



OFFICE OF LABOR RELATIONS

Management Benefits Fund

40 Rector Street, Third Floor, New York, N.Y. 10006
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nyc.gov/html/olr

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Management Benefits Fund (MBF) COBRA Continuation Coverage Election Notice

April/May 2009

This notice contains important information about your right to continue your MBF Superimposed Major Medical Plan (SMMP), Dental and Vision Care coverage under COBRA.

Background

You are receiving this election notice because you experienced a loss of MBF coverage that occurred during the period of September 1, 2008 through December 31, 2009. The American Recovery and Reinvestment Act of 2009 (ARRA) reduces COBRA premiums in some cases. You may be eligible for temporary premium reduction for up to nine months, if your loss of MBF coverage was due to **involuntary termination of your employment** and you meet the other conditions indicated in the “Summary of COBRA Premium Reduction Provisions Under ARRA,” which details the eligibility, restrictions, and obligations that apply.

According to the Internal Revenue Service (IRS), **involuntary termination** means “...severance from employment due to the independent exercise of unilateral authority of the employer to terminate the employment, other than due to the employee’s implicit or explicit request, where the employee was willing and able to continue performing services.”

Examples of what is NOT considered involuntary termination include, but are not limited to:

- Resignation
- Maternity leave
- Personal leave of absence, or absence due to illness or disability
- Reduction in work hours to less than 20 hours per week (which makes you ineligible for MBF benefits)

If You Believe You Meet The Criteria For The Premium Reduction

1. Follow the instructions on the following page to complete the enclosed COBRA Application.
2. Complete the “Application for Treatment as an Assistance Eligible Individual (AEI)” and return it with your completed MBF COBRA Application. **You must also include documentation from your former agency’s Human Resources department that you were involuntarily terminated from employment.**

If you qualify as an **AEI**, you will have the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009, which may last up to nine months.

Domestic Partners and same-sex spouses qualify for COBRA but do not qualify for treatment as an AEI.

Qualified Beneficiaries

Each person (Qualified Beneficiary) listed below is entitled to elect COBRA continuation coverage, for the specified period of time and depending on the qualifying event:

Qualifying Event	Qualified Beneficiary	Duration of Coverage
<ul style="list-style-type: none">o Reduction in hours of member's employmento Termination of member's employment (for any reason other than gross conduct)o Member's deferred retirement	Employee Spouse/Domestic Partner* Dependent child	18 Months
<ul style="list-style-type: none">o Death of covered employeeo Divorce or legal separation,o Member becomes eligible for Medicare	Spouse/Domestic Partner Dependent child	36 months
<ul style="list-style-type: none">o Loss of eligible dependent child status	Dependent child	36 months

***Domestic Partners and same-sex spouses do not qualify for treatment as an AEI and are therefore ineligible to receive a COBRA premium reduction.**

Changing Coverage Options

To change the coverage option for your COBRA continuation coverage to something different than what you initially elected, complete the enclosed Election Form and return it to MBF. **Please note that you can change your benefit option only if you are within the original 60-day time period from the date you received this Notice.** Available coverage options are:

- SMMP, Dental and Vision Care;
- Dental and Vision Care; Or
- SMMP only

Monthly COBRA Premiums: The premiums below are effective April 1, 2009. Please note that your premiums for March will differ slightly from the below premium amounts.

Coverage Type	Individual – without reduction	Family – without reduction	Individual – with reduction*	Family – with reduction*
SMMP, Dental & Vision Care	\$62.23	\$141.05	\$21.78	\$49.37
Dental & Vision	\$42.49	\$88.87	\$14.87	\$31.10
SMMP	\$19.74	\$52.18	\$6.91	\$18.27

***If you qualify as an AEI, your premiums may be reduced for up to nine months. In the case of a family enrollment that includes Domestic Partners or same-sex spouses, premiums will be prorated accordingly to account for these individuals.**

You do not have to send any payment with the MBF COBRA application Form. You will be billed directly by Healthplex, the MBF COBRA administrator. If you are currently enrolled in COBRA, and are eligible for the premium reduction under ARRA, your premiums will be adjusted accordingly to reflect the March amounts.

If You Do Not Elect COBRA Continuation Coverage:

Your coverage under MBF will end as of your date of termination from MBF, which is indicated at the top of this letter. Please refer to the table above for Qualifying Events that would cause your spouse/domestic partner and/or dependent children to lose MBF coverage.

If you have any questions about the information contained in this Notice, please contact MBF at (212) 306-7290. You may also send an e-mail through the MBF Web site by accessing the OLR Web site at www.nyc.gov/olr and clicking on "Management Benefits Fund" on the left-hand side of the page.

Instructions for MBF COBRA Continuation Coverage Application Form

This MBF COBRA information is for use only for the MBF member or the member's dependent when electing continuation of MBF benefit programs under COBRA. To request COBRA City Health Plan coverage information and an application, active City employees should contact their agency Human Resources department.

I. Electing Coverage

To elect MBF COBRA continuation coverage, complete the MBF COBRA Application Form on the next page and return it to MBF. Under federal law, you have **60 days** after the date of your enclosed Notice to decide whether you want to elect COBRA continuation coverage under MBF.

Send completed Application Form to: **Management Benefits Fund – COBRA Unit**
40 Rector Street, 3rd Floor
New York, NY 10006

This Application Form must be completed and returned by mail and must be post-marked no later than **60 days** after the date of the enclosed Notice.

If you are completing the “Application for Treatment as an Assistance Eligible Individual (AEI),” you must also include documentation from your Agency’s Human Resources Manager that you were involuntarily terminated from employment.

If you do not submit a completed MBF COBRA Application Form by the due date, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Application Form before the due date.

II. Changing Coverage Options

To change the COBRA benefit option to something different than what you initially elected, complete the MBF COBRA Application Form on the next page and return it to MBF. **Please note that you can change your benefit option only if you are within the original 60-day time period from the date you received your enclosed Notice.**

Send completed Application Form to: **Management Benefits Fund – COBRA Unit**
40 Rector Street, 3rd Floor
New York, NY 10006

This form must be completed and returned by mail and must be post-marked no later than **60 days** from the date of this Notice.

This COBRA Application is not for COBRA continuation of City health plan coverage



OFFICE OF LABOR RELATIONS
Management Benefits Fund

40 Rector Street, Third Floor, New York, N.Y. 10006
Tel: (212) 306-7290 (888) 4000MBF (outside NYC) / TTY: (212) 306-7629 / Fax: (212) 306-7353

Consolidated Omnibus Budget Reconciliation Act (COBRA) Application
for continuation of the
Superimposed Major Medical Plan (SMMP) and/or Dental and Vision Care Benefit Programs

I. REASON FOR SUBMISSION (PLEASE PRINT) (CHECK ONE)

Termination of Employment/Member, Reduction of Work Schedule, Divorce or Separation, Date of Qualifying Event, Death of Employee/Retiree, Loss of Dependent Eligibility, Termination of Domestic Partnership, Relationship to present or former member, Present or former member, Name, Soc. Security No.

II. APPLICANT INFORMATION (PLEASE PRINT)

Last Name, First Name, M.I., Social Security Number, Home Telephone #, Mailing Address, Apt., Date of Birth, Sex, City, State, Zip, Date of Event, Marital Status, Is applicant eligible for or covered by another group policy?

III. PLEASE LIST ALL PERSONS TO BE CONTINUED, INCLUDING EMPLOYEE IF APPLICABLE (PLEASE PRINT)

Table with columns: First Name, Last Name (if different), Social Security Number, Date of Birth, Relationship (Self, Spouse, Dom. Partner, Son, Daughter), Full Time Student, Permanently Disabled, Covered by Other Group Insurance

IV. COBRA ELECTION

I request COBRA coverage of Fund benefits as follows (Check one): Dental and Vision Care Only, Superimposed Major Medical Plan* only, Superimposed Major Medical Plan*, Dental, and Vision Care. *If you elected SMMP COBRA, please fill in your primary health coverage information below.

V. AUTHORIZATION

I certify that the above information is correct and understand that I am responsible for the full cost of Fund coverage and will be subject to the terms and conditions of Fund group contracts. I understand that I must submit this application within 60 days from the date of the Qualifying Event.

Applicant Signature, Date

MBF CERTIFICATION (FOR OFFICE USE ONLY)

Coverage (Check One): Individual, Family, Monthly Premium Rate \$, Certified by, Title, Date



Summary of the COBRA Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law provides “Assistance Eligible Individuals” the right to pay reduced COBRA 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 COBRA 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 COBRA coverage you can contact MBF at 40 Rector Street, 3rd Floor, New York, NY 10006, or call (212) 306-7290.

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 MBF at (212) 306-7290.

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/COBRA 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 MBF COBRA Application 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: *Management Benefits Fund, 40 Rector Street, 3rd Floor, NY, NY 10006*

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

Management Benefits Fund

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

40 Rector Street, 3rd Fl
New York, NY 10006

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page of this form):

Telephone number:

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) COBRA 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

*If you checked YES for statement 1, you must provide documentation from your Agency's Human Resources Manager that you were involuntarily terminated from employment.

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

ADDITIONAL ELECTION PERIOD

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, 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 MBF at (212)306-7290.

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.*	<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 COBRA coverage.**	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

*If you checked number 1, did the member provide documentation from his/her Agency's Human Resources Manager indicating that the member was involuntarily terminated from his/her employment?

**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 COBRA 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

a. _____

1. I elected (or am electing) COBRA 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

b. _____

1. I elected (or am electing) COBRA 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

c. _____

1. I elected (or am electing) COBRA 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 ➔ _____

This form is designed for plans to distribute to COBRA 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 and therefore not eligible for reduced premiums under ARRA.

Management Benefits Fund

Participant Notification

40 Rector Street, 3rd Fl
New York, NY 10006

PERSONAL INFORMATION

Name and mailing address:

Telephone number:

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 COBRA 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:

