**Model Alternative Notice of ARP Continuation Coverage Election Notice**
**(For use by insured coverage subject to state continuation requirements between April 1, 2021 and September 30, 2021.)**

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department of Labor (the Department) notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

Collection of this information is authorized by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Section 9501 of the American Rescue Plan Act (PL 117-2). The obligation for employers to respond to this collection is mandatory to provide the required notices to allow individuals to obtain benefits allowed by the law. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Regulations and Interpretations, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0167.

The public reporting burden for this collection of information is shown in the following table.

| **Notice Type** | **Estimated Average Time** |
|---|---|
| General Notice | Minimal additional burden as already covered under OMB Control Number 1210-0123. |
| Notice in Connection with Extended Election Periods | 1 minute per response |
| Alternative Notice | 2 minutes per response |
| Notice of Expiration of Premium Assistance | 1 minute per response |

**Model Alternative Notice of ARP Continuation Coverage Election Notice**
**(For use by insured coverage that is subject to state continuation requirements from April 1, 2021 through September 30, 2021.)**

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies), by name or status*]

**This notice has important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace®[1]. To sign up for Marketplace coverage visit www.HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325). You may be able to get coverage through the Health Insurance Marketplace® that costs less than continuation coverage after the premium assistance expires. 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 here: www.HealthCare.gov/marketplace-in-your-state/.**

Please read the information in this notice very carefully before you make your decision. If you choose to elect continuation coverage, you should use the election form provided later in this notice.

The American Rescue Plan Act of 2021 (ARP) provides temporary premium assistance for continuation coverage and, where the employer elects to offer the option, an opportunity to switch to a different health plan option offered by your employer (see below for more information). Premium assistance is available to certain individuals who are eligible for continuation coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment. If you qualify for premium assistance, you need not pay any of the continuation coverage premium otherwise due to the plan. This premium assistance is available from April 1, 2021 through September 30, 2021. If you continue your continuation coverage beyond this time, you may have to pay the full amount due.

To determine whether you are eligible for premium assistance under the ARP, carefully review this notice and the attached document titled "Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021." **If you believe you are eligible, complete the "Request for Treatment as an Assistance Eligible Individual" and return it to the health plan with your completed Election Form.**

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

If you do not elect continuation coverage, your coverage under the Plan will end on [*enter date*] due to [*check appropriate box(es)*]:

☐ End of employment (voluntary)
☐ 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

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

☐ Loss of dependent child status]

Each person in the category(ies) 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 Assistance Eligible Individuals 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:* "In addition, under the ARP, 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 continuation 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 Continuation 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).]

Continuation 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*]. If you qualify as an "Assistance Eligible Individual" this cost will be treated as having been paid in full from April 1, 2021 through September 30, 2021. You do not have to send any payment with the Election Form. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact [*enter name of party responsible for continuation coverage administration for the issuer, with telephone number and address*].

**Continuation Coverage Election Form**

**Instructions: To elect continuation coverage, 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 Election Form to: [*Enter Name and Address*]**

**This 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 Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject 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 continuation coverage, your 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.**

I (We) elect continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

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 individual(s) listed above

_____

_____

_____ _____

Print Address Telephone number

[*Only use this model form if the plan permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred.]*

**Form for Switching Continuation Coverage Benefit Options**

**Instructions: To change the benefit option(s) for your continuation coverage to something different than what you had on the last day of coverage, 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*].**

***THIS IS NOT YOUR ELECTION NOTICE***
**YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR CONTINUATION COVERAGE.**

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

Name Date of Birth Relationship to Employee SSN (or other 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 individual(s) listed above

_____

_____

_____ _____
Print Address Telephone number

**Important Information about Your Continuation Coverage Rights**

**What is continuation coverage?**

State law requires ***[insert state law requirements here]***, *for example: that most group health insurance coverage (including this coverage) give employees and their families the opportunity to continue their 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 health 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 [add if applicable: open enrollment and] special enrollment rights.]*

**How long will continuation coverage last?**

*[Insert length of coverage and any other relevant information including the availability of any extensions under state law.]*

**How can you elect continuation coverage?**

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. *[Insert information about any other state law provisions relevant to the election process, including the rights of family members.]*

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage may affect your special enrollment rights for group health plans under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health 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 continuation coverage cost?**

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

The ARP reduces the continuation coverage premium for certain individuals. Premium assistance is available to certain individuals who experience a qualifying event that is a reduction in hours or an 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 "Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021" 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 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 ARP 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 continuation coverage, or for months during which you remain an employee but are eligible for COBRA continuation coverage with premium assistance because of a reduction of hours. If you're 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's important that you choose carefully between continuation coverage and other coverage options, because once you've 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 coverage you should contact [*enter 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 "Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021" in order to satisfy ARP requirements]*

# Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021

President Biden signed H.R. 1319, the American Rescue Plan Act of 2021 (ARP), on March 11, 2021. This law subsidizes the full COBRA premium for "Assistance Eligible Individuals" for periods of coverage from April 1, 2021 through September 30, 2021.

To be eligible for the premium assistance, you:

- **MUST** have a COBRA qualifying event that is a reduction in hours or an involuntary termination of a covered employee's employment;
- **MUST** elect COBRA continuation coverage;
- **MUST NOT** be eligible for Medicare; AND
- **MUST NOT** be eligible for coverage under any other group health plan, such as a plan sponsored by a new employer or a spouse's employer. *

**♦ IMPORTANT ♦**

◊ If you do not elect to receive the premium assistance within 60 days of receipt of this form, you may be ineligible for the premium assistance.

◊ If you elect COBRA continuation coverage with premium assistance, and then become eligible for other group health plan coverage (not including coverage that is only excepted benefits (such as dental or vision coverage), a Qualified Small Employer Health Reimbursement Arrangement, or a health flexible spending arrangement), or if you become eligible for Medicare, you MUST notify the plan in writing. If you fail to provide this notice, you may be subject to a penalty of $250 (or if the failure is fraudulent, the greater of $250 or 110% of the premium assistance provided after termination of eligibility). You won't be subject to the penalty if your failure to notify the plan is due to reasonable cause and not due to willful neglect.

◊ Employers that don't satisfy COBRA continuation coverage requirements may be investigated by the Department of Labor and may be subject to an excise tax under the Internal Revenue Code.

◊ If you elect COBRA continuation coverage and are eligible for the premium assistance, you cannot claim the Health Coverage Tax Credit. You also cannot qualify for a premium tax credit to help pay for coverage through a Health Insurance Marketplace®[1], such as on HealthCare.gov, for any months that you are enrolled in COBRA continuation coverage with or without the premium assistance.

For general information on your plan's COBRA continuation coverage, contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].

For specific information on your plan's administration of the ARP premium assistance or to notify the plan of your ineligibility to receive premium assistance, contact [enter name of party responsible for ARP Premium Assistance administration for the Plan, with telephone number and address].

For more information regarding ARP 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)

* This restriction does not include coverage under a plan that provides only excepted benefits, a qualified small employer health reimbursment arrangement, or coverage under a health flexible spending arrangement.

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

**To apply for ARP Premium Assistance, complete this form and return it to your plan or employer. If you have not yet elected COBRA continuation coverage, you may send this form along with your Election Form. If you do not complete this form and return it within 60 days of receipt, you may be unable to receive the premium assistance.**

**If you are already enrolled in COBRA, you may send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to: [*Enter Name and Address*]**

**You may also want to read the important information about the rules for premium assistance included in the "Summary of the COBRA Premium Assistance Provisions Under the American Rescue Plan Act of 2021."**

| [*Insert Plan Name*] | **REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL** | [*Insert Plan Mailing Address*] |
|---|---|---|

## PERSONAL INFORMATION

| Name and mailing address of employee (list any dependents on the back of this form) | Telephone number<br><br>E-mail address (optional) |
|---|---|

To qualify, 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 |
| 3. I elected (or am electing) COBRA continuation coverage. | ☐ Yes ☐ No |
| 4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming premium assistance). | ☐ Yes ☐ No |
| 5. 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 |

I make an election to exercise my right to ARP premium assistance and attest that I meet the requirements for treatment as an Assistance Eligible Individual. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

**FOR EMPLOYER OR PLAN USE ONLY**

This 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 Other (please explain) | ☐ |

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 → _____

**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.**

**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 |

I make an election to exercise my right to ARP premium assistance. 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) 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 |

I make an election to exercise my right to ARP premium assistance. 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) 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 |

I make an election to exercise my right to the ARP premium assistance. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

**This form is designed for plans to distribute to COBRA qualified beneficiaries who are not paying premiums pursuant to ARP so they can notify the plan if they become eligible for other group health plan coverage, or Medicare.**

## Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for premium assistance under the ARP.

| Plan Name | **Participant Notification** | Plan Mailing Address |
|---|---|---|
| | | |

## PERSONAL INFORMATION

| Name and mailing address | Telephone number |
|---|---|
| | E-mail address (optional) |

## PREMIUM ASSISTANCE INELIGIBILITY INFORMATION – Check one

| | |
|---|---|
| I am eligible for coverage under another group health plan.<br>If any dependents are also eligible, include their names below.<br>Insert date you became eligible_____ | ☐ |
| I am eligible for Medicare.<br>Insert date you became eligible_____ | ☐ |

## IMPORTANT

**If you fail to notify your plan when you become eligible for other group health plan coverage or Medicare AND continue to receive COBRA premium assistance you may be subject to a penalty of $250 dollars (or if the failure is fraudulent, the greater of $250 or 110% of the amount of the premium assistance provided after termination of eligibility). You won't be subject to the penalty if your failure to notify the plan is due to reasonable cause and not due to willful neglect.**

**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 → _____

Type or print name → _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____ _____

_____ _____