

Customer Name:
Address:
Customer Number:
Employer:

The purpose of this notice is to inform you of recent changes to an important emergency rule recently passed under 2009 Wisconsin Act 11, Section 9126 which created INS § 3.75 Wis. Admin. Code. This notice contains important information about your right to continue your health care coverage under this rule.

You are receiving this notice because our records indicate that you may have lost your group health insurance coverage when your former employer ceased business operations or otherwise discontinued, without replacing, the WPS group health insurance policy that provided you coverage on or after June 30, 2009. Wisconsin continuation insurance coverage requirements under Ins 3.75, Wis. Adm. Code provide you the right to continue your group health insurance coverage as long as you are eligible for a premium subsidy as an “assistance eligible individual” (AEI) as explained elsewhere in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010 (2010 DOD Act) reduces the state continuation coverage premium you are required to pay in some cases for up to 15 months. 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 February 28, 2010, may be eligible for the temporary premium reduction for up to 15 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 Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations, and the “Application for Treatment as an Assistance Eligible Individual.”

If it is determined that you are an eligible former employee, you may be entitled to elect continuation coverage for yourself and your eligible dependent(s) which will continue group health care coverage under until one of the following events occur:

- 1) You establish residence outside of Wisconsin;
- 2) You fail to make timely payment of premium;
- 3) You become eligible for Medicare or similar coverage under your spouses or another employer’s group policy;
- 4) You cease to be eligible for premium assistance as an Assistance Eligible Individual;
- 5) Your eligibility for continued coverage would have otherwise ceased under Wisconsin continuation requirements, if the group policy had not been discontinued.

If you believe you meet the criteria for the premium reduction, complete and return the attached “Application for Treatment as an Assistance Eligible Individual Under Former Employer’s Discontinued (and not replaced) Group Health Policy” election form and submit it to the address listed on the form.

To apply for ARRA Premium Reduction AND/OR to elect Wisconsin Continuation coverage and treatment as an AEI under your former employer's discontinued (and not replaced) group health policy, please complete this form and return it to:

Wisconsin Physicians Service Insurance Corporation
Attention: Michelle Johnson, Member Services
P.O. Box 8190
Madison, WI 53708-8190
(800) 748-0575

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."

Enter Employer Name	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL UNDER FORMER EMPLOYER'S DISCONTINUED (AND NOT REPLACED) GROUP HEALTH POLICY	Wisconsin Physicians Service Ins. Corp. P.O. Box 8190 Madison, WI 53708-8190 (800) 748-0575
----------------------------	---	--

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. Please check one box below to designate the circumstances of the loss of employment. <input type="checkbox"/> Discharge <input type="checkbox"/> Permanent Layoff <input type="checkbox"/> Temporary Layoff <input type="checkbox"/> Other	<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 February 28, 2010. Please provide the date of termination: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. 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
4. I elected (or am electing) continuation coverage because my former employer's group health policy was discontinued and not replaced.	<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 → _____

FOR WPS USE ONLY

This application is: ☐ Approved ☐ Denied (explain in #5 below)
Specify reason below and then return a copy of this form to the applicant and WPS.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

- | | |
|---|--------------------------|
| 1. Loss of employment was voluntary and individual does not meet the definition of an AEI. <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> |
| 2. The involuntary loss did not occur between September 1, 2008 and February 28, 2010. | <input type="checkbox"/> |
| 3. Individual did not elect continuation coverage | <input type="checkbox"/> |
| 4. The employer has replaced group coverage between June 30, 2009 and the date of application | <input type="checkbox"/> |
| 5. 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 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 WPS that you are eligible for other group health plan coverage or Medicare.

Plan Name	Participant Notification	Wisconsin Physicians Service Ins. Corp. P.O. Box 8190 Madison, WI 53708-8190 (800) 748-0575
------------------	---------------------------------	--

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, such as a plan sponsored by a successor employer or by a spouse's employer. 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 WPS 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:

Summary of the Premium Reduction Provisions under ARRA

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009 and this law was amended in December 2009 by the Department of Defense Appropriations Act, 2010 (2010 DOD Act). The law gives “assistance eligible individuals”(AEIs) the right to pay reduced premiums for periods of COBRA or state continuation coverage beginning on or after February 17, 2009, and can last up to 15 months. Please note, you may be eligible for Wisconsin continuation coverage but not qualify as an assistance eligible individual due to ARRA qualifying requirements for premium reduction.

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 February 28, 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 February 28, 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 and while you are paying the reduced premium, you become eligible for other group health plan coverage 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, 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, please 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

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.