



Office of Employer and Member Health Services
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February 4, 2010

Name
Address
City, State, Zip

Subject **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Premium Reduction Provisions under the American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010**

Background **This notice contains important information about additional rights you may have related to the continuation of your health care coverage or to your COBRA continuation coverage. Please read the information contained in this notice very carefully.**

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The ARRA reduces the COBRA premium in some cases. You are receiving this notice because you experienced a qualifying event that is an involuntary termination of employment at some time on or after September 1, 2008, and you 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 COBRA Premium Reduction Provisions under ARRA, as amended” (Attachment A) with details regarding eligibility, restrictions, and obligations. You should also reference the “Request for Treatment as an Assistance Eligible Individual” (Attachment C).

COBRA Continuation Coverage If you meet the definition of an Assistance Eligible Individual and experienced a qualifying event that is an involuntary termination of employment at some time on or after September 1, 2008, you may be eligible for the temporary ARRA premium reduction for up to 15 months.

Electing Coverage To elect COBRA continuation coverage, complete the “COBRA Continuation Coverage Election” (Attachment B) and submit it to your former employer, from which your involuntary termination from employment occurred.

If you do not submit a completed “COBRA Continuation Coverage Election” (Attachment B) to your former employer within 60 days of receiving this notice, you will lose your right to elect COBRA continuation coverage.

Qualifying for Premium Reduction If you qualify for the premium reduction, you need only contribute 35 percent of the total COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will then be required to pay the full amount of the COBRA continuation premium to continue your COBRA continuation coverage. To take advantage of the premium reduction for up to fifteen months, complete the “Request for Treatment as an Assistance Eligible Individual” (Attachment C).

Where to Mail Completed form Complete and return the “COBRA Continuation Coverage Election” (Attachment B) and “Request for Treatment as an Assistance Eligible Individual” (Attachment C) to your former employer from which your involuntary termination occurred.

Contact Information For additional information regarding electing COBRA continuation coverage, please contact your former employer. If you need additional information, please contact CalPERS at **888 CalPERS** (or **888-225-7377**).

For general information about the ARRA Premium Reduction, please visit U.S. Department of Labor website at www.dol.gov/COBRA , or call directly at 1-866-444-EBSA (3272).

Sincerely,

HOLLY A. FONG, Chief
Office of Employer and Member Health Services