If you are denied treatment as an Assistance Eligible Individual you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: www.cms.hhs.gov/COBRAContinuationofCov or NewCobraRights@cms.hhs.gov.

To apply for ARRA Premium Reduction, complete this form and return it to your former employer along with your Election/Notification Form. 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*.

Former Employer's Group Name	APPLICATION FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	Former Employer's Mailing Address
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Personal Information

Name and mailing address of employee: <i>(list any dependents on the back of this form)</i>	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 wish to waive my rights to premium assistance.	<input type="checkbox"/>

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: _____

EMPLOYER MUST COMPLETE THE FOLLOWING:

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: _____

Employer: Please submit Election Forms and the Application for Treatment as an Assistance Eligible Individual through your standard enrollment channel. Note: CareFirst Connect cannot be used to enroll eligible individuals into State Continuation Coverage.

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.

Former Employer's Group Name	PARTICIPANT NOTIFICATION	Former Employer's 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 _____		<input type="checkbox"/>
I am eligible for Medicare. Insert date you became eligible _____		<input type="checkbox"/>

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:

_____	_____
_____	_____
_____	_____