(Prepare on Employer Letterhead)

EXTENDED COVERAGE Additional Election Period Notice

[*Insert date of notice; Distribution is required prior to 4/18/2009*]

Dear: **[*Insert name of the qualified beneficiary(ies), by name or status*]**

This notice contains important information about additional rights to continue your health care coverage in The Local Choice (TLC) Health Benefits Program (the Plan) sponsored by [*Insert Name of Local Employer*]. Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the EXTENDED COVERAGE premium in some cases. You are receiving this notice because you experienced a loss of coverage at some time from September 1, 2008 through February 16, 2009 and either chose not to elect EXTENDED COVERAGE continuation coverage at that time OR elected EXTENDED COVERAGE but subsequently discontinued that coverage. If your loss of health coverage was due to an involuntary termination of employment you may be eligible for a second EXTENDED COVERAGE election opportunity and a 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 EXTENDED COVERAGE Premium Reduction Provisions under ARRA" 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" and return it to the Group Benefits Administrator at your former employer with your completed Election Form.**

To elect EXTENDED COVERAGE continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to your Group Benefits Administrator.

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect EXTENDED COVERAGE continuation coverage, which generally will continue group health care coverage under the Plan for up to 18 months after an involuntary termination of employment. **[*Check appropriate box or boxes; names may be added*]**:

- ☐ Employee or former employee
- ☐ Spouse or former spouse
- ☐ Dependent child(ren) covered under the Plan on the day before the involuntary termination of employment (and any new dependents born, adopted, or placed for adoption between the date coverage was lost and February 17, 2009).

If elected, EXTENDED COVERAGE continuation coverage will begin retroactively on **[*insert the date of the first day of the first month beginning on or after February 17, 2009*]** and can last until **[*insert the date that is 18 months after the qualifying event*]**.

EXTENDED COVERAGE continuation coverage will cost: **[*enter amount each qualified beneficiary will be required to pay each month.*]** If you qualify as an "Assistance Eligible Individual" this cost can be reduced to **[*insert the amount that is 35 percent of the amount above for each option*]** for up to nine months. You do not have to send any payment with the Election Form. Important additional information about payment for EXTENDED COVERAGE continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to EXTENDED COVERAGE continuation coverage, you should contact:

[Insert Name of Local Employer]
[Insert Group Benefits Administrator]
[Insert Local Employer Address]
[Insert Local Employer Telephone Number]

EXTENDED COVERAGE Continuation Election Form

Instructions: Under the American Recovery and Reinvestment Act you are only entitled to elect EXTENDED COVERAGE continuation coverage at this time if you lost group health plan coverage due to an involuntary termination of employment during the period that begins with September 1, 2008 and ends with December 31, 2009. To elect EXTENDED COVERAGE continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect EXTENDED COVERAGE continuation coverage under the Plan.

Send completed Election Form to:

[Insert Name of Local Employer]
[Insert Group Benefits Administrator]
[Insert Local Employer Address]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [insert *date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect EXTENDED COVERAGE continuation coverage. If you reject EXTENDED COVERAGE continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting EXTENDED COVERAGE continuation coverage, your EXTENDED COVERAGE continuation coverage will begin on the date you furnish the completed Election Form.

I (We) elect or decline Extended Coverage as indicated below. If coverage is elected, please check whether you will continue Medical Coverage:

Name	Date of Birth	Current ID Number	Social Security No.	Elect (√) Coverage	Decline (√) Coverage
Employee**					
Spouse:					
Child:					
Child:					

If additional qualified beneficiaries should be listed, please attach a separate sheet.

**Signature _____ Date_____

Print Name _____

Relationship to individual(s) listed above_____

Print Address _____

_____

Telephone Number_____

Important Information About Your EXTENDED COVERAGE Continuation Rights

Am I eligible to elect EXTENDED COVERAGE continuation at this time?

Only individuals who lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period, and who did not elect EXTENDED COVERAGE continuation coverage during their first election period OR who elected but subsequently discontinued Extended Coverage (for reasons other than becoming eligible for another group health plan or Medicare), are entitled to elect coverage at this time. If you lost group health coverage for any other reason between these dates and did not elect EXTENDED COVERAGE continuation coverage when it was first offered, you are not entitled to this second election period.

Am I eligible for the premium reduction?

If you lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below under the question, "How much does EXTENDED COVERAGE continuation cost?"

How long will continuation coverage last?

Your coverage will begin retroactively on [insert date that is the beginning of the first month of coverage on or after February 17, 2009] and can generally continue for up to 18 months from the date of your involuntary termination of employment. The duration of the premium reduction is determined separately and may not last for the entire length of your Extended Coverage. See the question below entitled *"How much does EXTENDED COVERAGE continuation cost?"*

Continuation coverage will be terminated before the end of the 18 month period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of EXTENDED COVERAGE continuation ?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your Group Benefits Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of EXTENDED COVERAGE continuation and must last at least until the end of the 18-month period

of continuation coverage. Your Group Benefits Administrator must receive notification of the disability determination within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through the General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary;
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative);
- If the address of record is incorrect, a correct mailing address.

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. . Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- The type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party;
- If the address of record is incorrect, a correct mailing address.

Failure to furnish timely and complete notification of the second qualifying event or disability determination will result in loss of additional Extended Coverage eligibility. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by your Group Benefits Administrator.

How can you elect EXTENDED COVERAGE continuation ?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

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 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. If you do elect continuation coverage under this additional election period, the period from qualifying event to the date coverage begins under your election will not count as a break in coverage in determining whether you had a 63-day break in coverage.

How much does EXTENDED COVERAGE continuation 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 may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the EXTENDED 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 percent of the EXTENDED COVERAGE premium otherwise due to the plan. This premium reduction is available for up to nine months. If your EXTENDED COVERAGE continuation lasts for more than nine months, you will have to pay the full amount to continue your EXTENDED COVERAGE continuation. See the attached "Summary of the EXTENDED COVERAGE Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When and how must payment for EXTENDED COVERAGE continuation be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact your Group Benefits Administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage month. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of each coverage month. If you make a periodic payment on or before the first day of the coverage month to which it applies, your coverage under the Plan will continue for that coverage month without any break. The Plan will not send periodic notices of payments due for these coverage months.

Grace periods for periodic payments

Although periodic payments are due on the first day of the coverage month, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent in the manner outlined by your former employer to:

[Insert Name of Local Employer]
[Insert Group Benefits Administrator]
[Insert Local Employer Address]

For more information

This notice does not fully describe Extended Coverage or other rights under the Plan. Questions concerning your Plan or your Extended Coverage rights should be addressed to the contacts listed below:

For information about Extended Coverage, initial notification of qualifying events, and initial enrollment:

[Insert Name of Local Employer]
[Insert Group Benefits Administrator]
[Insert Local Employer Address]
[Insert Local Employer Telephone Number]

To makes changes to Extended Coverage after initial enrollment:

[Insert Name of Local Employer]
[Insert Group Benefits Administrator]
[Insert Local Employer Address]
[Insert Local Employer Telephone Number]

The plan administrator is:

Department of Human Resource Management
101 N. 14th Street, 13th Floor
Richmond, VA 23219
Telephone: 804/225-2131

State and local government employees seeking more information about rights, including EXTENDED COVERAGE, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans should contact HHS-CMS at www.cms.hhs.gov/EXTENDED COVERAGEContinuationofCov/ or NewExtended CoverageRights@cms.hhs.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator 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 Plan Administrator.

Summary of the EXTENDED 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 EXTENDED COVERAGE 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.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

♦ IMPORTANT ♦

- ◊ If, after you elect EXTENDED 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 webpage on ARRA at www.irs.gov.

For general information regarding your plan's Extended Coverage you can contact your Group Benefits Administrator at **[*enter telephone number and address*].**

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 your Group Benefits Administrator at **[*enter telephone number and address*].**

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/EXTENDED COVERAGE 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.

To apply for ARRA Premium Reduction, complete this form and return it to us along with your 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: *[Enter Employer's Name and Address]*

You may also want to read the important information about your rights included in the "Summary of the EXTENDED COVERAGE Premium Reduction Provisions Under ARRA."

[Insert Employer Name]	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	*[Insert Employer Mailing Address]*

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.	☐ Yes ☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	☐ Yes ☐ No
3. I elected (or am electing) EXTENDED COVERAGE continuation coverage.*	☐ Yes ☐ 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).	☐ Yes ☐ 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).	☐ Yes ☐ No

***If you checked NO for statement 3, you may still be eligible. See below for more information.**

ADDITIONAL ELECTION PERIOD

If your EXTENDED COVERAGE continuation relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, EXTENDED COVERAGE continuation **OR** you elected but subsequently discontinued EXTENDED COVERAGE, you may have the right to an additional 60-day election period. You should receive a new election notice with an Election Form which you MUST complete and return. If you believe you should have received this additional notice but have not, contact your Group Benefits Administrator at **[*enter telephone number and address*].**

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 EMPLOYER OR PLAN 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.	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual did not elect Extended Coverage.*	☐
4. Other (please explain)	☐

***If you checked number 3, was individual eligible for, and given, the Additional Election Period described above?**

Signature of employer, plan administrator, or other party responsible for EXTENDED 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) EXTENDED COVERAGE continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ 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) EXTENDED COVERAGE continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ 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) EXTENDED COVERAGE continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ 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 → _____

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

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

[Insert Employer Name]	**Participant Notification**	[Insert Employer Mailing Address]

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 plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced EXTENDED 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:

_____ _____

_____ _____