



11971 Foundation Place
Rancho Cordova, CA 95670
ATTN: Cobra DP MS CA -903-02-05

Name
Address
City, ST Zip

Dear Health Net Member-

Please stop and read this packet in its entirety. This packet will include information on enrollment under Cal COBRA and the Premium Reduction Subsidy provided by the ARRA.

To ensure that your applications are processed in a timely manner please verify that you have included the following documents that are applicable.

For Subsidy Enrollment please return

Request for Treatment as an Assistance Eligible Individual (AEI) (Page 5-7)

Your subsidy will be effective March 1, 2009 if you were enrolled on COBRA prior to March 1 2009.

If enrolled after March 1, 2009 the effective date of the subsidy will be your current COBRA enrollment date.

Any over payment of premiums will be credited to future billings.

Model Cal-COBRA Continuation Coverage Supplemental Notice
For qualified beneficiaries currently enrolled in Cal-COBRA coverage with qualifying events that occurred on or after September 1, 2008 to advise them of the availability of the premium reduction.

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice contains important information about additional rights you may have related to your Cal-COBRA continuation coverage through Health Net. Please read the information contained in this notice very carefully.

CAL-COBRA PREMIUM REDUCTION

The federal American Recovery and Reinvestment Act of 2009 (ARRA) reduces the Cal-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 Cal-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 Continuation Coverage Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations and the “Request for Treatment as an Assistance Eligible Individual.” **If you believe you meet the criteria for the premium reduction, complete the “Request for Treatment as an Assistance Eligible Individual” and return it to us at 11971 Foundation Place, Rancho Cordova, CA 95670 Attn: Cobra DP MS CA-903-02-05.**

VERIFICATION OF ELIGIBILITY FOR PREMIUM REDUCTION

To qualify for the subsidy you must be able to show that your former employer involuntarily terminated you. If you have a document that shows that you were involuntarily terminated, you may submit that as verification you were terminated.

Health Net may also request verification from your former employer that you were involuntarily terminated once you submit your “Request for Treatment as an Assistance Eligible Individual” form. Your employer must respond within 10 calendar days from the date Health Net sends the request for verification. If you are denied treatment as an Assistance Eligible Individual, you have the right to have your denial reviewed.

OPTION TO CHANGE TO ANOTHER HEALTH PLAN

If you are eligible for the premium reduction, your former employer may permit you to change the coverage option(s) for your Cal-COBRA continuation coverage to something different than what you had on the last day of employment. Contact your former employer for further information, including health plans options and premiums. If your former employer allows you to change your coverage you may use the attached election form. **This form must be sent by your employer to the new health plan within 90 days from the date of this notice.** If your employer grants the option to change to a new health plan, he or she must fill in the appropriate portions of the form and submit it to the new plan, along with any other necessary information. In addition to contacting your employer, if you are permitted to change your health plan, you should also contact the new health plan for premium and benefit information before submitting the “Election Form to Change to a New Health Plan.”

IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE OR IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OF YOUR RIGHTS TO CONTINUATION COVERAGE, PLEASE CONTACT HEALTH NET AT 800-977-2207 OR THE TDD LINE AT 800-995-0852 FOR THE HEARING AND SPEECH IMPAIRED.

Important Information about Your Cal-COBRA Continuation Coverage Rights

How much does Cal-COBRA continuation coverage cost?

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 generally may not exceed 110 % of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated covered employee or dependent who is not receiving continuation coverage. In the case of a qualified beneficiary who is determined to be disabled under the Medicare statutes, the cost is 150% of the group rate after the first 18 months of Cal-COBRA continuation coverage. The required payment for your coverage (and that of your dependents, if any) has been reflected in the monthly billings you have received from Health Net.

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 % of the Cal-COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your Cal-COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your Cal-COBRA 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. Note, you may have dependents enrolled that qualify for Cal-COBRA coverage but do not qualify for the premium reduction (examples include domestic partners, same gender spouses and grandchildren).

When and how must payment for Cal-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 Health Net as directed on your monthly billing notice.

You may contact Health Net at (800) 977-2207 to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction. Note, if you qualify, the subsidy is available as of March 1, 2009. You will be credited on your bill for any amounts you may have overpaid based on the subsidy beginning on March 1st. That will be reflected on the monthly bill you receive from Health Net.

For more information

This notice does not fully describe continuation coverage or other rights under the group health plan. More information about continuation coverage and your rights under the group health plan is available in your original Evidence of Coverage.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your Evidence of Coverage, contact Health Net at the telephone number on your Health Net ID card.

Keep Your Plan Informed of Address Changes

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

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 March 1, 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.*

.. IMPORTANT ..

- ? If, after you elect Cal-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 continuation coverage, you can contact Health Net at the telephone number noted on your ID card.

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 Health Net.

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

* 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.

To apply for AARA Premium Reduction, please complete this form (Request for Treatment as an Assistance Eligible Individual) and return to: *Health Net, 11971 Foundation Place, Rancho Cordova, CA 95670 Attn: Cobra DP Unit, MS CA 903-02-05*

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".

Health Net	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	11971 Foundation Place Rancho Cordova, CA 95670 MS CA-903-02-05
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PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form):	Telephone number:
	E-mail address (optional):

Health Net SSN:
Name of Health Plan Group Number:

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) Cal-COBRA 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 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): _____

1. I elected (or am electing) Cal-COBRA 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
4. I am NOT a Domestic Partner of the subscriber.	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. I am NOT a same-sex spouse of the subscriber.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. I am NOT a grandchild of the subscriber.	<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): _____

1. I elected (or am electing) Cal-COBRA 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
4. I am NOT a Domestic Partner of the subscriber.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT a same-sex spouse of the subscriber.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. I am NOT a grandchild of the subscriber.	<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: _____

FOR PLAN OR CARRIER 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Individual did not elect Cal-COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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: _____

This form is designed for carriers to distribute to qualified Cal-COBRA beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the carrier if they become eligible for other group health plan coverage or Medicare.

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

Health Net

PARTICIPANT NOTIFICATION OF INELIGIBILITY

11971 Foundation Place
Rancho Cordova, CA
95670 MS CA-903-02-05

PERSONAL INFORMATION

Name and mailing address:

Telephone number:

Social Security 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 for other coverage, include their names below.

Insert date you became eligible: _____

I am eligible for Medicare.

Insert date you became eligible for other coverage: _____

IMPORTANT

If you fail to notify your carrier 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:

ELECTION FORM FOR CHANGING TO A NEW HEALTH PLAN

This form must be submitted to your former employer. If your employer chooses to allow qualified individuals to change health plans, he or she must complete the appropriate portions of this form and forward it, and any other necessary information, to the new health plan.

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form):	Telephone number:
	E-mail address (optional):
	Social Security Number:
Name and mailing address of former employer:	Telephone number:
	E-mail address (optional):

Name and Member ID of current health plan:

To qualify for the Option to Change to a New Health Plan, you must be able to check 'Yes' for all statements.

1. I am currently enrolled in Cal-COBRA with my current health as named above or I am electing Cal-COBRA coverage under this notice and changing to a new health plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. 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
4. The former employer allows a change in coverage to a different health plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I am exercising my right to enroll in this health plan's Cal-COBRA continuation coverage as permitted by my employer. 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

EMPLOYER - COMPLETE THIS SECTION AND SUBMIT TO THE HEALTH PLAN YOU HAVE APPROVED FOR ALTERNATIVE COVERAGE

Name and address of alternative plan:	Phone number:
1. The applicant was validly enrolled in group health coverage at the time of their qualifying event.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. The former employer allows a change in coverage to a different health plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. The premiums for new coverage do not exceed the premiums for the enrollee's original coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of the former employer or party authorized to act for the employer:

_____ Date: _____

Type or print name: _____

Telephone number: _____ E-mail address: _____

FOR PLAN OR CARRIER 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The individual's employer does not permit a change in coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Other (please explain):	<input type="checkbox"/>

Signature of plan, carrier, or other party responsible for administration of the Cal-COBRA coverage:

_____ Date: _____

Type or print name: _____

Telephone number: _____ E-mail address: _____