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MS SALLY CURR-ENROLLED
456 BEE STREET
MY TOWN PA 55456

COBRA Continuation Coverage Supplemental Notice

Dear: Ms Sally Curr-Enrolled

This notice contains important information about additional rights you may have related to your COBRA continuation coverage in the plan(s) below. Please read the information contained in this notice very carefully.

Plan ID Plan Information

501 Group Health Plan for Test Company
 Mr. Test PlanAdmin -- Administrator
 123 Road Suite 2
 Test City MN 55401
 (123) 456-5432

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. You are receiving this notice because you experienced a loss of coverage at some time on or after September 1, 2008 and chose to elect COBRA continuation coverage. If your loss of health coverage was due to an involuntary termination of employment you 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, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA" 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 to us at the following address :

ARRA Enrollment 218
c/o HR Simplified
8441 Wayzata Blvd., Suite 300
Mpls, MN 55426
866-963-0580

Important Information about Your COBRA Continuation Coverage Rights

How much does COBRA continuation coverage cost?

Your total non-subsidized monthly premium is:

	<u>Carrier Name</u>	<u>Description</u>	<u>Amount Due</u>	<u>Bill.Cycle</u>
TSTHMO :1M	Test HMO for Test Company	Sgl Test HMO	\$ 150.00	1 Month

Your total monthly premium after the subsidy is:

	<u>Carrier Name</u>	<u>Description</u>	<u>Amount Due</u>	<u>Bill.Cycle</u>
TSTHMO :1M	Test HMO for Test Company	Sgl Test HMO	\$ 52.50	1 Month

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) reduces the COBRA 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 COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine 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" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

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

Other than the amount, nothing else about the payment has changed. All periodic payments for continuation coverage should be sent to:

ARRA Enrollment 218
c/o HR Simplified
8441 Wayzata Blvd., Suite 300
Mpls, MN 55426
866-963-0580

You may contact HR Simplified, Inc. 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:

ARRA Enrollment 218
c/o HR Simplified
8441 Wayzata Blvd., Suite 300
Mpls, MN 55426
866-963-0580

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov.

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.

Summary of the COBRA 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 COBRA 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.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

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 or 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,

Please Contact,

ARRA Enrollment 218

c/o HR Simplified

8441 Wayzata Blvd., Suite 300

Mpls, MN 55426

866-963-0580

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

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

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Return this form to HR Simplified if electing coverage

Instructions

To apply for ARRA Premium Reduction, complete this form and return it to us along with your Election Form.

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA." 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 the contact information found under *Additional Election Period* section.

Personal Information

Name: Ms Sally Curr-Enrolled

Telephone: _____ - _____ - _____

Address: 456 Bee Street
My Town, PA 55456

Email (Optional): _____

To Qualify, you must be able to circle 'Yes' for all the 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) COBRA 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

*If you circled NO for statement 3, you may still be eligible. See below for more information.

ADDITIONAL ELECTION PERIOD

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through the date of this letter and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. Included is a new election notice, The Election Form **MUST** be completee and returned. If you believe you should have received this additional notice but have not, contact

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c/o HR Simplified
8441 Wayzata Blvd.
Suite 300
Mpls, MN 55426
866-963-0580

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 provided on this form are true and correct.

PRINT NAME

SIGNATURE

DATE

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
2. The involuntary loss did not occur between September 1,2008 and December 31,2009
3. Individual did not elect COBRA coverage.*
4. Other (please explain on reverse side)

*If you checked number 3, was individual eligible for, and given, the Additional Election Period described on reverse side?

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

PRINT NAME

SIGNATURE

DATE

Telephone number _____

E-mail address _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)
Return this form to HR Simplified if electing coverage

Last Name, First **Birthdate** **Gender** **Relationship** **Dependents SSN**
_____ ____/____/____ _____ _____ ____-____-____

1. I elected (or am electing) COBRA 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 _____

Last Name, First **Birthdate** **Gender** **Relationship** **Dependents SSN**
_____ ____/____/____ _____ _____ ____-____-____

1. I elected (or am electing) COBRA 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 _____

Last Name, First **Birthdate** **Gender** **Relationship** **Dependents SSN**
_____ ____/____/____ _____ _____ ____-____-____

1. I elected (or am electing) COBRA 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 _____

Participant Notification

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

Personal Information

Name: Ms Sally Curr-Enrolled

Telephone: _____ - _____ - _____

Address: 456 Bee Street
My Town, PA 55456

Email (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:
