isolved Benefit Services

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

Complete this form within the on our secure website, www.isolvedbenefitservices.com if all of your family members, who will be enrolled, meet all of the below requirements, or you can answer yes for all of the below statements. If this does not apply to all family member, please return this form to: isolved Benefit Services, Attention: Payment Center, PO Box 949, Coldwater, MI 49036; or via email at qbmail@isolvedhcm.com.

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

Important - Please review

- 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®, 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 isolved Benefit Services at 877-384-635 or via email at qbmail@isolvedhcm.com. For specific information on your plan's administration of the ARPA subsidy or to notify the plan of your ineligibility to receive premium assistance, contact isolved Benefit Services at 877-384-6356 or via email at qbmail@isolvedhcm.com.

For more information regarding ARPA subsidy 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).

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.

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REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Name: _____

Former Employer: _____

SSN: _____

Phone: _____

Email: _____

To apply for ARPA Premium Assistance, complete this form online or return it to: isolved Benefit Services, Attention: Payment Center, PO Box 949, Coldwater, MI 49036; or via email at qbmail@isolvedhcm.com. 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. 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."

To qualify, you must 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 or State continuation 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

☐ 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 believe all of the answers I have provided on this form are true and correct.

If you cannot answer yes to every enrolled family member, you must list each member below and designate person by person if they meet each requirement above.

First & Last Name of family member where criteria from above is not met.

_____
_____
_____
_____

Signature: _____ Date: _____

Printed Name: _____ Relationship to employee: _____

Daytime Phone: _____ E-Mail Address: (optional) _____

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Name: _____

Former Employer: _____

SSN: _____

Phone: _____

Email: _____

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**	
Loss of employment was voluntary.	☐
Individual did not experience a reduction in hours.	☐
Individual did not elect COBRA coverage.	☐
Other (please explain)	☐

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan

Signature: _____ Date: _____

Printed Name_____ Phone: _____

E-Mail Address: (optional) _____