



DATE

NAME
ADDRESS
CITY

Dear Employee and Covered Dependents:

This notice contains important information about your right to continue your dental care coverage with Delta Dental of South Dakota dental plan (the Plan). Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. You are receiving this election notice because you experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with May 31, 2010 and you may be eligible for the temporary premium reduction for up to fifteen 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” with details regarding eligibility, restrictions, and obligations and the “Request for Treatment as an Assistance Eligible Individual.” **If you believe you meet the criteria for the premium reduction, complete the “Request for Consideration as an Assistance Eligible Individual” and return it with your completed Election Form.**

To elect COBRA continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on _____ due to:

Each person (“qualified beneficiary”) that is currently covered under your dental plan is entitled to elect COBRA continuation coverage, which will continue group dental care coverage under the Plan for up to _____ months. Please note, you may separately enroll each qualified beneficiary individually.

If elected, COBRA continuation coverage will begin on _____ and can last until _____.

COBRA continuation coverage cost is shown below along with the cost if you qualify as an Assistance Eligible Individual (AEI):

Coverage Type	Regular Monthly Cost	AEI Subsidy Cost
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Premium Amounts change from time to time. You will be notified of any change in premium amount. If you are an assistance eligible individual the AEI Subsidy is available for up to fifteen months. You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following this letter.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact Delta Dental of South Dakota, P.O. Box 1157, Pierre, SD 57501 or call 1-800-627-3961.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage? Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their dental care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group dental plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the 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 Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last? In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

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

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group dental plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary, or
- the employer ceases to provide any group dental 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 COBRA continuation coverage? (This is applicable only if your COBRA coverage is less than 36 months): 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 Delta Dental of South Dakota 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 COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify Delta Dental within 60 days of an entitlement by the Social Security Administration. 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 or legal separation from the covered employee, 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. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage? To elect continuation coverage, you must complete the COBRA Continuation Coverage 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 dental 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 dental plans if you have a 63-day gap in coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual dental coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group dental plan for which you are otherwise eligible

(such as a plan sponsored by your spouse's employer) within 30 days after your group dental coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage 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 dental 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 COBRA 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 May 31, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to fifteen months. If your COBRA continuation coverage lasts for more than fifteen months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA 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 COBRA continuation coverage 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 within the 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 Delta Dental of South Dakota to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. Under the Plan, each of these monthly payments for continuation coverage is due on the first of each month. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments: Although monthly payments are due on the first of the month, you will be given a grace period of 30 days after the first day of the coverage period 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 monthly 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 monthly 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 monthly 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 monthly payments for continuation coverage should be sent to Delta Dental of South Dakota, P.O. Box 1157, Pierre, SD 57501

For more information This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact your Human Resource Director or Delta Dental of South Dakota.

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact State and local government employees should contact Maximus, a CMS-sponsored contractor, at www.ContinuationCoverage.net or ContinuationCoverage@maximus.com.

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 COBRA Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. ARRA has been amended three times, on December 19, 2009, March 2, 2010, and April 15, 2010. These laws give “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 15 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- **MUST** have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at any time from September 1, 2008 through May 31, 2010;*
- **MUST** elect the coverage; 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.¹

* The involuntary termination must occur on or after March 2, 2010 if it is preceded by a qualifying event that was a reduction of hours occurring at any time from September 1, 2008 through May 31, 2010.

◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group dental plan coverage 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 your Human Resources Director or Delta Dental of South Dakota, P.O. Box 1157, Pierre, SD 57501, phone (605)224-7345.

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 Human Resources Director or Delta Dental of South Dakota, P.O. Box 1157, Pierre, SD 57501, phone (605)224-7345.

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)

¹ 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.



DATE

NAME

ADDRESS

CITY

10 DIGIT ID NUMBER

GROUP & LOC #'S

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA 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 COBRA continuation coverage under the Plan.

Send completed Election Form to: Delta Dental of South Dakota, P.O. Box 1157, Pierre, SD 57501. This Election Form must be completed and returned by mail (postmarked) or faxed to Delta Dental at (605) 224-0909 within 60 days of this notice or the date of the event, whichever is later.

If you do not submit a completed Election Form by the due date shown above, 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 Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form. Read the important information about your rights included in the pages after the Election Form.

Person to carry insurance if different than listed above:

Social Security # _____
Last Name _____ First Name _____ MI _____
Address _____
City, State, Zip _____
Date of Birth _____

Qualifying Event: _____

List of eligible family members to be insured:

Last Name (if different) First Name Sex Date of Birth Social Security #

Signature

Date

Print Name

Relationship to individual(s) listed above

Telephone Number



REQUEST FOR CONSIDERATION AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

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."

10 DIGIT ID NUMBER & GROUP & LOC

Send this form to:

Delta Dental of South Dakota
P.O. Box 1157
Pierre, SD 57501

PERSONAL INFORMATION

Employee name _____

Employee mailing address _____

Employee phone number _____ Employee e-mail address _____

Employee dependents (please complete the form on the back side of this sheet, listing each dependent that is separately applying for the COBRA subsidy).

To qualify, none of your answers below can be "No".

- 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 May 31, 2010. Yes No
- 3. I elected (or am electing) continuation coverage. Yes No
- 4. If the loss of employment was preceded by a qualifying event that was a reduction of hours, the reduction of hours took place at some point between September 1, 2008 and May 31, 201 AND the loss of employment occurred on or after March 2, 2010. Yes No N/A
- 5. I am eligible for other group dental plan coverage (or I was eligible for other group dental plan coverage during the period for which I am claiming a reduced premium). Eligible Not Eligible

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 DELTA DENTAL USE ONLY

This application is: Approved Denied Approved for some/denied for others (explain in #5 below)

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

- 1. The loss of employment was voluntary.
- 2. The involuntary loss did not occur between September 1, 2008 and May 31, 2010.
- 3. The qualifying event was a reduction of hours and was not followed by a termination of employment (or the termination occurred prior to March 2, 2010 or after May 31, 2010).
- 4. Individual eligible for other dental plan coverage.
- 5. Other (please explain)

Signature of party responsible for continuation coverage administration for the Plan

Signature _____ Date _____

Type or print name _____

Phone number _____ E-mail address _____



DEPENDENT INFORMATION (Parent or guardian should sign for minor children.) If more lines are needed, please attach additional information on a separate sheet of paper.

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 eligible for other group dental plan coverage.	<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 eligible for other group dental plan coverage.	<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 eligible for other group dental plan coverage.	<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)

d. _____

1. I elected (or am electing) continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am eligible for other group dental plan coverage.	<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 dental plan coverage.

Delta Dental of South Dakota

Participant Notification

Plan Mailing Address
P.O. Box 1157
Pierre, SD 57501

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 dental plan.
If any dependents are also eligible, include their names below.

Insert date you became eligible _____

IMPORTANT

If you fail to notify your issuer of becoming eligible for other group dental plan coverage AND continue to pay reduced continuation 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 dental plan and that plan covers dependents you must also list their names here:
