

New York State Continuation Coverage Election Notice

Date of Notice: August 7, 2009

Dear Subscriber and Eligible Dependents:

This notice contains important information about your right to continue your health care coverage in your group health plan.

Please read the information contained in this notice very carefully.

New York State's "continuation coverage" law requires group health insurance plans, including this plan, 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 percent 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 began September 1, 2008 and ended December 31, 2009 may be eligible for the temporary premium reduction for up to nine 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."

HOW TO APPLY FOR CONTINUATION COVERAGE AND THE PREMIUM REDUCTION

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Form A, entitled "Continuation Coverage Election Form" and submit it to the former employer (i.e., the Employer who sponsored the group health plan from which you were recently terminated). If you previously declined continuation coverage and your employment was involuntarily terminated between September 1, 2008 and February 17, 2009, then you now have a second opportunity to elect coverage.

If you elect continuation coverage AND believe that you meet the criteria for the premium reduction, then complete the enclosed Form B, entitled "Request for Treatment as an Assistance-Eligible Individual," and return it with your completed Continuation Coverage Election Form (Form A).

If you currently have continuation coverage AND believe that you meet the criteria for the premium reduction, then complete the enclosed Form B, entitled "Request for Treatment as an Assistance-Eligible Individual."

If you do not elect continuation coverage, your coverage under the Plan will end — or has already ended — due to one of the following events:

- End of employment
- Entitlement to Medicare
- Death of employee
- Divorce or legal separation

- Reduction in hours of employment
- Loss of dependent child status

Each person in the category (ies) 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:

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

For Assistance-Eligible Individuals who previously declined continuation coverage and whose coverage was involuntarily terminated between September 1, 2008 and February 17, 2009, continuation coverage will be retroactive to the first day of the first coverage period beginning on or after February 17, 2009. For monthly coverage, this means that coverage commences on March 1, 2009. For these individuals, any gap in coverage between September 1, 2008 and February 17, 2009 will be disregarded for the purpose of determining whether a pre-existing condition limitation applies. For all other individuals, continuation coverage commences on the date that health care coverage otherwise would have been lost due to a qualifying event.

If you are an “Assistance-Eligible Individual,” you may change the coverage option(s) for your continuation coverage to something other than what you had on the last day of employment, if your former employer permits you to and offers other coverage options. To change coverage option(s), complete the enclosed Form C, entitled “Form for Switching Continuation Coverage Benefit Options,” and return it to us. You must still complete Form A 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.

WHAT DOES CONTINUATION COVERAGE COST?

Continuation coverage will generally cost 102 percent of the premium applicable to other group members for the same coverage.

If you qualify as an “Assistance-Eligible Individual,” this cost can be reduced by up to 65 percent. The first

premium payment must be given to us in advance to establish payment not more frequently than on a monthly basis.

You may contact us to determine or confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

If you have any questions about this notice or your rights to continuation coverage, you should contact us at

HIP Health Plan of New York
P.O. Box 2806
New York, NY 10116-2806
1-800-HIP-TALK (1-800-447-8255)

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 February 17, 2009 and can last up to nine 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 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 Web page on ARRA at www.irs.gov.

For general information regarding continuation coverage, you can contact us at the phone number in the box at the end of the cover letter or visit the New York State Insurance Department Web site at www.ins.state.ny.us.

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 us at the customer service telephone number indicated on the cover letter or write to us at the address indicated on the cover letter.

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.

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 September 1, 2008 and ending December 31, 2009. 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 nine months. If your state continuation coverage lasts for more than nine 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. See the attached "Summary of the Continuation FAQ 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 percent 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 percent 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 was involuntarily terminated between September 1, 2008 and February 17, 2009 and previously declined continuation coverage, did not elect continuation coverage when it was first offered to me, or elected continuation coverage and let it lapse?

New York State law creates a special election period for individuals whose employment was involuntarily terminated between September 1, 2008 and February 17, 2009 who did not elect continuation coverage, elected continuation coverage and let it lapse, or received a notice of the right to continue coverage and did not respond to the notice. These individuals have a second opportunity to elect continuation coverage, this time with a premium reduction, if they are Assistance-Eligible Individuals. You must elect continuation coverage within 60 days of receiving notice.

Note that coverage may not continue beyond the time it would have ended had you elected continuation coverage when it was first offered. The period beginning on the date that you were involuntarily terminated and ending when the continuation coverage starts, will be disregarded for the purpose of determining whether a condition is pre-existing.

What if I already paid the full continuation coverage premium and am later determined to be eligible for the premium reduction?

The continuation administrator 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.

For more information

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 the 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 the health plan.



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FORM A 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 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: Former Employer

This Election Form must be completed and returned by mail; it must be postmarked 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.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage in the HIP Health Plan of New York (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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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

FORM B

To apply for ARRA Premium Reduction, complete this form and return it to us with FORM A, the "Continuation Coverage Election Form." 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: Former Employer

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."



REQUEST FOR TREATMENT AS AN ASSISTANCE-ELIGIBLE INDIVIDUAL

P.O. Box 2806
New York, NY 10116-2806

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)

<First Name> <Last Name>
<Street Address 1>
<Street Address 2>
<City,> <State> <Zip Code>
<Group ID>

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) 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 → _____

FOR ISSUER 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"/>
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/>
3. Individual did not elect continuation coverage.	<input type="checkbox"/>
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 → _____

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.	<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

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.	<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

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)

c. _____

1. I elected (or am electing) 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

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 → _____

**Use This Form To Notify Your Issuer That You Are Eligible
For Other Group Health Plan Coverage or Medicare**



Participant Notification

P.O. Box 2806
New York, NY 10116-
2806

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 _____

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 percent 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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FORM C

Form for Switching Continuation Coverage Benefit Options

Instructions: To change the benefit option(s) for your continuation coverage to something other 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.

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: 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.

THIS IS NOT YOUR ELECTION NOTICE

YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE (FORM A) TO SECURE YOUR CONTINUATION COVERAGE.

I (We) would like to change the continuation coverage option(s) in HIP Health Plan of New York (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