

WEBCOBRA ARRA 2009 LETTERS

03/04/2009

CONTENTS

WebCOBRA ARRA Letters.....	2
Printing ARRA Letters	2
ReNotification COBRA Election Packet	2
ReNotification Wizard	2
QB Add Wizard.....	2
System Integrator	2
ARRA Enrollment Form.....	2
ReNotification Wizard	2
ReNotification COBRA Election Packet.....	3
Manually Scheduling	3
ARRA Open Enrollment Letter	3
Manually Scheduling	3
ARRA Enrollment Confirmation.....	3
Authorizing QB for ARRA.....	3
APPENDIX A	4
ARRA Open Enrollment Letter	4
Appendix B.....	5
ARRA Enrollment Form	5
Appendix C.....	6
ARRA Enrollment Form w/ Election Packet.....	6
Appendix D	7
ARRA Stimulus Confirmation Letter.....	7

The American Recovery and Reinvestment Act, ARRA, of 2009 went into effect on March 1, 2009. The WebCOBRA.com system has been upgraded with the capability to process ARRA Elections and Re-Notifications.

This document will guide you through the process of printing letters specifically created for ARRA qualifying QBs.

WEBCOBRA ARRA LETTERS

1. ReNotification COBRA Election Packet
2. ARRA Enrollment Form
3. ARRA Open Enrollment Letter
4. ARRA Enrollment Confirmation

PRINTING ARRA LETTERS

RENOTIFICATION COBRA ELECTION PACKET

You can print the ReNotification COBRA Election Packet the following ways:

RENOTIFICATION WIZARD

- Users can run the Involuntary Term Re-Notification Wizard, available from the home page, for either Site Users or Client Administrators.
- Users can run the Re-Notification Wizard for either All Clients or a Single Client.
- QBs will be Re-Notified through this wizard who:
 - Have the event type of Termination or Loss of Coverage and an event date on or between 9/1/2008 and 2/17/2009.
 - Have a secondary event, and the primary event was Termination or Loss of Coverage and an event date between 9/1/2008 and 2/17/2009.
- The Wizard will create a new QB Group with a First Day after Loss of Coverage as 3/1/2009 for these QBs, and their COBRA period will not be extended.

QB ADD WIZARD

Users can run the QB Add Wizard with an event type of Involuntary Termination and an event date on or between 9/1/2008 and 2/17/2009.

SYSTEM INTEGRATOR

Users can upload a CSV or XML file with a QBEventCode of 25, ARRA Involuntary Termination.

ARRA ENROLLMENT FORM

RENOTIFICATION WIZARD

Currently enrolled QBs will receive an ARRA Enrollment Form with a greeting paragraph explaining ARRA and why they are receiving this form.

RENOTIFICATION COBRA ELECTION PACKET

If you send the ARRA Enrollment Form out with the ReNotification COBRA Election Packet, it will not contain the aforementioned greeting paragraph.

MANUALLY SCHEDULING

If you manually schedule the ARRA Enrollment Form to print for a QB, if the QB is enrolled in COBRA coverage, the enrollment form will contain a greeting paragraph explaining why the QB is receiving this new enrollment form.

ARRA OPEN ENROLLMENT LETTER

MANUALLY SCHEDULING

To send the ARRA Open Enrollment Letter, you have to manually schedule the letter to print for either a QB or a class of QBs.

ARRA ENROLLMENT CONFIRMATION

AUTHORIZING QB FOR ARRA

Users will go to the QBs Action Tab and select Authorize for ARRA Stimulus. Doing this will enroll them in the 65% Government Subsidy and print the ARRA Enrollment Confirmation Letter that will be sent to the QB.

ARRA OPEN ENROLLMENT LETTER

[Client/Employer Name]

[Client/Employer Address 1]

[Client/Employer Address 2]

[Client/Employer City], [Client/Employer State] [Client/Employer Zip]

[Date (mm/dd/yyyy)]

[Blank Line]

[Blank Line]

[Blank Line]

[Blank Line]

[QB Full Name w/ Title]

[QB Address Line 1]

[QB Address Line 2]

[QB Address City], [QB State] [QB Zip]

[Blank Line]

[Blank Line]

[QB Greeting]:

Because of the American Recovery and Reinvestment Act of 2009 (ARRA), you may be eligible to enroll in benefit coverage that is different from the coverage you have been offered or are in which you are enrolled under the Group Health Enrollment Plan.

This benefit coverage, if elected by you and your other qualified beneficiaries, will replace the coverage you have been offered or have elected under the Group Health Continuation Plan.

Details of the coverage are found on the informational materials accompanying this letter. For more information, please contact the Plan Administrator at:

[Administrator Name]

[Administrator Address Line 1]

[Administrator Address Line 2]

[Administrator City], [Administrator State] [Administrator Zip]

Sincerely,

[Client/Employer Contact Name]

[Client/Employer Contact Title]

ARRA ENROLLMENT FORM

**HEALTH BENEFITS CONTINUATION PLAN ENROLLMENT FORM
ARRA TEST**

02/27/2009

Mr. Merv George
1920 Dofc27
Houston, TX 77079

The Health Insurance Assistance for the Unemployed Act of 2009 was enacted as part of the American Recovery and Reinvestment Act of 2009. This new law may give you and your additional qualified beneficiaries premium assistance equal to 65% of your paid continuation premiums for up to nine months of your continuation period beginning as early as March 1, 2009.

In order to be certified as qualified for premium assistance, you must

- (a) have been involuntarily terminated from employment with the employer shown above between September 1, 2008 and December 31, 2009,
- (b) have become eligible for COBRA or other state-law based continuation coverage subsequent to that involuntary termination and
- (c) not have become eligible for other group health insurance coverage or Medicare since your original termination date.

Also, premium assistance is reduced for those who are eligible for assistance but whose Modified Adjusted Gross Income (MAGI) is above \$125,000 per year (\$250,000 for joint filers). Premium assistance is not available at all for those whose MAGI is \$145,000 per year (\$290,000 for joint filers).

If you decide to enroll, as evidenced by your completing and signing the enclosed Enrollment Form which confirms your belief that you are an "Assistance Eligible Individual" and that you would like to enroll at this time in the Group Health Continuation Plan, then once we receive your completed and signed Enrollment Form we will validate your eligibility for premium assistance.

Once that verification is complete, you receive a confirmation of your eligibility.

Telephone:
Department:
Qualifying Event: Termination
First Day After Loss of Coverage / First Day Continuation Coverage will Begin: 12/01/2008

List Eligible Persons to be Covered Below: (Persons Previously Covered Only)

Name: Last	First	M	DOB	Sex	SSN #
_____	_____	_____	__/__/____	M / F	__-__-____
_____	_____	_____	__/__/____	M / F	__-__-____
_____	_____	_____	__/__/____	M / F	__-__-____
_____	_____	_____	__/__/____	M / F	__-__-____
_____	_____	_____	__/__/____	M / F	__-__-____

Medical Standard QB and Child \$218.87
HMO

Total: \$218.87

I HEREBY REQUEST ENROLLMENT IN THE HEALTH BENEFITS CONTINUATION PLAN FOR MYSELF AND ELIGIBLE QUALIFIED DEPENDENTS LISTED ON THIS FORM AND AGREE TO PAY THE PREMIUM AS REQUIRED. I UNDERSTAND THAT CONTINUATION COVERAGE WILL TERMINATE UNDER SEVERAL CIRCUMSTANCES, INCLUDING: THE DATE I OR A CONTINUED DEPENDENT BECOME COVERED UNDER ANOTHER GROUP HEALTH/DENTAL PLAN, BECOME ENTITLED TO MEDICARE, OR ON THE DATE ON WHICH THE GROUP HEALTH/DENTAL PLAN ENDS. I ALSO UNDERSTAND THAT IF I WAS DISABLED WITHIN 60 DAYS OF THE COBRA QUALIFYING EVENT, I MAY BE ELIGIBLE FOR EXTENDED CONTINUATION COVERAGE.

Additionally, I understand that my eligibility for up to nine months of premium assistance requiring payments of the total monthly premiums shown above will be determined by my Plan Administrator after receipt of this completed Enrollment Form.

I believe that I qualify for this assistance because

- (a) I was involuntarily terminated between September 1, 2008 and December 31, 2009
- (b) I have not become eligible for any other group health plan or Medicare since my termination, and
- (c) I fall below the income limits required by the law.

ARRA STIMULUS CONFIRMATION LETTER

[Client/Employer Name]

[Client/Employer Address 1]

[Client/Employer Address 2]

[Client/Employer City], [Client/Employer State], [Client/Employer Zip]

[Date (mm/dd/yyyy)]

[Blank Line]

[Blank Line]

[Blank Line]

[Blank Line]

[QB Full Name w/ Title]

[QB Address Line 1]

[QB Address Line 2]

[QB Address City], [QB State], [QB Zip]

[Blank Line]

[Blank Line]

[QB Greeting]:

We have reviewed your Group Health Continuation Plan Enrollment Form and agree that you are eligible for premium assistance under the American Recovery and Reinvestment Act of 2009. Your coverage in the Group Health Continuation Plan will begin as of [Continuation Coverage Start Date] and continue until [Continuation Coverage End Date].

In order for coverage to begin, we must receive your initial premium payment as shown on the enclosed form. Payment of premium going back to your start of coverage date under this enrollment offer must reach us no later than 45 days from the date of this letter in order for your coverage to begin.

If at any time you become eligible for any other group health plan or become eligible for Medicare during this period you are enrolled in continuation coverage and qualify for premium assistance, you must notify us immediately of your eligibility by contacting us at the address and telephone number indicated.

Sincerely,

[Client/Employer Contact Name]

[Client/Employer Contact Title]