COBRA ELECTION NOTICE - NEW YORK STATE CONTINUATION OF COVERAGE

This is an important notification regarding a subsidy that may be available to you through recent changes to the New York State Continuation of Coverage ("State COBRA").

The new changes to State COBRA provides a subsidy to help alleviate some of the burden of COBRA premium payments for most Assistance Eligible Individuals ("Eligible Individual"). The subsidy will cover 65% of the premium charged to the Eligible Individual, meaning that the Eligible Individual is only responsible for paying 35% of the original COBRA premium to the former employer. Atlantis Health Plan will collect the remaining 65% subsidy from the government.

An Eligible Individual is a person who becomes qualified for COBRA between September 1, 2008 and May 31, 2010 due to involuntary termination of employment. The subsidy also applies to COBRA qualified spouses and dependents of Eligible Individuals.

In order to qualify for the full subsidy, the Eligible Individual's modified adjusted gross income cannot exceed $125,000 and a couple's annual salary cannot exceed $250,000.

A reduced subsidy is available for applicants ("High Income Individuals") whose modified adjusted gross income is between $125,000 and $145,000 ($250,000 and $290,000 for joint filers). High Income Individuals who take the subsidy will be subject to increased tax liability for any subsidy taken in the tax year they receive the subsidy. Their subsidy is taxed in gradual incremental amounts until the income is $145,000 ($290,000 for joint filers), at which point, the High Income Individual must repay the entire subsidy. High income individuals have the option to waive the subsidy.

If the applicant's modified adjusted gross income exceeds $145,000, $290,000 for those filing joint returns, the full amount of the subsidy must be repaid as an additional tax. There is no additional tax for individuals with modified adjusted gross income less than these income levels.

This subsidy will be available for 15 months, but not beyond the end of the maximum period of coverage required under COBRA. Coverage will also terminate should the person become entitled to coverage under another group health plan or Medicare.

Additionally, if available, Eligible Individuals may elect to change their health care coverage to a less expensive coverage option, provided that you do so within 90 days after date of this notice. Please check with your former employer if other options are available.

Note: Eligible Individuals must notify the former employer and Atlantis when they or any of their dependents no longer eligible for the subsidy or face financial penalties.

Please review the enclosed materials carefully, there are several forms enclosed. Please complete all forms as they apply to your request.

*If available and you choose to change your coverage to a less expensive option offered by your former employer, please also fill out the "Switching Continuation Coverage Benefit Options Form".

Please send all applicable forms to your former employer. In addition, your first premium payment must be sent to your former employer. All subsequent premium payments must also be sent to your former employer who will send to Atlantis Health Plan. Please note that if payment is not received, your coverage will terminate.

For more information on this law, please visit the US Department of Labor – www.dol.gov and the NY State Department of Insurance – www.ins.state.ny.us. Please contact your former employer for questions regarding the status of your application you sent to them. Additionally, they will be able to assist you with questions on what benefits are available to you under their plan.

New York State Continuation Coverage Election Notice
For use where coverage is subject to New York State continuation requirements during the period that begins with September 1, 2008 and ends with May 31, 2010.

Date of Notice: _____

This notice contains important information about your right to continue your health care coverage with Atlantis Health Plan (the Plan). Please read the information contained in this notice very carefully.

New York State's "continuation coverage" law 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 102% of the 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 May 31, 2010 may be eligible for the temporary premium reduction for up to 15 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."

SUMMARY OF THE CONTINUATION OF 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 with September 1, 2008 – May 31, 2010 and can last up to 15 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 May 31, 2010 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 May 31, 2010;
- 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.

HOW TO APPLY FOR CONTINUATION COVERAGE AND THE PREMIUM REDUCTION

Please be sure to fill out the following forms. Return all completed forms directly to you former employer. Be sure to include Form A for your former employer to fill out. They will send the completed application to Atlantis.

- To elect COBRA, follow the instructions on the following pages and complete the enclosed Form B, labeled "Continuation Coverage Election Form" and submit it to your former employer.
- If you elect continuation coverage AND believe that you meet the criteria for the premium reduction, then complete the enclosed:
  - Form B "Continuation Coverage Election Form"
  - Form C "Request for Treatment as an Assistance Eligible Individual"
  - Form D "Part 1 Employer Information and Verification"

  Return these forms directly to your former employer.
- If you currently have continuation coverage AND believe that you meet the criteria for the premium reduction, then complete the enclosed:
  - Form C labeled "Request for Treatment as an Assistance Eligible Individual"
  - Form D Part 1 "Employer Information and Verification".

ATTENTION FORMER EMPLOYERS

For each and every applicant, please be sure to fill out shaded sections labeled "FOR EMPLOYER USE ONLY".

- Form A – Entire Form
- Form C – Bottom Portion
- Form D – Only Part 2

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* 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 Continuation Coverage Rights

What is continuation coverage?
New York State's continuation coverage law gives individuals and their families the opportunity to continue their coverage when there is a qualifying event that results in a loss of coverage under an employer's plan. Depending on the type of qualifying event, qualified beneficiaries may include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the covered employee's dependent children.

Continuation coverage is the same coverage that the group health 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 group health plan as other participants or beneficiaries covered under the plan.

How long does continuation coverage last?
If an individual loses coverage due to end of employment or reduction in hours of employment, then coverage generally may be continued for up to 36 months from the date coverage would otherwise terminate. If an individual loses coverage due to an employee's death, divorce or legal separation, eligibility for Medicare benefits, or loss of dependent child status, then coverage may be continued for up to 36 months. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

How can you elect 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 will 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 get continuation coverage for the maximum time available to you.

How much does 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 May 31, 2010. 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 15 months. If your state continuation coverage lasts for more than 15 months or if you are not eligible for the premium assistance, then you will have to pay the full amount to continue your state continuation coverage. **Please note that if your former employer's group plan renews during your time on COBRA, your rate may change based on the group's renewal rate.** See the attached "Summary of the Continuation Coverage Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the forms necessary to establish eligibility.

If applicable: 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 already paid the full continuation coverage premium and am later determined to be eligible for the premium reduction?
The Plan and your former employer 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 continuation coverage be made?
The first premium payment must be given to your former employer to establish payment not more frequently than on a monthly basis in advance. You may contact your former employer or 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 your former employer.

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 or the Plan. If you have any questions concerning the information in this notice, your rights to coverage you should contact your former employer or the Plan. For more information about your rights under state continuation law, contact the New York State Insurance Department at 1-800-342-3736 or visit their web site at www.ins.state.ny.us.

Keep Your Plan Informed of Address Changes
In order to protect your and your family's rights, you should keep Atlantis Health 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 your former employer and Plan.

For general information regarding continuation coverage you can contact your former employer or Atlantis Health Plan at 866-747-8422 (Prompt 4).

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 or Atlantis Health Plan at 866-747-8422 (Prompt 4).

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

FORM A
EMPLOYER APPLICANT FORM

FOR EMPLOYER USE ONLY

If you do not elect continuation coverage, your coverage under the Plan will end on _____(date) due to:

☐ End of employment
☐ Involuntary ☐ Voluntary
☐ Divorce or legal separation
☐ Death of employee
☐ Entitlement to Medicare
☐ Reduction in hours of employment
☐ Loss of dependent child status

Each person in the category(ies) checked below is entitled to elect continuation coverage, which will continue group health care coverage under the Plan for up to the Maximum Period shown below.

Check One	Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
☐	Termination or reduction in hours of employment	Employee Spouse Dependent Child	36 months
☐	Employee enrollment in Medicare	Spouse Dependent Child	36 months
☐	Death of employee	Spouse Dependent Child	36 months
☐	Loss of "dependent child" status under the plan	Dependent Child	36 months
☐	Divorce or legal separation	Spouse Dependent Child	36 months

If elected, continuation coverage will begin on _____ (date) and can last until _____ (date).

WHAT DOES CONTINUATION COVERAGE COST?

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 can be reduced to $_____ [*include the amount that is 35 percent of the amount above*] for up to nine months. The first premium payment must be given to your former employer to establish payment not more frequently than on a monthly basis in advance.

FORM B
Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under New York State law, you have 60 days 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 your former employer.

This Election Form must be completed and returned by mail. It must be post-marked no later than 60 days 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.

I (We) elect continuation coverage with Atlantis Health 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

ATLANTIS
HEALTH PLAN

FORM C
REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

To apply for ARRA Premium Reduction, complete this form and return it along with any other required forms you must You may also send this form in separately.

<u>If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to your former employer.</u>

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."

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.	☐ Yes ☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before May 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 → _____

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.	☐ 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 electing) 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 electing) 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 → _____

FOR EMPLOYER 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 May 31, 2009.	☐
3. Individual did not elect continuation coverage.	☐
4. Other (please explain)	☐

Signature of party responsible for continuation coverage administration for the Plan

→ _____ Date _____

Type or print name → _____

Telephone Number → _____ Email → _____

ATLANTIS
HEALTH PLAN

FORM D
EMPLOYER INFORMATION AND VERIFICATION FORM

PART 1: EMPLOYEE TO FILL OUT

Dear Former Employer:

I received information from the insurance carrier regarding New York Continuation coverage and have completed the "Request for Treatment as an Assistance Eligible Individual" The carrier also sent me this Employer Information and Verification to send to you to complete.

In order for the carrier to determine if I am eligible for the ARRA Premium Reduction, please complete the following and return it to the carrier, along with my Request for Treatment as an Assistance Eligible Individual and my continuation election form, if it is enclosed. Please complete and mail immediately so the carrier may process my request.

Please understand that your cooperation in providing this information will **not** result in you being required to pay the 65% reduction. The carrier will pay it. Without this information I may not be able to take advantage of the premium reduction. While the carrier and I anticipate you will cooperate, the New York Department of Labor and Workforce Development has indicated it will take necessary action if an employer fails to cooperate. Further, if you fail to complete the Employer Information and Verification, the carrier will deny my request for treatment as an assistance eligible individual, which will entitle me to appeal rights with the U.S. Department of Health and Human Services.

Former Employee Name: _____
Fill in Your Name

ATLANTIS
HEALTH PLAN

FORM D
EMPLOYER INFORMATION AND VERIFICATION FORM

PART 2: FOR EMPLOYER USE ONLY

Date Employment Terminated: _____

Was the termination an *involuntary* termination of employment? ☐ Yes ☐ No
If no, the premium reduction is not available. Briefly describe the circumstances of the termination:

_____
_____

Date medical coverage terminated: _____

Do you currently offer group medical coverage to active employees? ☐ Yes ☐ No

If no, continuation is not available and neither is the premium reduction.

Has your company continuously maintained group medical coverage under our plan or under a succeeding carrier's plan since the date the employee was terminated? ☐ Yes ☐ No

If no, continuation is not available and neither is the premium reduction.

Do you offer more than one plan option to employees? ☐ Yes ☐ No

If yes, name the carriers and identify the other plans.

Carrier Name Plan (name and brief description)
_____ _____
_____ _____

Is your current group medical coverage issued by another carrier? ☐ Yes ☐ No

If yes, identify the carrier _____

If yes and your former employee was involuntarily terminated from employment between September 1, 2008 and December 31, 2009, please send a copy of this form to this other carrier at the address you currently use for new enrollments so the former employee may secure New York Continuation coverage and the premium reduction under that carrier's plan.

_____ _____
Employer – Signature Date

_____ _____ _____
Employer – Printed name Telephone E-mail

Instruction to Former Employer: Send this Employer Information and Verification form along with the New York Continuation Election Form, if any, Form for Switching Plan Options, if any and the Request for Treatment as an Assistance Eligible Individual to:

Atlantis Health Plan
COBRA B&E
90 Matawan Road, Suite 204
Matawan, NJ 07747

ATLANTIS
HEALTH PLAN

FORM E
SWITCHING CONTINUATION COVERAGE BENEFIT OPTIONS

"Assistance Eligible Individual," may change the coverage option(s) for their continuation coverage to something different than what they had on the last day of employment, if the former employer permits you to and offers other coverage options. To change coverage option(s), complete this form and return it to the former employer. You must still complete Form B to secure your continuation coverage. Contact your former employer to obtain information on available coverage options, if any. The different coverage must cost the same or less than the coverage you had at the time of the qualifying event; be offered to active employees; and cannot be limited to only dental coverage, vision coverage, counseling coverage, a flexible spending arrangement (FSA), including a health reimbursement arrangement that qualifies as an FSA, or an on-site medical clinic. Only Assistance Eligible Individuals may change coverage. Those who are not eligible for federal assistance may not change coverage.

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 your former employer. This Form must be completed and returned by mail. It must be post-marked no later than 90 days after the date of this notice.

I (We) would like to change the continuation coverage option(s) with Atlantis 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

ATLANTIS
HEALTH PLAN

FORM F
NO LONGER ELIGIBLE NOTIFICATION

Attention COBRA Participants use this form to notify your former employer that you are eligible for other group health plan coverage or Medicare and subsequently no longer qualified for COBRA. Keep this form for future use.

Participant Notification

PERSONAL INFORMATION

Name and Mailing Address _____

_____

_____

Telephone Number _____

Email 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:

_____ _____

_____ _____

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