Health Net
11971 Foundation Place
Rancho Cordova, CA 95670

Name
Address
City, ST Zip

Date

RE: American Recovery and Reinvestment Act of 2009 (the "Act")

Dear Valued Health Net Customer:

As you know, the referenced Act provides for a 65 percent federal subsidy of COBRA continuation coverage premiums for qualified beneficiaries that were ***involuntarily*** terminated from employment in the period from September 1, 2008 through December 31, 2009. The Act also provides a special 60-day election period for qualified beneficiaries that experienced an ***involuntary*** termination of employment on or after September 1, 2008 but prior to February 17, 2009 (the "enactment" date), but did not elect COBRA during their initial 60-day election period, or elected COBRA coverage but subsequently lost that coverage prior to the enactment date.

All those experiencing a qualifying event during the September 1, 2008 through December 31, 2009, not just those related to involuntary termination of employment, must receive a notification of the subsidy program.

The Act requires that all federal COBRA subsidies must be administered and recovered by the employer group, and not the carrier. Therefore, because you have previously chosen to be a "direct pay" federal COBRA group, with Health Net billing and collecting the applicable COBRA premium directly from your former employees and their eligible dependents, Health Net must bill you for the 65% portion of the federal COBRA premium for the "assistance eligible individuals" (AEI's).

Health Net will assist employer groups to identify AEI's, meet the notice requirement listed above and effectively administer the ongoing eligibility and premium remittance requirements of the Act. Health Net is providing the enclosed list to you identifying all members from your group who had a qualifying event from September 1, 2008 through March 16, 1009. Please review the enclosed list and indicate the members who were involuntarily terminated from employment. Additionally, please verify that the member information we have provided on the list is correct. Please return the enclosed report with your revisions to Health Net within (10) business days of the date of this letter so we may confirm who is eligible to receive the subsidy.

The U.S. Department of Labor has published model COBRA Premium Reduction application forms for issuing to the potential AEI's. For your convenience, we have enclosed a revised version of the model form for you to send to COBRA eligible applicants. Please send the form to the members on the enclosed employee listing as soon as possible, but no later than April 17, 2008. The completed form is to be forwarded by the applicant to Health Net at the address listed on the form. Health Net will process it and forward a copy to you for your payroll tax documentation.

Employers also must provide any AEI's still in their original 60-day COBRA election period, a notice advising them of their rights and the requirements to receive the subsidy.

Individuals who are denied status as AEI's and therefore denied eligibility for the premium reduction may appeal such decision to the U.S. Department of Labor at www.DOL.gov or 1-866 444-3272. Under the Act, the DOL must make a determination within 15 business days of receipt of a completed request for review. The DOL is developing processes and forms required for appeals.

Employer Actions:

- You are required to send the enclosed COBRA Premium Reduction Application and a Health Net COBRA application along with COBRA Rights and Rates to all members on the enclosed list, regardless of the termination reason. Applicants must send completed forms to Health Net, 11971 Foundation Place, Rancho Cordova, CA 95670, Attn: Cobra Direct Pay Unit, Mailstop: CA-903-02-05.
- You must review the enclosed list, identify the involuntary terminations from employment, make any changes/updates necessary and forward to Health Net, 11971 Foundation Place, Rancho Cordova, CA 95670, Attn: Cobra Direct Pay Unit, Mailstop: CA-903-02-05.
- Moving forward, you will be required to provide the enclosed COBRA Premium Reduction Application to all terminated members along with the Health Net Cobra Application, Rights and Rates. You may copy this form and provide it to the members on the enclosed list. The member will have 60 days from the date of receipt to submit the completed Form to Health Net.

Additional Health Net Actions:

- Upon receipt and review of completed COBRA Premium Reduction Applications, Health Net will forward a copy to the employer group for tax record purposes. Employers will take the subsidy as a reduction to payroll tax deposits and/or on the IRS Form 941.
- Once the AEI elects and remits the initial 35% premium payment, Health Net will bill the employer group 65%, which will be due on or before the first of the following month. The 2% administration fee is included in the calculation. Health Net will send a separate billing statement to you and not be consolidating with your active group member billing due to tax purposes.

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Enclosure(s): Member Listing
COBRA Premium Reduction Application Form
Return Envelope

Health Net

American Recovery and Reinvestment Act Application/Attestation Form
Federal Cobra Premium Reduction

PLEASE MAIL BACK TO: Health Net, 11971 Foundation Place, Rancho Cordova, CA 95670
Attn: Cobra Direct Pay Unit / Mailstop: CA-903-02-05

To apply for the ARRA Premium Reduction, please complete this form and **return within 60 days** of receipt to the Health Net address above.

PERSONAL INFORMATION:

_____

Previous Employer Group Name:

_____

Last Name, First Name (subscriber) **Social Security Number** **Date of Birth**

_____

Address **City** **ST** **Zip Code** **Phone Number**

To qualify, you must be able to check YES for all statements below:	Yes	No
1. The loss of employment was involuntary		
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009		
3. I elected (or am electing) COBRA continuation coverage*		
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).		
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).		
IF YOU CHECKED "NO" FOR #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 subsidy election notice with a Cobra application form from your previous employer, which you must return to Health Net to the address provided above. If you qualify for the additional election period, your enrollment effective date will be March 1, 2009. If you believe you should have received this and have not, please contact your previous employer.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and believe, all of the answers I have provided on this form are true and correct.

Signature _____ Date: _____

Type or Print Name: _____ Relationship to Employee: _____

Health Net

DEPENDENT INFORMATION (parent or guardian should sign for minor children)

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

Please complete all questions below for dependent #1	Yes	No
1. I elected (or am electing) COBRA continuation coverage		
2. I am NOT eligible for other group health plan coverage		
3. I am NOT eligible for Medicare		
4. I am NOT a domestic partner of the subscriber		
5. I am NOT the same sex spouse of the subscriber		

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: _____

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

Please complete all questions below for dependent #2	Yes	No
1. I elected (or am electing) COBRA continuation coverage		
2. I am NOT eligible for other group health plan coverage		
3. I am NOT eligible for Medicare		
4. I am NOT a domestic partner of the subscriber		
5. I am NOT the same sex spouse of the subscriber		

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: _____

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

Please complete all questions below for dependent #3	Yes	No
1. I elected (or am electing) COBRA continuation coverage		
2. I am NOT eligible for other group health plan coverage		
3. I am NOT eligible for Medicare		
4. I am NOT a domestic partner of the subscriber		
5. I am NOT the same sex spouse of the subscriber		

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: _____

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 whether you take or decline the other coverage. However, eligibility for other coverage does not include any time spent in a waiting period.

FOR EMPLOYER OR PLAN USE ONLY

This application is: ÿ **Approved** ÿ **Denied** ÿ **Approved for some/Denial for others (explain in #4 below)**

Specify the reason below and return a copy of this form to the applicant

REASON FOR DENIAL AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary	ÿ
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009	ÿ
3. The individual did not elect COBRA coverage. *	ÿ
4. Other (please explain):	ÿ

If you checked #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

_____ _____

Signature Date

_____

Print Name