CHALLENGES
IN OFFERING COBRA IN 2021

FORMS PACKAGE

(REVISED TO INCLUDE CHANGES REQUIRED BY THE RELEASE OF THE MODEL NOTICES)

COBRA ADMINISTRATION CAN BE HANDLED BY EITHER THE EMPLOYER OR A THIRD-PARTY ADMINISTRATOR, BUT AS THE LEGAL OBLIGATION STILL FALLS TO THE EMPLOYER TO COMPLY WITH THE LAW, ALL EMPLOYERS SHOULD MAKE SURE THESE ADMINISTRATIVE STEPS ARE BEING COMPLETED AND DONE SO IN A TIMELY MANNER.

CONTENTS

EXPLANATION OF THE NEW COBRA PREMIUM ASSISTANCE FOR EMPLOYERS

The American Rescue Plan Act of 2021 ("Act") signed by President Biden on March 11, 2021, provides new COBRA premium assistance provisions and special enrollment rights that will require employers to take action quickly.

What premium assistance is provided?

Eligible individuals are entitled to a 100% premium assistance for the cost of COBRA or state continuation coverage for up to six months (ending September 30, 2021) for individuals who qualify for COBRA coverage beginning on April 1, 2021. This includes the 2% administrative fee.

Who is considered eligible for this premium assistance?

Any individual who is a COBRA qualified beneficiary eligible for COBRA due to a reduction in hours or involuntary termination of employment and who elects COBRA or state continuation coverage will be eligible for the premium assistance.

Would COBRA coverage for an employee's spouse or other dependents be eligible for premium assistance?

Yes. The premium assistance applies not only to the employee who lost coverage due to a reduction in hours or involuntary termination (other than for gross misconduct) but also to any other qualified beneficiaries who were covered through the employee and lost coverage as a result of the employee's reduction in hours or an involuntary termination of employment (e.g., spouse, children).

For what period does the premium assistance apply?

It applies for COBRA or state continuation coverage from April 1, 2021, through September 30, 2021.

In any case, where it is not the employer or a multiemployer plan, the insurer is the person to whom premiums are payable.

Does the employer have to provide an additional election opportunity to those eligible individuals who either did not elect COBRA or state continuation coverage or discontinued COBRA or state continuation coverage?

Yes. An additional COBRA or state continuation election opportunity must be provided for any eligible individuals who either do not elect federal COBRA or state continuation coverage but would have been eligible for premium assistance or who had elected federal COBRA or state continuation coverage previously but discontinued COBRA or state continuation coverage before April 1, 2021. Employers are required to provide notices to these eligible individuals, as provided below.

This special enrollment right must only be offered to those who are eligible for COBRA or state continuation due to a reduction in hours or involuntary termination of employment

Please note that individuals who discontinued COBRA or state continuation coverage do not have to be assistance eligible to take advantage of this extended election period.

Eligible individuals may elect COBRA or state continuation coverage during the period beginning on April 1, 2021, and ending 60 days after the date on which they are provided Notice by the employer/plan administrator as required. This elected COBRA or state continuation coverage elected begins on or after April 1, 2021, and does not extend beyond the maximum period of COBRA or state continuation coverage that would have been required if the individual had elected COBRA at the time of the original event (or had not discontinued coverage that was elected at that time).

When can the premium assistance be terminated?

An individual ceases to be eligible for premium assistance for months of coverage that begin on or after the earlier of:

- The first date the individual is eligible for coverage under Medicare or any other group health plan (other than coverage that is only "excepted benefits," coverage under a health flexible spending account, or coverage under a qualified small employer health reimbursement arrangement), or

- The date following the expiration of the normal maximum COBRA period, which generally would be 18 months from the qualifying event. State continuation periods will vary.

For an individual who did not originally elect COBRA or state continuation or who originally elected but then discontinued COBRA or state continuation coverage, this period is measured from what would have been the beginning of the COBRA or state continuation coverage period if the individual had elected when originally eligible or had not discontinued COBRA (in other words measured by reference to a reduction in hours or involuntary termination of employment that caused the loss of coverage).

Can an employer give an eligible individual the option to change coverages?

Yes. An employer can allow an assistance eligible individual who is enrolled in coverage under the employer plan to change to a different coverage option offered under the plan. The election to change coverage options must be made by the individual no later than 90 days after the date of Notice of the right to change options is provided to the individual. The premium for the new

coverage option must not exceed the premium for the coverage in which the individual was enrolled at the time of the reduction in hours or involuntary termination of employment, and the new coverage option must be coverage that is offered to similarly situated active employees at the time the election to change is made, and cannot be coverage that provides only "excepted benefits," a flexible spending account, or a qualified small employer health reimbursement arrangement.

What are the new required notice requirements?

The following new notice requirements are imposed on employers/plan administrators and on individuals:

Additional Required Information for COBRA Election Notices. COBRA election notices provided to individuals who become eligible to elect COBRA coverage during the period between April 1, 2021, and September 30, 2021, must include additional information regarding the premium assistance. This additional information can be incorporated into the normal election notice or can be provided by including a separate document with the normal election notice.
The Notice must include all of the following additional information:

- The forms necessary for establishing premium assistance;

- The name, address, and telephone number necessary to contact the plan administrator and any other person maintaining relevant information in connection with premium assistance;

- A description of the extended election period;

- A description of the individual's obligation to provide Notice if the individual becomes eligible for other group health coverage or Medicare, and of the penalty for failure to provide such Notice (see below);

- A description "displayed in a prominent manner" of the individual's right to a subsidized premium and any conditions on entitlement to the subsidized premium; and

- If the employer has chosen to offer the optional plan coverage option change, a description of that option.

Notice of Extended Election Period. For individuals who became entitled to elect COBRA before April 1, 2021, the plan administrator must provide a Notice to the individual no later than May 31, 2021 (60 days after April 1, 2021). The Notice must satisfy the requirements described above. This Notice must be sent to individuals who are eligible for premium assistance, individuals who would be assistance eligible if they had a COBRA or state continuation election in effect on April 1, 2021, and individuals who had elected COBRA or state continuation previously but discontinued COBRA before April 1, 2021 (whether or not assistance eligible).

• Notice of Availability of COBRA or state continuation Premium Assistance for COBRA or State Continuation Participants – This form provides a summary of COBRA or state continuation Premium Assistance and the special enrollment rights state continuation Coverage.
- Alternative Premium Assistance Election Notice- This form explains the procedures for electing state continuation coverage and/or receiving Premium Assistance.
• Continuation Coverage Election Form-- Notice of Eligibility for Other Group Insurance Coverage or Medicare Form-This form is provided to an eligible individual when he or she elects state continuation coverage. The eligible individual must be instructed that he or she must return this form when he or she becomes eligible for other coverage.
• Form for Switching Continuation Coverage Benefit Options- This form is only provided to an eligible individual if the employer provides the eligible individual with the option to switch continuation coverages.
- Notice of Eligibility for Other Group Insurance Coverage or Medicare Form-This form is provided to an eligible individual when he or she elects COBRA or state continuation coverage. The eligible individual must be instructed that he or she must return this form when he or she becomes eligible for other group coverage or Medicare.

What other forms are in this package?

• Discussion of What is Gross Misconduct under COBRA- This form is not provided to an eligible individual. It summaries the rules for determining if a former employee has engaged in gross misconduct and can be denied COBRA coverage.
• New Periods to make Elections for Benefits or Coverage
- This form should be provided to all participants of your ERISA plans. It explains which deadlines have been delayed or suspended.

A DISCUSSION OF WHAT IS GROSS MISCONDUCT UNDER COBRA

There is one exception for extending COBRA coverage to former employees. That exception would be when the employee is terminated for gross misconduct. When that happens, the termination is not considered a COBRA-qualifying event, and the employer does not have to offer

Notice of Expiration of Premium Assistance. Between 45 days and 15 days before the premium assistance period ends for an individual (not including premium assistance that ends because the individual becomes eligible for other group health plan coverage or Medicare), the plan administrator must provide written Notice to the individual in "clear and understandable" language that premium assistance for the individual will "expire soon" and include prominent identification of the date of such expiration and that the individual may be eligible for continued COBRA without premium assistance or coverage under a group health plan.

Notice by Individual. As noted above, an individual ceases to be eligible for premium assistance for months of COBRA or state continuation coverage that begin on or after the date the person is eligible for Medicare or coverage under any other group health plan (other than coverage that is only "excepted benefits," coverage under a health flexible spending account, or coverage under a qualified small employer health reimbursement arrangement). An assistance eligible individual must notify the group health plan of such eligibility "in such time and manner as may be specified by the Secretary of Labor." A new provision has been added to the Internal Revenue Code to impose a $250 penalty on an individual who fails to provide such Notice, except where the failure was due to reasonable cause and not willful neglect. The penalty may be increased where the failure to provide Notice was fraudulent. In that case, the penalty is the greater of $250 or 110% of the premium assistance provided to the individual after the individual's eligibility ended due to the other coverage.

What forms in this forms package must be provided to eligible individuals to elect coverage and the COBRA or state continuation Premium Assistance?

The following forms must be provided to an eligible individual to elect COBRA coverage and the COBRA Premium Assistance:

- Notice of Availability of COBRA or State Continuation Premium Assistance for COBRA or State Continuation Participants – This form provides a summary of COBRA or state continuation Premium Assistance and the special enrollment rights.
- COBRA Special Enrollment Election Notice- This form explains the procedures for electing COBRA coverage and receiving COBRA Premium Assistance.
- COBRA Premium Assistance Special Enrollment Election Form- The eligible individual, uses this form to elect COBRA coverage and/or claim the Premium Assistance.
- Form for Switching COBRA Coverage Benefit Options - This form is only provided to an eligible individual if the employer provides the eligible individual with the option of changing his or her coverage option.
- Notice of Eligibility for Other Group Insurance Coverage or Medicare Form- This form is provided to an eligible individual when he or she elects COBRA or state continuation coverage. The eligible individual must be instructed that he or she must return this form when he or she becomes eligible for other group coverage or Medicare.

The following forms must be provided to an eligible individual to elect state continuation coverage:

COBRA coverage to the ex-employee, or the ex-employees covered spouse or dependent child(ren).

The COBRA statute does not specifically define the term gross misconduct, so the courts have taken the lead on deciding whether to apply it on a case-by-case basis. That means it is up to employers to determine whether their gross misconduct definition meets the standards that were previously ruled on from past court cases as well as regulatory and legal developments.

Courts that have faced the gross misconduct case generally refer to the two questions below when deciding if the conduct is truly gross misconduct.

Was the conduct intentional, willful, deliberate, or reckless, and was that conduct performed with a conscious or reckless disregard of the consequences of one's acts for the very purpose of causing harm or with the knowledge that harm would result in the employer's best interest?

Did the conduct have a connection or series of connections or physical presence linking the gross misconduct or performance directly to the employer, a co-worker, or a current or former client or customer?

To minimize their risk, many employers have decided not to apply the gross misconduct exception at all but, instead, to extend COBRA to all terminated employees regardless of the reason for the termination. Another way an employer can limit their risk is to clearly communicate to employees the type of behavior an employer considers to be gross misconduct. This can be done by adding this policy to its employee handbook or to an employee's contract of employment. When an employer identifies gross misconduct in advance, it must inform its employees what it considers to be significant, and this will assist the employer later should it find it has a claim for not providing COBRA to an employee who was terminated for this cause.

Here is a list of conduct that most employers would consider being gross misconduct:

- Fighting, physical assault, abuse, or threatening behavior
- Blatant disregard for the safety of others or serious breaches of health and safety rules
- Deliberate acts of vandalism or sabotage
- Any attempts to financially defraud the company or theft
- Significant levels of insubordination
- Dishonesty, falsification of documents, or other forms of misrepresentation
- Offensive or unlawful behavior (such as discrimination, harassment, or bullying)
- Working under the influence of illegal drugs or alcohol

Should an employer decide to deny COBRA to an ex-employee on the basis of gross misconduct, be sure the employer keeps detailed records of the process used to determine the gross misconduct along with any notices or correspondence to the ex-employee.

Just remember, COBRA mistakes can be costly, whether they were intentional or not. Employers may be liable for a penalty of up to $110 per employee or family member for each day of

noncompliance. The Employee Retirement Income Security Act (ERISA) provides for additional penalties and gives affected persons—as well as the Department of Labor—the right to file a lawsuit. Be sure that the employer is sending timely notifications to its plan administrator when a qualifying event occurs, including terminations or a reduction in hours, such as a leave of absence or a layoff.

COBRA ARPA SUBSIDY STEPS FOR SELF-ADMINISTERED EMPLOYERS

COBRA administration can be handled by either the employer or a third-party administrator, but as the legal obligation still falls to the employer to comply with the law,

all employers should make sure these administrative steps are being completed and done so in a timely manner.

In an effort to assist self-administered employers with ARPA subsidy compliance for AEIs, the following steps should be taken:

Step 1: Identify all Assistance Eligible Individuals

Review list of all COBRA qualified beneficiaries who experienced a qualifying event of termination of employment or reduction in hours and are still within the original 18-month period of COBRA eligibility, even if they never elected COBRA when initially offered or discontinued COBRA at any point during the 18-month period. Generally, this would include those with applicable qualifying events as far back as October 1, 2019.

Then, identify which COBRA beneficiaries are considered Assistance Eligible Individuals (AEIs) within this list.

Step 2: Election Notification

Employers must ensure that a COBRA Extended Election Period Notice is provided to all AEIs currently enrolled in COBRA, as well as those who would be AEIs had they elected or maintained COBRA continuation coverage (those identified under Step 1). This Notice must be sent within 60 days of April 1 (no later than May 31, 2021).

Employers must also provide an ARP General Notice and Continuation Coverage Election Notice to all qualified beneficiaries who experience qualifying events within the period of April 1, 2021, through September 30, 2021.

Hand delivery of notices to employees with participating spouses is not recommended as it does not satisfy the requirement to directly notify the spouse, who could also be an AEI. Instead, the best option for providing Notice is to send a letter by first-class mail to the employee's home address with the employee's name and the spouse's name or "& Family," if applicable.

Some individuals may contact their former employer and ask if they are eligible for the subsidy. In that instance, the employer may want to have them fill out the REQUEST FOR TREATMENT AS AN ASSITANCE ELIGIBLE INDIVIDUAL form contained in this packet.

Step 3: ARPA Election Notices

In general, individuals who are eligible for COBRA continuation coverage have 60 days after the date that they initially receive their COBRA election notice to elect COBRA continuation coverage.

Therefore, potential AEIs must also elect COBRA continuation coverage within 60 days of receipt of the relevant Notice or forfeit their right to elect COBRA continuation coverage with premium assistance.

Step 4: Returned Election Form and Attestation

Employers should include and request back from the potential AEI the COBRA Continuation Coverage Election Form contained on the last few pages of the sample notices in this packet or the Model notices provided by the DOL.

In addition, employers should request that the potential AEIs complete a form attesting to the fact that they qualify as AEI and are not eligible for other group coverage or Medicare (see sample attestation form).

**Note, if the employer will allow AEIs to switch to a lower-cost plan (optional), the sample form provided in the notices "Form for Switching COBRA Continuation Coverage Benefit Options" should be included in the election notice and returned by the AEI within 90 days from the date of the election notice.

Step 5: Insurance Carrier Notification

Employers must notify the insurance carrier when an AEI's COBRA is elected, and insurance must be reinstated as of the date the subsidy applies or back to the original COBRA start date if the individual pays the prior month's premiums (before April 1).

Step 6: Election and Payment

If COBRA coverage is not elected within 60 days of when the election notice was sent, the employer's obligations end and no further action is required.

If COBRA coverage is elected within 60 days of when the election notice was sent, employers must allow 45 days from the date of the election for the initial premiums owed to be paid. Once received, the employer must notify the insurance carrier to reinstate coverage back to the initial end date, so there is no gap in coverage. If the employee continues to pay premiums on a timely basis and no secondary qualifying event or allowable reason for early termination occurs, no further action is needed.

Step 7 (if needed): Early Termination of Subsidy

If a current COBRA participant who is an AEI exhausts 18 months of COBRA, becomes eligible for Medicare, or is eligible for another group health plan while on COBRA, including a spouse's

employer's plan, the employer may cancel the COBRA subsidy coverage earlier than September 30, 2021. A written notice (see Notice of Expiration of the COBRA or State Continuation Premium Assistance) must be provided 15- 45 days before the individual's premium assistance expires.

Step 8: Termination of Subsidy Period

Once the subsidy period expires as of September 30, 2021, AEIs must also be notified of the expiration of the premium subsidy and that the individual may be eligible for coverage without any premium assistance through COBRA continuation coverage or coverage under a group health plan (Notice of Expiration of the COBRA or State Continuation Premium Assistance). When the subsidy period concludes, the individual may generally continue at their own expense, drop continuation coverage, or enroll in some other applicable health plan option.

NOTICE OF AVAILABILITY OF COBRA OR STATE CONTINUATION PREMIUM ASSISTANCE FOR COBRA OR STATE CONTINUATION PARTICIPANTS

On March 11, 2021, President Biden signed into law the American Rescue Plan Act of 2021. This law may provide you with the opportunity to receive (1) assistance in paying for your COBRA or state continuation premiums or (2) a second chance for electing COBRA or state continuation coverage. ***If you are eligible for assistance in paying your COBRA or state continuation premium, then for a limited period, as described below, you will not pay anything for the monthly cost of your premium for group health coverage under COBRA or state continuation coverage.*** Please read the information contained below carefully to determine if you are eligible to receive premium assistance or have another opportunity to elect COBRA or state continuation coverage and how you may apply for this coverage and/or assistance.

Who is Eligible for the COBRA or state continuation Premium Assistance?

You are eligible for the COBRA or state continuation Premium Assistance if you meet the following conditions:

1) At any time during the period that begins after October 1, 2019, and ends with September 30, 2021, you were either involuntarily terminated from employment, other than for gross misconduct, or have a reduction of hours with your employer and you, your qualified spouse and/or dependent(s) are eligible for COBRA or state continuation coverage.

Note: The beginning period may be different for state continuation coverage.

2) You, your qualified spouse, or dependent(s) are eligible to elect COBRA or state continuation coverage.

What if you, your spouse, or dependents did not elect COBRA or state continuation coverage, and your initial enrollment period has expired?

You, your spouse, and/or dependent(s) will have 60 days from the Date of this Notice to elect COBRA or state continuation coverage again. You will be eligible for COBRA or state continuation coverage from April 1, 2021, through what would have been the end of your typical COBRA or state continuation coverage period. You may do so by completing the attached COBRA or state continuation Election Form and returning it to [insert name of entity]. You must pay the initial COBRA premium within 45 days of your election for COBRA coverage if you are not eligible for premium assistance and are electing COBRA or state continuation coverage.

When will your COBRA or state continuation coverage start?

If you are eligible, your coverage under your employer's group health plan will be effective the later of either any coverage beginning (April 1, 2021) or your date of involuntary termination or reduction of hours with your employer.

When will your eligibility for premium assistance end?

You will no longer be eligible for premium assistance for months of coverage that begin on or after the earlier of:

- The first date you are eligible for coverage under Medicare or any other group health plan (other than coverage that is only "excepted benefits," dental and vision coverage under a health flexible spending account, or coverage under a qualified small employer health reimbursement arrangement), or

- The date following the expiration of the normal maximum COBRA or state continuation period, which generally would be 18 months from the qualifying event.

Optional:

Can I enroll in another health plan that costs less money?

Your employer may decide to allow you to select from the current plan(s) available, which have a lower monthly premium. You will have 90 days from the Date of this Notice to change your current benefit election(s). A Summary Plan Description (SPD) is included for your review along with a Special Enrollment Election Form or Continuation Coverage Election Form. Please note: The plan with lower premiums may offer fewer benefits than you currently receive. Make your selection carefully, as you will not be allowed to make any other changes to your COBRA or state continuation coverage until the next open enrollment.

If you decide to change from your current COBRA or state continuation plan(s), you must complete the enclosed Special Enrollment Election Form or Continuation Coverage Election Form. The new plan will be effective on the later of April 1, 2021, or on the COBRA or state continuation coverage effective date following your involuntary termination or reduction of hours. Upon approval, you will be notified of the new COBRA or state continuation premium.

When will your COBRA or state continuation coverage end?

Your COBRA coverage will terminate on the earliest of the following events to occur:

1) 18 months after your original qualifying event date (or the end of the coverage period for the standard extensions of coverage under COBRA such as the death of the employee, dependent ceases to be eligible for coverage, you are on Military Leave or you become SSA disabled);

Note: The period for coverage under state continuation coverage may be shorter.

2) The date you are covered under any group health plan;

3) The Date, your Employer, ceases to maintain any group health plan for its employees; or

4) You become entitled to Medicare.

What Group Health Plans are eligible for the premium assistance?

The following plans are eligible for the premium assistance under COBRA:
1) Medical coverage
2) Dental coverage

3) Vision coverage
4) Employee Assistance Plans (other than referral only plans)
5) Health Reimbursement Arrangements (HRA's)

Remember, many state continuation coverages only apply to medical coverage.

Note: Health Care Flexible Spending Account plans are not eligible for this subsidy.

Whom do you notify if you think you are eligible for either the COBRA or state continuation Premium Assistance and/or to elect COBRA or state continuation coverage?

You may notify the COBRA or state continuation Plan Service Provider with any questions or to apply for the COBRA or state continuation coverage:

[Insert Company Name/Address/Phone/Email]

If you have questions regarding the plans, you may contact the Plan Administrator at:

[Insert Plan Admin Name/Address/Phone/Email]

What do you complete to show that you are eligible for the COBRA or state continuation Premium Assistance?

To apply for the COBRA or state continuation Premium Assistance and to elect coverage, complete the Special Election Form or the Continuation Coverage Election Form and return it to your plan or employer. If you have not yet elected COBRA coverage, you must complete this form and return it within 60 days of receipt, or you may be unable to receive the premium assistance or coverage.

How do you notify the Plan Administrator of your or your dependent's eligibility for coverage under another Group Health Plan or Medicare after you begin to receive the COBRA Premium Assistance Subsidy?

You must notify [Insert Name] within 30 days of the first date on which you or your dependents will be eligible for coverage under another group health plan as described in this Notice or Medicare. You must do so in writing and use the Notice of Eligibility for Other Group Insurance Coverage or Medicare Form.

Note: Failure to provide notification of your eligibility for coverage under another group health plan may result in a penalty of $250, except where your failure was due to reasonable cause and not willful neglect. The penalty may be increased where the failure to provide Notice was fraudulent. In that case, the penalty is the greater of $250 or 110% of the premium assistance provided after the individual's eligibility ended due to the other coverage.

For more information regarding COBRA premium assistance and eligibility questions, visit: https://www.dol.gov/cobra-subsidy or contact the Department of Labor at askebsa.dol.gov or 1-866-444-EBSA (3272)

If you have any questions regarding this notice or need assistance in completing the appropriate forms, please contact _____ [Insert Contact Info]. at _____ [Insert phone #].

_____ (Name of Company's Welfare Plan) (the" Plan")

(Date): _____

To: _____ (Name of Covered Employee and/or other Qualified Beneficiaries)

From: _____ (Name of contact at the Employer or COBRA Administrator)

Re: COBRA Special Election Notice

This Notice contains important information about your special rights to continue your (Specify all that apply): □ medical, □ dental, and/or □ vision coverage in the plan. Please make sure that you read the information contained in this Notice very carefully. We use the pronoun "you" in this Notice (including in the enclosed Election Form) to refer to each of the individuals addressed above who are entitled to make an election under COBRA.

The American Rescue Plan Act of 2021 (ARPA) provides COBRA premium assistance in some cases. You are receiving this Notice because you experienced a loss of coverage at some time after October 1, 2019, through April 1, 2021, and you either chose not to elect COBRA coverage at that time OR elected COBRA coverage but subsequently discontinued that coverage. If your loss of coverage was due to an involuntary termination of employment (other than for gross misconduct) or reduction of hours, you may be entitled to Premium Assistance for up to six months.

If you either did not elect COBRA coverage or dropped COBRA coverage, you may elect COBRA coverage beginning April 1, 2021.

To help determine whether you are eligible to receive the Premium Assistance, you should read this Notice and the attached documents carefully. In particular, reference the "NOTICE OF AVAILABILITY OF COBRA OR STATE CONTINUATION PREMIUM ASSISTANCE FOR COBRA OR STATE CONTINUATION PARTICIPANTS" with details regarding eligibility, restrictions, and obligations."

If you believe you meet the criteria for the COBRA Premium Assistance, complete the information below and return it with your completed COBRA Special Election Form to the address indicated at the bottom of the form.

Below is a listing of the individuals and coverages eligible:

□ Employee or former employee: _____
(Indicate name of individual and type of coverage available)

□ Spouse or former spouse: _____
(Indicate name of individual and type of coverage available)

□ Dependent child(ren) covered under the Plan on the day before the qualifying event that caused the loss of coverage: _____ (Indicate name of individual(s) and type of coverage available)

If elected, COBRA coverage begins effectively on _____ [enter the date of the first day of the first coverage period beginning on or after April 1, 2021] and can last until _____. The current monthly cost of your COBRA coverage is as follows. (Note that this amount will change in the future and will most likely be higher than they are now. You will be notified of COBRA premium changes.) (Indicate all coverages that apply)

[If the plan permits you, your or your dependent children to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred, insert: "To change the coverage option(s) for your COBRA coverage to something different than what you had on the last day of employment, complete the "Form for Switching COBRA Coverage Benefit Options" and return it to us. Available coverage options are: [insert list of available coverage options]." The different coverage must cost the same or less than the coverage the individual had at the time of the qualifying event; be offered to active employees; and cannot be limited to only dental coverage, vision coverage, counseling coverage, a flexible spending arrangement (FSA), including a health reimbursement arrangement that qualifies as an FSA, or an on-site medical clinic.]

If you qualify for the COBRA Premium Assistance, there will be no cost for coverage for up to six months (April 1, 2021, through September 30, 2021).

Medical:

If not eligible for the COBRA Premium Assistance:

Family coverage: $ _____ or Individual coverage: $ _____

Dental:

If not eligible for the COBRA Premium Assistance:

Family coverage: $ _____ or Individual coverage: $ _____

Vision:

If not eligible for the Premium Assistance:

Family coverage: $ _____ or Individual coverage: $ _____

You do not have to send any payment with the Election Form. Important additional information about payment for COBRA coverage is included in the attachment following the Election Form. However, until the full initial premium payment is received, your coverage will not be reinstated, and claims will not be paid.

_____ (Indicate name of Plan or COBRA Administrator) is the (either the Plan Administrator or COBRA Administrator). If you have any questions about this notice or your rights to elect COBRA coverage, you should contact:

_____ (Individual's Name

_____ (Individual's Title)

_____ (Company or COBRA Administrator's Name)

_____ (Street Address)

_____ (City, State and Zip Code)

_____ (Telephone Number)

Please read the information in this Notice very carefully before you make your decision. If you now choose to elect COBRA overage, you should use the election form provided later in this Notice.

If I did not have COBRA coverage and now elect COBRA coverage, when will my coverage begin, and how long will the coverage last?

If elected, COBRA coverage will begin on [***enter date***] and can last until [***enter date***].

COBRA coverage may end before the date noted above in certain circumstances, including for failure to pay premiums, for fraud, or if you become covered by another group health plan.

Note, due to the COVID-19 National Emergency, the Department of Labor, the Department of the Treasury, and the Internal Revenue Service issued a Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak ("Joint Notice"). This Notice provided relief for certain actions related to employee benefit plans required or permitted under Title I of ERISA and the Code, including the 60-day initial election period for COBRA coverage. The Department of Labor's Employee Benefits Security Administration (EBSA) provided further guidance on this relief in EBSA Disaster Relief Notice 2021-01. The extended deadline relief provided in the Joint Notice and Notice 2021-01 does not apply, however, to the 60-day election period related to COBRA premium assistance under the ARP. Potential individuals eligible for COBRA Premium Assistance, therefore, must elect COBRA coverage within 60 days of receipt of the relevant Notice or forfeit their right to elect COBRA coverage with premium assistance.

However, a potential Assistance Eligible Individual has the choice of electing COBRA coverage beginning April 1, 2021, or after (or beginning prospectively from the date of your qualifying event if your qualifying event is after April 1, 2021), or electing COBRA coverage commencing from an earlier qualifying event if you are eligible to make that election, including under the extended time frames provided by the Joint Notice. The election period for COBRA coverage with premium assistance does not cut off an individual's preexisting right to elect COBRA coverage, including

[1] 85 FR 26351 (May 4, 2020).

[2] Available at https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01.pdf.

under the extended timeframes provided by the Joint Notice and EBSA Disaster Relief Notice 2021-01.

Can I now extend the length of COBRA coverage?

If you now elect COBRA coverage, you may be able to extend the length of COBRA coverage if a qualified beneficiary is disabled or if a second qualifying event occurs. You must notify [***enter the name of the party responsible for COBRA administration***] of a disability or a second qualifying event within a certain time period to extend the period of COBRA coverage. If you do not provide Notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of COBRA coverage.

For more information about extending the length of COBRA coverage, visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

How much does COBRA coverage now cost?

COBRA coverage will cost: [***enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.***] The COBRA premium is reduced to zero for certain individuals. Premium assistance is available to certain individuals who are eligible for COBRA coverage due to a qualifying event that is a reduction in hours or involuntary termination of employment. If you qualify for premium assistance, you need not pay any of the COBRA premium otherwise due to the plan. This premium assistance is available from April 1, 2021, through September 30, 2021. If you choose to continue your COBRA coverage beyond that date, you may have to pay the full amount due. See the attached "Notice of Availability of the COBRA or State Continuation Premium Assistance Provisions for COBRA or State Continuation Participants" for more details, restrictions, and obligations, as well as the form to complete to establish eligibility.

If you are eligible for COBRA Premium Assistance, this monthly premium cost will be zero from April 1, 2021, through September 30, 2021, and you do not have to send any payment with the election form.

The plan will send you additional payment information after receiving the election form.

Are there other coverage options besides COBRA coverage?

Yes. There may be other coverage options for you and your family through the Health Insurance Marketplace®, Medicare, or other group health plan coverage options (such as a spouse's plan) through a special enrollment period. Additionally, you may apply for and, if eligible, enroll in Medicaid at any time. If you are not eligible for COBRA Premium Assistance, some of these options may cost less than COBRA coverage. If you are eligible for other group health plan coverage, such as through a new employer's plan or a spouse's plan (not including excepted benefits, a qualified small employer health reimbursement arrangement, or a health flexible spending arrangement), or if you are eligible for Medicare, you are not eligible for COBRA Premium Assistance. However, if you have individual market health insurance coverage, like a plan through the Marketplace, or if you have Medicaid, you may be eligible for COBRA Premium Assistance if you elect COBRA coverage. Note, however, that you will not be eligible for a premium tax credit, or advance payments of the premium tax credit, for your Marketplace

coverage for months that you are enrolled in COBRA coverage, and you may not be eligible for months during which you remain an employee but are eligible for COBRA coverage with premium assistance because of a reduction of hours. If you are eligible for Medicare, consider signing up during its special enrollment period to avoid a coverage gap when your COBRA coverage ends and a late enrollment penalty.

You should compare your other coverage options with COBRA coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. Also, keep in mind that if you elect COBRA coverage with premium assistance, then you may qualify for a special enrollment period to enroll in Marketplace coverage when your premium assistance ends. You may use the special enrollment period to enroll in Marketplace coverage with a tax credit if you end your COBRA coverage when your premium assistance ends, and you are otherwise eligible.

When you lose job-based health coverage, it is important that you choose carefully between COBRA coverage and other coverage options because once you have made your choice, it can be difficult or impossible to switch to another coverage option until the next available open enrollment period.

For more information

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

If you have questions about the information in this Notice, your rights to coverage, or if you want a copy of your summary plan description, contact [enter name of party responsible for COBRA administration for the plan, with telephone number and address].

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's EBSA website at https://www.dol.gov/agencies/ebsa, go to www.askebsa.dol.gov, or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace®, and to locate an assister in your area whom you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes
To protect your and your family's rights, still, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also still keep a copy of any notices you send to the Plan Administrator.

_____ (Name of Company's Welfare Plan)(the "Plan")

COBRA PREMIUM ASSISTANCE
SPECIAL ENROLLMENT ELECTION FORM

INSTRUCTIONS:

Under the American Rescue Plan Act of 2021, if you lost group health plan coverage due to an involuntary termination of employment or reduction of hours, you are only entitled to elect COBRA Coverage and/or be entitled to Premium Assistance during the period that begins with April 1, 2021. To elect COBRA coverage and/or apply for premium assistance complete this Special Election Form and return it to _____ (Indicate name of Plan Administrator or COBRA Administrator, if applicable). Under federal law, you have sixty (60) days after the Date of this Notice to decide whether you want to elect COBRA coverage under the plan.

Note: If you already have COBRA coverage and wish to claim the COBRA Premium Assistance, you must complete this Special Enrollment Election Form to claim it.

Once you have completed this form, you must either mail or hand-deliver it to:

_____ (Individual's Name)

_____ (Individual's Title)

_____ (Company or COBRA Administrator's Name)

_____ (Street Address)

_____ (City. State and Zip Code)

Any other communication in oral, written, or electronic form will not be as accepted as a COBRA election and will not preserve your COBRA rights under the plan.

WARNING: If you decide to mail a completed Special Election Form to the address specified above, it must be postmarked no later than _____ (Specify Date) If you decide to hand-deliver the completed form, it must be received by the individual at the address specified above no later than _____ (Specify date).

IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THE DUE DATE SHOWN ABOVE, YOU WILL LOSE YOUR RIGHT TO COBRA Premium Assistance and/ or COBRA coverage FOR ANY TIME IN THE FUTURE. If you reject COBRA coverage before the due date specified above, you may change your mind as long as you furnish a completed Election Form before the due date.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

To qualify for premium assistance for yourself, you must be able to check 'Yes' for all statements.

1. The qualifying event was a loss of employment that was involuntary or a reduction in hours.	☐ Yes ☐ No
2. I elected (or am electing) COBRA coverage.	☐ Yes ☐ No
3. 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 premium assistance).	☐ Yes ☐ No
4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance).	☐ Yes ☐ No
5. I have not exhausted the time period for receiving COBRA coverage.	☐ Yes ☐ No

To qualify for premium assistance for each of your dependents, you must be able to check 'Yes' for all statements.

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) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No
5. I have not exhausted the time period for receiving COBRA coverage.	☐ Yes ☐ No

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

B. _____

1. I elected (or am electing) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No
5. I have not exhausted the time period for receiving COBRA coverage.	☐ Yes ☐ No

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

C. _____

1. I elected (or am electing) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No
5. I have not exhausted the time period for receiving COBRA coverage.	☐ Yes ☐ No

For Further Assistance, you may contact the Department of Labor's Employee Benefits Administration at 1-866-444-3272 or online at https://www.askebsa.dol.gov/WebIntake.

Read the important information about your rights included in the attachment following the Election Form.

I make an election to exercise my right to COBRA premium assistance and continued COBRA coverage and attest that I meet the requirements for being eligible for receiving the COBRA Premium Assistance and continued COBRA coverage. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

I (We) elect COBRA coverage or continued COBRA coverage under the plan as indicated below. I (We) hereby certify from the answers to the questions above, I (We) are □ eligible or □ not eligible for the COBRA Premium Assistance.

As a result. you may elect one or more of the medical, dental, and/or vision benefits of the plan listed below after your name.

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

a. _____

Medical, dental, and/or vision elected (Specify Coverage Elected):

_____

a. _____
Medical, dental, and/or vision elected (Specify Coverage Elected):

_____

I (We) have received and read this entire Special Enrollment Election Form, including the attached explanation.

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____
Print Address

_____ _____
Telephone Number E-mail Address

FOR EMPLOYER OR PLAN USE ONLY

This request is: ☐ Approved ☐ Denied Specify reason in #3 below and 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. Individual did not experience a reduction in hours.	
3. Individual did not elect COBRA coverage.	
4. Individual has exhausted his COBRA coverage period.	

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 _____

[Only use this model form if the employer permits those eligible for COBRA Premium Assistance to elect to enroll in coverage that is different from coverage in which the individual was enrolled at the time the qualifying event occurred.]

FORM FOR SWITCHING COBRA COVERAGE BENEFIT OPTION

Instructions: To change the benefit option(s) for your COBRA coverage to something different than what you had on the last day of employment, complete this Form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.

Send completed Form to: [*Enter Name and Address***]**

This 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 [***enter date***].**

I (We) would like to change the COBRA coverage option(s) in the [enter name of the plan] (the plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or another identifier)

a. _____

Old Coverage Option: _____

New Coverage Option:_____

b. _____

Old Coverage Option: _____

New Coverage Option:_____

c. _____

Old Coverage Option: _____

New Coverage Option:_____

_____ _____
Signature Date

_____ _____
Print Name Relationship to the individual(s) listed above

_____
_____
_____ _____
Print Address Telephone number

☐ End of employment (involuntary)

☐ Reduction in hours

[*Add any other events that would give rise to a right to continuation coverage under state law, such as*

☐ Divorce or legal separation

☐ Death of employee

☐ Entitlement to Medicare

☐ Loss of dependent child status]

Each person in the category or categories checked below is entitled to elect continuation coverage, which will continue group health care coverage under the plan for up to ___ months [*enter appropriate timeframe*]

[*Add appropriate categories and check appropriate box or boxes*.) Categories may include:

☐ Employee or former employee

☐ Spouse or former spouse

☐ Dependent child(ren) covered under the plan on the day before the event that caused the loss of coverage

☐ Child who is losing coverage under the plan because he or she is no longer a dependent under the plan]

If elected, continuation coverage will begin on [enter date] and can last until [*enter date*].

[*Add, if appropriate*: You may elect any of the following options for continuation coverage: [*list available coverage options*]].

[*If the issuer permits those eligible for premium assistance to elect to enroll in coverage that is different from coverage in which the individual was enrolled at the time the qualifying event occurred, insert: "In addition, you may have the right to change to additional coverage options that you were not previously enrolled in*. To change the coverage option(s) for your COBRA coverage to something different than what you had on the last day of employment or before your reduction in hours, complete the "Form for Switching COBRA coverage Benefit Options" and return it to us. Available coverage options are: [*insert list of available coverage options*]." To be eligible for premium assistance, the different coverage must cost the same or less than the coverage the individual had at the time of the qualifying event; be offered to similarly situated active employees; and cannot be limited to only excepted benefits, a qualified small employer health reimbursement arrangement (QSEHRA), or a health flexible spending arrangement (FSA).]

How much does continuation coverage cost?

[*Insert general information regarding the cost of continuation coverage.*]

The continuation coverage premium cost is reduced for certain individuals. Premium assistance is available to certain individuals who experience a qualifying event that is a reduction in hours or involuntary termination of employment. If you qualify for premium assistance, you need not pay any of the continuation coverage premium otherwise due to the issuer. This premium assistance is available from April 1, 2021, through September 30, 2021. If your continuation coverage lasts beyond September 30, 2021, you may have to pay the full amount due if you choose to continue your continuation coverage. Review the attached "Notice of Availability of COBRA or State Continuation Premium Assistance for COBRA or State Continuation Participants" for more details, restrictions, and obligations, as well as the form to complete to establish eligibility. However, when your premium assistance ends, you may qualify for a special enrollment period to enroll in coverage through the Health Insurance Marketplace® (see the section on "other coverage options" below).

When and how must payment for continuation coverage be made if I am not eligible for the premium assistance or if I continue my continuation coverage past September 30, 2021?

[*Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.*]

You may contact [***enter appropriate contact information for the party responsible for continuation coverage administration under the plan***] to confirm the correct amount of your payment or to discuss payment issues related to the premium assistance.

Your payment(s) for continuation coverage (if you are not eligible for premium assistance or if you continue on such coverage past September 30, 2021) should be sent to:

[*enter appropriate payment address*]

Are there other coverage options besides continuation coverage?

Yes. There may be other coverage options for you and your family through the Health Insurance Marketplace®, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." You may apply for and enroll in Medicaid at any time. If you are not eligible for premium assistance under the ARP, some of these options may cost less than continuation coverage. If you are eligible for other group health coverage, such as through a new employer's plan or a spouse's plan (not including excepted benefits, a QSEHRA, or a health FSA), or if you are eligible for Medicare, you are not eligible for premium assistance. However, if you have individual market health insurance coverage, like a plan through the Marketplace, or if you have Medicaid, you may be eligible for ARP premium assistance if you elect continuation coverage. You will not be eligible for a premium tax credit or advance payments

of the premium tax credit, for your Marketplace coverage once you elect COBRA coverage, or for months during which you remain an employee but are eligible for COBRA coverage with premium assistance because of a reduction of hours. If you are eligible for Medicare, consider signing up during its special enrollment period to avoid a coverage gap when your COBRA coverage ends and a late enrollment penalty.

You should compare your other coverage options with continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under continuation coverage because the new coverage may impose a new deductible. Also, keep in mind that if you elect continuation coverage with premium assistance, then you may qualify for a special enrollment period to enroll in Marketplace coverage when your premium assistance ends. You may use the special enrollment period to enroll in Marketplace coverage with a premium tax credit if you end your continuation coverage when your premium assistance ends, and you are otherwise eligible.

When you lose job-based health coverage, it is important that you choose carefully between continuation coverage and other coverage options because once you have made your choice, it can be difficult or impossible to switch to another coverage option until the next available open enrollment period.

For more information

This Notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from [***enter appropriate contact information for the party responsible for continuation coverage administration under the plan]***.

If you have any questions concerning the information in this Notice, your rights to the coverage you should contact [***enter the name of party responsible for continuation coverage administration for the plan, with telephone number and address***].

For more information about your rights under state law, contact [***insert appropriate contact information.***]

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep [***enter name and contact information for the appropriate party responsible for continuation coverage administration under the plan***] 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 [***enter the name of the party responsible for continuation coverage administration under the plan***].

[*Attach "Notice of Availability of COBRA or State Continuation Premium Assistance for COBRA or State Continuation Participants*]

CONTINUATION COVERAGE ELECTION FORM

Instructions: To elect continuation coverage or apply for premium assistance, complete this Election Form, and return it to us. Under [*insert applicable law*], you have *[insert number of days*] after the date of this notice to decide whether you want to elect continuation coverage.

Send completed Continuation Coverage Election Form to: [*Enter Name and Address*]

This Continuation Coverage 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 [*enter date*].

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

Note: If you already have continuation coverage and wish to claim the Premium Assistance, you must complete this Continuation Coverage Election Form to claim it.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

To qualify for premium assistance for yourself, you must be able to check 'Yes' for all statements.

1. The qualifying event was a loss of employment that was involuntary or a reduction in hours.	☐ Yes ☐ No
2. I elected (or am electing) COBRA coverage.	☐ Yes ☐ No
3. 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 premium assistance).	☐ Yes ☐ No
4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming premium assistance).	☐ Yes ☐ No
5. I have not exhausted the time period for receiving COBRA coverage.	☐ Yes ☐ No

To qualify for premium assistance for each of your dependents, you must be able to check 'Yes' for all statements.

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) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No
5. I have not exhausted the time period for receiving COBRA coverage.	☐ Yes ☐ No

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

B. _____

1. I elected (or am electing) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No
5. I have not exhausted the time period for receiving COBRA coverage.	☐ Yes ☐ No

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

C. _____

1. I elected (or am electing) COBRA 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
4. The qualifying event was an involuntary termination or a reduction in hours.	☐ Yes ☐ No
5. I have not exhausted the time period for receiving COBRA coverage.	☐ Yes ☐ No

For Further Assistance, you may contact the Department of Labor's Employee Benefits Administration at 1-866-444-3272 or online at https://www.askebsa.dol.gov/WebIntake.

Read the important information about your rights included in the attachment following the Election Form.

I make an election to exercise my right to COBRA premium assistance and continued COBRA coverage and attest that I meet the requirements for being eligible for receiving the COBRA Premium Assistance and continued COBRA coverage. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

I (We) elect COBRA coverage or continued COBRA coverage under the plan as indicated below. I (We) hereby certify from the answers to the questions above, I (We) are □ eligible or □ not eligible for the COBRA Premium Assistance.

I (We) elect COBRA coverage or continued COBRA coverage under the plan as indicated below. I (We) hereby certify from the answers to the questions above, I (We) are □ eligible or □ not eligible for the COBRA Premium Assistance.

As a result. you may elect one or more of the medical, dental, and/or vision benefits of the plan listed below after your name.

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

a. _____

[*Add if appropriate*: Coverage option(s): _____]

b. _____

[*Add if appropriate*: Coverage option(s): _____]

c. _____

[*Add if appropriate*: Coverage option(s): _____]

_____ _____
Signature Date

_____ _____
Print Name Relationship to the individual(s) listed above

_____
_____
_____ _____
Print Address Telephone number

FOR EMPLOYER OR PLAN USE ONLY

This request is: ☐ Approved ☐ Denied Specify reason in #3 below and 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. Individual did not experience a reduction in hours.	
3. Individual did not elect COBRA coverage.	
4. Individual has exhausted his COBRA coverage period.	

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 _____

[Only use this model form if the employer permits those eligible for COBRA Premium Assistance to elect to enroll in coverage that is different from coverage in which the individual was enrolled at the time the qualifying event occurred.]

FORM FOR SWITCHING COBRA COVERAGE BENEFIT OPTION

Instructions: To change the benefit option(s) for your COBRA coverage to something different than what you had on the last day of employment, complete this Form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.

Send completed Form to: [*Enter Name and Address***]**

This 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 [***enter date***].**

I (We) would like to change the COBRA coverage option(s) in the [enter name of the plan] (the plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or another identifier)

a. _____

Old Coverage Option: _____

New Coverage Option:_____

b. _____

Old Coverage Option: _____

New Coverage Option:_____

c. _____

Old Coverage Option: _____

New Coverage Option:_____

_____ _____
Signature Date

_____ _____
Print Name Relationship to the individual(s) listed above

_____
_____
_____ _____
Print Address Telephone number

NOTICE OF ELIGIBILITY FOR OTHER GROUP INSURANCE COVERAGE OR MEDICARE FORM

YOUR PERSONAL INFORMATION:

Your Plan's Name and Mailing Address:	
Your Name and Mailing Address:	Phone Number:
	Email:

COBRA or STATE CONTINUATION PREMIUM ASSISTANCE INELIGIBILITY INFORMATION (Check all that apply)

I am eligible for coverage under another group plan Insert date you became eligible_____	☐
My dependent became eligible for another group health plan. Please indicate names of dependent(s) below: _____ _____ Insert date(s) he or she or they become eligible_____	☐
I am eligible for Medicare Insert date you became eligible_____	☐
My dependent became eligible Medicare. Please indicate names of dependent(s) below: _____ _____ Insert date(s) he or she or they become eligible_____	☐

IMPORTANT

If you fail to notify your group health plan of becoming eligible for another group health plan or Medicare and you continue to receive the COBRA or state continuation Premium Assistance, you could be subject to a fine of $250, except where your failure was due to reasonable cause and not willful neglect. The penalty may be increased where your failure to provide Notice was fraudulent. In that case, the penalty is the greater of $250 or 110% of the premium assistance provided to you after your eligibility ended due to the other coverage.

Eligibility for other coverage 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 _____

Individual completing this Application is [*Specify*]: ☐ Former Employee, ☐ Spouse of Former Employee or ☐ Dependent of Former Employee.

Employer or Plan Administrator's Acknowledgement:

I received this application on _____ (date)

Signature: _____

NOTICE OF EXPIRATION OF PERIOD OF THE COBRA OR STATE CONTINUATION PREMIUM ASSISTANCE

Name of Company or COBRA Administrator
Street Address
City, State, Zip
Phone

[*Date*]

Name of Individual
Street address
City, State Zip

Re: Notice of Expiration of the Period of COBRA or State Continuation Premium Assistance

Dear Ms. or Mr. _____ [*Individual's last name*]:

This is notice that COBRA or state continuation Premium Assistance under_____ [***Name of the Company's Welfare Plan***] (the "Plan") will be ending on _____ *[**date***] for the following individuals:
_____
_____
_____

The COBRA or state continuation Premium Assistance will be ending because (Specify the reason):

□ Individual(s) named above became eligible for coverage under another group health plan

□ Individual(s) named above became eligible in Medicare.

□ The employer has terminated all group health plans for its employees.

□ The maximum period for receiving the COBRA or state continuation Premium Assistance is ending

□ The individual has notified us that he or she wishes to terminate early.

Under the Plan, the individual(s) indicated above have the right to continue COBRA or state continuation coverage until _____. Please remember if you wish to continue COBRA or state continuation coverage after the COBRA or state continuation Premium Assistance, you will be responsible for the entire COBRA or state continuation premium. After [enter date premium assistance ends], this COBRA or state continuation coverage does not include federal premium assistance and costs $ _____ per month]. COBRA coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or if you become covered under another group health plan. If you wish to continue COBRA or state continuation coverage, please contact _____ at _____. You will be provided with information premium rates and coverages that are available.

What are other coverage options available besides COBRA or state continuation coverage?

Now that your premium assistance is expiring, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace®, Medicare, or other group health plan coverage options (such as a spouse's plan) through what is called a "special
enrollment period." Additionally, you may apply for and, if eligible, enroll in Medicaid at any time. Some of these options may cost less than COBRA or state continuation coverage. If you are eligible for Medicare, consider signing up during its special enrollment period to avoid a coverage gap when your COBRA coverage ends and a late enrollment penalty.

If you have not yet exhausted COBRA or state continuation coverage, you should compare your other coverage options with COBRA or state continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA coverage because the new coverage may impose a new deductible.

It is important that you choose carefully between maintaining COBRA or state continuation coverage and other coverage options because once you have made your choice, it can be difficult or impossible to switch to another coverage option until the next available open enrollment period.

You may qualify for a special enrollment period to enroll in Marketplace coverage when your COBRA coverage and/or your premium assistance ends. You may be able to get coverage through Medicaid or the Health Insurance Marketplace® that costs less than COBRA or state continuation coverage without premium assistance. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace®?

The Health Insurance Marketplace® offers "one-stop shopping" to find and compare private individual health insurance options. In the Marketplace, you could be eligible for a subsidy that lowers your monthly premiums and for cost-sharing reductions that lower your out-of-pocket costs for deductibles, coinsurance, and copayments right away, and you can see what your subsidized premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you can also learn if you may qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). People in most states use www.HealthCare.gov to apply for and enroll in Marketplace coverage; if your state has its own Marketplace platform, you can find contact information for your State Marketplace here: https://www.healthcare.gov/marketplace-in-your-state/.

Coverage through Medicaid or the Marketplace may cost less than COBRA or state continuation coverage. Being offered COBRA or state continuation coverage will not limit your eligibility for Medicaid. In addition, if you have been offered COBRA or state continuation coverage because you are a former employee of the employer offering the coverage, the offer of coverage will not limit your eligibility for Marketplace coverage or for a subsidy or a premium tax credit to help pay for your Marketplace coverage. However, you will not be eligible for a premium tax credit, or advance payments of the premium tax credit, during any month that you are enrolled in COBRA or state continuation coverage. Therefore, if you qualify for a special enrollment period to enroll in Marketplace coverage and also qualify for advance payment of the premium tax credit that you would like to use, you should end your COBRA or state continuation coverage before your Marketplace coverage starts.

If you are currently employed by the employer offering the COBRA or state continuation coverage with premium assistance, you may enroll in Marketplace coverage, but you may be ineligible for a subsidy or a premium tax credit for the Marketplace coverage for the period you are offered the COBRA or state continuation coverage with premium assistance.

When can I enroll in Marketplace coverage?

Marketplace-eligible consumers can enroll in Marketplace coverage if they qualify for a special enrollment period. When your COBRA coverage expires or your employer stops contributing to COBRA or state continuation, including through your COBRA or state continuation premium assistance, you may qualify for a special enrollment period to enroll in Marketplace coverage. Under this special enrollment period, Marketplace-eligible consumers have 60 days from the end of their COBRA or state continuation coverage or the last day of the period for which COBRA coverage is subsidized by an employer or by premium assistance to select a Marketplace plan through HealthCare.gov. Alternatively, Marketplace-eligible consumers may report the upcoming loss of premium assistance or the end of their COBRA or state continuation coverage and may be eligible to enroll in a new health plan up to Sixty days before the event triggering the special enrollment period to get Marketplace coverage. Sixty days after the last day of the period for which COBRA or state continuation coverage is subsidized by an employer or premium assistance or the end of the COBRA or state continuation coverage, your special enrollment period will end, and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, Marketplace-eligible consumers can enroll from November 1 – December 15 in Marketplace coverage that starts on January 1. Finally, you can apply for and, if eligible, enroll in Medicaid coverage at any time.

Note that, due to COVID-19, for Marketplaces that use HealthCare.gov, all Marketplace-eligible consumers who are submitting a new application or updating an existing application can access a special enrollment period available at HealthCare.gov from February 15 through August 15, 2021. For more information, please see www.HealthCare.gov/sep-list/. Marketplace-eligible consumers in states with Marketplaces that do not use the HealthCare.gov platform should consult your Marketplace to find out if you have a special enrollment period available to them. If your state has its own Marketplace platform, you can find contact information for your State Marketplace here: https://www.HealthCare.gov/marketplace-in-your-state/.

Additionally, under the ARP, individuals, and families may be eligible for a temporary increase in their premium tax credit and advance payments of the premium tax credit, for 2021 and 2022, with no one who is eligible paying more than 8.5% of their household income towards the cost of the benchmark plan or a less expensive plan.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period. If your state has its own Marketplace platform, you can find contact information for your State Marketplace here: https://www.HealthCare.gov/marketplace-in-your-state/. Note, you may apply for and, if eligible, enroll in Medicaid coverage at any time.

If I am able to and choose to continue on COBRA or state continuation coverage after the end of premium assistance, can I switch to coverage in the Marketplace after the 60-day special enrollment period ends? What about if I choose Marketplace coverage and want to switch back to COBRA or state continuation coverage?

If you continue with COBRA or state continuation coverage after the end of the premium assistance, you can switch to a Marketplace plan during the annual Marketplace open enrollment period or during a special enrollment period. Additionally, if you initially decide to keep COBRA coverage, you may still be able to enroll in Marketplace coverage until the end of a special enrollment period, which is 60 days after your loss of COBRA or state continuation premium assistance. Depending on your circumstances, you may also qualify for a tax credit if you end your COBRA or state continuation coverage by the time your Marketplace coverage starts, and you are otherwise eligible.

But be careful: if you terminate your COBRA or state continuation coverage early without another event that qualifies you for a special enrollment period, you will have to wait to enroll in Marketplace coverage until the next available open enrollment period and could end up without any health coverage in the interim.

Alternatively, once you have exhausted your COBRA or state continuation coverage, you may be eligible for a special enrollment period to enroll in Marketplace coverage if you are Marketplace-eligible, even if Marketplace open enrollment has ended due to your exhaustion of COBRA coverage. For more information on COBRA or state continuation coverage and the Marketplace, see www.HealthCare.gov/unemployed/cobra-coverage/.

If you sign up for Marketplace coverage and terminate your COBRA or state continuation coverage, you cannot switch back to COBRA or state continuation coverage.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan) if you request enrollment within 30 days of the end of the maximum period of COBRA or state continuation coverage.

If you have not yet reached the end of the maximum period of COBRA or state continuation coverage, contact the other group health plan to see when you may be eligible to enroll.

Can I enroll in Medicare instead of COBRA coverage after my group health plan coverage ends?

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to sign up, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare Part B and elect COBRA coverage instead, you may have to pay a Part B late enrollment penalty, and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA coverage and then enroll in Medicare Part A or B before the COBRA coverage ends, the [Plan or Policy] may terminate your COBRA coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA coverage and Medicare, Medicare will generally pay first (as the primary payer), and COBRA coverage will pay second. Certain COBRA coverage may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit https://www.medicare.gov/medicare-and-you.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: After the premium assistance expires, your previous plan or policy can charge up to 102% of total plan premiums for COBRA coverage (or up to 150% of total plan premiums after 18 months if you choose to extend the COBRA coverage period beyond 18 months due to the disability of a qualified beneficiary). Other options, like coverage on a spouse's plan, Medicaid, or through the Marketplace plan, may be less expensive at that point.

- Provider Networks: If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network and whether you will have access to that network through any other option as you consider options for health coverage.

- Drug Formularies: If you are currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan or policy. You may want to check to see if your current medications are listed in drug formularies for other health coverage options.

- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA coverage premium payments for a period of time. In this scenario, you may want to contact the Department of Labor at askebsa.dol.gov or 1-866-444-3272 to discuss your options.

- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan or policy has a service or coverage area or other similar limitations.

- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums but a much higher deductible and higher copayments. You may also want to consider whether you have met your deductible or maximum out-of-pocket limit under your COBRA or state continuation coverage.

If you do not agree with this determination that the premium assistance is ending and feel that your COBRA or state continuation premium assistance should continue, you may request us to reconsider our decision by filing an appeal as follows:

1. Send a written appeal to: [Individual's Name, Title, at Company's Name, Company's Address] within 30 days of your receipt of this Notice.

2. Explain why you believe COBRA or state continuation coverage was improperly terminated, including all information that you wish to be reviewed. It is important that you include your name, address, and the name of any other individuals that you wish to include in your appeal.

We will respond within 14 days of our receipt of your appeal.

If any individuals named above do not reside with you at the address indicated above, we request that you immediately notify us at the address and telephone number indicated above so that we can provide a copy of this Notice to those individuals.

If you have any questions regarding the information in this Notice, please contact me.

Sincerely,

_____
Individual's name

_____
Individual's Title

IMPORTANT NOTICE
NEW PERIODS TO MAKE ELECTIONS FOR BENEFITS OR COVERAGE

Due to the ongoing national emergency related to the Coronavirus, the Labor Department and IRS had released guidance which required all welfare benefit plans subject to the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (Code) to disregard the period beginning from March 1, 2020, until sixty days after the announced end of the national emergency or such other date announced by the agencies in a future notice ("Outbreak Period") in determining the following periods and dates:

- The 30-day period (or 60-day period, if applicable) to request special enrollment for employee, spouse, or child during a plan or policy year

- The 60-day election period to elect COBRA coverage

- The date for making COBRA premium payments

- The date for individuals to notify the plan of a qualifying event or determination of disability

- The date within which individuals may file a benefits claim under the plan's claims procedure.

- The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure.

- The date within which claimants may file a request for an external review after receipt of a final internal adverse benefit determination.

- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to applicable appeal rules.

The national emergency continues. Under federal law, such delays cannot exceed one year. On February 26, 2021, Labor Department clarified that the above timeframes subject to relief under the prior guidance will be disregarded for individuals until the **earlier of (a) one year from the date they were first eligible for relief or (b) 60 days after the announced end of the National Emergency (i.e., the end of the Outbreak Period, which is still ongoing).**

This means that this maximum 12-month period of suspension will be calculated on an individual-by-individual, and for each individual, on an action-by-action basis.

Example: Assume an employee had a new baby on September 1, 2020. Per the terms of the health plan, the employee must enroll the child within 30 days of the date of birth, which is October 1, 2020.

The entire one-year period is tolled, from September 1, 2020, to August 31, 2021. The employee has 30 days from the end of the one-year tolling period to elect coverage for the baby — October 1, 2021. (This example assumes that the Outbreak Period has not ended at an earlier date.)

The delay created by the Outbreak Period only applies if the deadline for making an election, giving Notice, or making a claim did not expire before March 1, 2020.

What this means to Employees, Former Employees, and Beneficiaries

Beginning March 1, 2020, if an employee, former employee, or beneficiary failed to elect COBRA coverage, pay a COBRA premium, add him or herself, his or her spouse or child to coverage, or failed to file a claim for benefits that individual has an extended period of time to file or to make an election.

To make a new election for coverage or benefits, give notice or make a claim for benefits, please contact: _____

Information herein provided by:

BCS BENEFITS COMPLIANCE SOLUTIONS