

Colorado Continuation of Coverage Election Notice

(For use where coverage is subject to Colorado Continuation of Coverage requirements during the period that begins with September 1, 2008 and ends with December 31, 2009.)

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

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. 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,” on page 10 of this packet, 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” on page 5 of this packet and return it with your completed Election Form, found on page 4 of this packet.**

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to us. If you do not elect continuation coverage, your coverage under the Plan will not recommence.

Each of the listed persons is entitled to elect continuation coverage, which will continue group health care coverage under the Plan for up to the period of time (no longer than eighteen months from the date coverage under the Plan was originally lost) that Colorado law provides under C.R.S. 10-16-108.

If elected, continuation coverage will begin on [enter date] and can last no longer than 18 months from the date you lost coverage due to employment termination, change in marital status or the death of a covered employee.

If the Plan permits you to change your coverage to a different coverage that is currently offered by the Plan, other than the coverage in which you were enrolled on the day before the event that caused the loss of coverage, complete the “Form for Switching Continuation Coverage Benefit Options” found on page 6 of this packet and return it to us. *The different coverage must cost the same or less than the coverage the individual 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.* Please check with the Plan Administrator (usually, the employer that is sponsoring the Plan) whether the Plan permits you to change your coverage; RMHP may not know.

Based upon the covered family members that were enrolled on the date you lost coverage, continuation coverage will cost:

	Employee Only	Employee/Spouse	Employee/Children	Family
Medical	<<Medical1>>	<<Medical2>>	<<Medical3>>	<<Medical4>>
Dental	<<Dental1>>	<<Dental2>>	<<Dental3>>	<<Dental4>>
Vision	<<Vision1>>	<<Vision2>>	<<Vision3>>	<<Vision4>>
Total Due:	<<Total1>>	<<Total2>>	<<Total3>>	<<Total4>>

If you qualify as an “Assistance Eligible Individual” because you lost your job involuntarily, this cost will be as indicated below for up to nine months.

	Employee Only	Employee/Spouse	Employee/Children	Family
Medical	<<Medical1a>>	<<Medical2a>>	<<Medical3a>>	<<Medical4a>>
Dental	<<Dental1a>>	<<Dental2a>>	<<Dental3a>>	<<Dental4a>>
Vision	<<Vision1a>>	<<Vision2a>>	<<Vision3a>>	<<Vision4a>>
Total Due:	<<Total1a>>	<<Total2a>>	<<Total3a>>	<<Total4a>>

Though you do not have to send any payment with the Election Form, you must actually pay for elected continuation coverage, in full and in good funds, within thirty (30) days of the date of this Notice. **If you have already received a CCOC election notice, only “Assistance Eligible Individuals” are entitled to elect CCOC continuation coverage now and receive the subsidy.** Also, you are not entitled to add dependents to receive CCOC continuation coverage if such dependents were not covered on the day before you lost coverage.

You must pay the premiums for CCOC continuation coverage no later than sixty (60) days after the date of this notice, for all months of coverage prior to your payment. Important additional information about payment 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 may contact RMHP by calling 970-244-7975, option 5, or toll free at 800-515-5153, option 5.

RMHP COBRA Billing Team
P.O. Box 10600
Grand Junction, CO 81502

Email: cobrabilling@rmhp.org
Fax: 970-244-7769

You may also contact the Plan Administrator.

Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to us. You have thirty (30) days after the date of this notice to decide whether you want to elect continuation coverage, and to pay for any continuation coverage that you elect.

Send completed Election Form to: RMHP COBRA Billing Team, P.O. Box 10600, Grand Junction, CO 81502, or you may email it to cobrabilling@rmhp.org, or fax it to 970-244-7769.

This Election Form must be completed and returned by mail, email or fax by <<Date1>>. If mailed, it must be post-marked no later than <<Date1>>. If sent to us by email or fax, it must be **received** by us by <<Date1>>.

If you do not submit a completed Election Form and make payment by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form and make payment before the due date. Elected continuation coverage will be retroactive to the date following your loss of coverage, except that it will not extend earlier than March 1, 2009.

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 employer] Group Health Plan (the Plan) for the individuals listed below. I can elect to cover myself and dependents noted, or remove individuals by writing "NONE" on the "Coverage option(s) elected" line.

I understand that I can not add new dependents who were not covered at the time I lost coverage.

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____	_____	_____	_____
Coverage option(s) elected (medical, dental, vision, none, etc.): _____			
b. _____	_____	_____	_____
Coverage option(s) elected (medical, dental, vision, none, etc.): _____			
c. _____	_____	_____	_____
Coverage option(s) elected (medical, dental, vision, none, etc.): _____			

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

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

If you are already currently receiving CCOC continuation coverage, 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: RMHP COBRA Billing Team, P.O. Box 10600, Grand Junction, CO 81502, or you may email it to cobrabilling@rmhp.org, or fax it to 970-244-7769.

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."

(Group Name) Group Health Plan

**REQUEST FOR
TREATMENT AS AN
ASSISTANCE ELIGIBLE
INDIVIDUAL**

RMHP COBRA Billing Team
P.O. Box 10600
Grand Junction, CO 81502

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) COBRA continuation coverage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. I (and/or any of my electing dependents) 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 (and/or any of my electing dependents) 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 → _____

Only use this form if (a) you believe you are an "Assistance Eligible Individual" because you were involuntarily terminated between September 1, 2008 and December 31, 2009; (b) the Plan offers more than one type of coverage; (c) 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; (d) the coverage in which you wish to enroll costs the same or less than the coverage you had the day before you lost coverage due to a qualifying event; and (e) the coverage is not 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.

Form for Switching COBRA 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.

Send completed form to: RMHP COBRA Billing Team, P.O. Box 10600, Grand Junction, CO 81502, or you may email it to cobrabilling@rmhp.org, or fax it to 970-244-7769.

This form must be completed and returned by mail, email or fax by <<Date2>>. If mailed, it must be post-marked no later than <<Date2>>. If sent to us by email or fax, it must be received by us by <<Date2>>.

THIS IS NOT YOUR ELECTION NOTICE

YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE NO LATER THAN [due date] TO SECURE YOUR CONTINUATION COVERAGE. IF YOU DO NOT TIMELY SEND YOUR ELECTION NOTICE, THEN TIMELY SENDING THIS FORM WILL NOT ENTITLE YOU TO CCOC CONTINUATION COVERAGE.

I (We) would like to change the COBRA continuation coverage option(s) in the <<GRGR_NAME>> Group Health Plan (the Plan) as indicated below:

Old Coverage Option: _____

New Coverage Option: _____

Signature

Date

Print Name

Print Address

Telephone number

Important Information about Your Continuation Coverage Rights

What is continuation coverage?

Colorado state law requires that employers who offer group health plan (the Plan) coverage offer employees whose employment is terminated, and their covered dependents who lose their Plan coverage because of the employee's termination of employment, the employee's change in marital status, or the employee's death, the opportunity to continue Plan coverage for up to eighteen months.

This continuation coverage is the same coverage that the Plan gives to other active employees and their dependents 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 active employees and their dependents covered under the Plan, including open and special enrollment rights.

How long will continuation coverage last?

Continuation coverage may last for up to eighteen months. It will end on the earliest of (a) the date through which premiums for continuation coverage are paid; (b) the date other group health plan coverage becomes available to a person covered under continuation coverage; (c) the date a person covered under continuation coverage becomes covered by Medicare; (d) the date a person covered under continuation coverage becomes covered by Medicaid; or (e) the date the Plan coverage terminates for other participants or beneficiaries under the Plan who are not receiving continuation coverage.

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each former employee and his or her covered dependents may elect continuation coverage separately.

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 law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a greater than ninety day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the right to purchase individual health coverage (known as conversion coverage) that does not impose a preexisting 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 law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Continuation coverage costs 100% of the premium that is charged by Rocky Mountain Health Plans to the Plan sponsor for the coverage provided to other active employees and their dependents under the Plan.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the continuation coverage premium in some cases. The premium reduction may be 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. As of the date of the Notice you received, Colorado is not providing a retroactive election right to persons (and their dependents covered under the Plan) experiencing involuntary termination of employment between September 1, 2008 and February 17, 2009, the date ARRA was passed. If Colorado law changes, then persons who lost coverage between September 1, 2008 and February 17, 2009 for any reason that leads to a right to obtain continuation coverage will receive a subsequent notice from Rocky Mountain Health Plans. If you are entitled now to elect continuation coverage, then the ARRA premium reduction commenced effective March 1, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the continuation coverage premium otherwise due to Rocky Mountain Health Plans. This premium reduction is available for up to nine months. Rocky Mountain Health Plans will adjust your future premiums or refund you if you paid a full premium for continuation coverage in March, 2009. If your continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your continuation coverage after the premium reduction expires. 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 nonforfeitable 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?

Though payment for elected continuation coverage need not accompany your Election Form, payment must be made in full, in good funds, by the date the Election Form is due. Payment for subsequent months of coverage is billed on or about the fifth of the month prior to the month for which CCOC coverage is sought, and is due on the first of the month for which CCOC coverage is sought. If premium for CCOC coverage is not timely paid, then you will be billed for the subsequent month of CCOC coverage on or about the fifth of the month, and you will owe two

months of premium. If both months of premium are not timely paid, your CCOC coverage will be terminated effective the end of the subsequent month. You will be responsible to RMHP for all unpaid premium; your coverage will not be terminated retroactively. You will be responsible for paying claims for health care services you receive after continuation coverage ceases.

You may contact Rocky Mountain Health Plans' COBRA Billing Team, at P.O. Box 10600, Grand Junction, CO 81502, or you may email us at cobrabilling@rmhp.org, or fax us at 970-244-7769, or call us at 970-244-7975, option 5, or toll free at 800-515-5153, option 5 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:

RMHP COBRA Billing Team
P.O. Box 10600
Grand Junction, CO 81502

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 Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage you should contact the RMHP COBRA Billing Team, P.O. Box 10600, Grand Junction, CO 81502, or you may email us at cobrabilling@rmhp.org, or fax us at 970-244-7769, or call us at 970-244-7975, option 5, or toll free at 800-515-5153, option 5. You may also contact the Plan Administrator.

For more information about your rights under state law, contact the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202, 303-894-7499, toll-free outside Denver, 800-930-3745.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep Rocky Mountain Health Plans 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 Rocky Mountain Health Plans.



Summary of the Continuation 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.*
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◆ 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 you can contact the RMHP COBRA Billing Team, P.O. Box 10600, Grand Junction, CO 81502, or you may email us at cobrabilling@rmhp.org, or fax us at 970-244-7769, or call us at 970-244-7975, option 5, or toll free at 800-515-5153, option 5. You may also contact the Plan Administrator.

For 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, contact the RMHP COBRA Billing Team, P.O. Box 10600, Grand Junction, CO 81502, or you may email us at cobrabilling@rmhp.org, or fax us at 970-244-7769, or call us at 970-244-7975, option 5, option 5, or toll free at 800-515-5153, option 5. You may also contact the Plan Administrator.

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.

**DO NOT SEND THIS FORM TO RMHP WITH YOUR ELECTION FORM.
KEEP THIS FORM UNTIL YOU NEED IT.**

This form is designed for plans to distribute to Assistance Eligible Individuals so they can notify RMHP if they become eligible for other group health plan coverage or Medicare. If you do not give such a notice, you may face a federal income tax penalty.

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

(Group Name) Group Health Plan	Participant Notification	RMHP COBRA Billing Team P.O. Box 10600 Grand Junction, CO 81502 FAX: 970-244-7769
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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:
