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 or 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 **NORTHERN CALIFORNIA TILE INDUSTRY TRUST FUNDS, PO BOX 1607 SAN RAMON, CA 94583, (888) 208-0250**.

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. 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: Northern California Tile Industry Trust Funds, PO Box 1607 San Ramon, CA 94583, (888) 208-0250

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."

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number 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
2. I elected (or am electing) COBRA 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 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 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.

Participant Notification

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. If any dependents are also eligible, include their names below. Insert date you became eligible_____	☐
I am eligible for Medicare. 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:

_____ _____

_____ _____

Northern California Tile Industry Trust Funds

Health & Welfare • Vacation & Holiday • Defined Benefit Pension • Defined Contribution Pension

IMPORTANT INFORMATION ABOUT COBRA PREMIUM ASSISTANCE UNDER THE AMERICAN RESCUE PLAN ACT OF 2021 (ARPA)

ACTION NEEDED EVEN IF YOU DECLINED OR DROPPED COBRA

The notices and forms in this packet are being sent to you because you **may** qualify as an "ASSISTANCE ELIGIBLE INDIVIDUAL" under ARPA who can receive FREE COBRA continuation coverage for you and your dependents for **up to 6 months** between April 1 and September 30, 2021. Receipt of that free COBRA continuation coverage if you qualify for it will depend on you filling out the enclosed forms and returning them to this office postmarked **no later than 60 days** from the date of this notice.

The enclosed documents were primarily written by the U.S. Department of Labor and have a lot of information in them. Please review them carefully in full. The following are some items we want to draw to your attention, so they are not overlooked:

- The free COBRA premium only applies between April 1 and September 30, 2021.
- There are two qualifications: your loss of employment must have been involuntary, and you must not have other group health coverage available. If those apply to you, you must fill out the form with the correct boxes checked and return in within 60 days from the date of the enclosed notices.
- If you **already elected** COBRA and have been paying premiums – you still have to return the **Request for Treatment As An Assistance Eligible Individual Form** within 60 days to get the COBRA premium assistance.
- **If you did not elect COBRA for a qualifying loss of eligibility November 2019 and after, or did elect COBRA and then did not pay the premium or dropped it – you can still elect COBRA now for any remainder of your 18-month COBRA period.**
- If you are not currently enrolled but want to be, you need to return both the **COBRA Enrollment Form** and the **Request for Treatment As An Assistance Eligible Individual Form if applicable** within 60 days of this notice.
- You have to return the forms within 60 days to get the free COBRA, even though the 60 days to make the COBRA election itself may be extended due to the COVID-19 pandemic.
- The 18 month COBRA period in your applicable COBRA notice has **not** been extended by ARPA.
- If you do not qualify for the premium subsidy, and do not want to pay for COBRA, you do not need to take any action.
- If you are qualified as an "ASSISTANCE ELIGIBLE INDIVIDUAL" and already paid your April 2021 COBRA premium, that will be refunded to you.
- Becoming Medicare eligible or eligible for other health coverage will terminate your eligibility for the COBRA premium assistance and it is your responsibility to advise this office if that occurs.
- Your questions can be directed to the Administrative Office.

7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566
P.O. Box 1607 San Ramon, CA 94583
Phone 925.208.9995 • Toll Free 888.208.0250 • Facsimile 925.462-0108
www.bac3tilebenefits.org • staff@bac3tilebenefits.org

Northern California Tile Industry Trust Funds

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IMPORTANT – PLEASE READ CAREFULLY
EXTENSION OF IMPORTANT COBRA DEADLINES DURING
CORONAVIRUS OUTBREAK PERIOD

This notice updates the deadlines that are found in the enclosed notice about COBRA continuation coverage. COBRA deadlines have been extended because of guidance released by the Internal Revenue Service and Department of Labor. The deadline to submit your COBRA continuation coverage election notice is the earlier of (a) one (1) year from the date you were first eligible for relief or (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period, which has not yet been announced).

The Plan will disregard the Outbreak Period when determining deadlines for the following:

- Notification of a Qualifying Event (e.g., divorce, separation, a child's loss of dependent status, or a disability)
- Electing COBRA continuation coverage
- Payment of COBRA continuation coverage premiums

EXAMPLES

1. Paul is a participant in the Health and Welfare Plan. Due to reduction of hours, he loses coverage under the Health Plan and is provided a COBRA continuation of coverage election notice on January 1, 2021. Under normal rules, he has sixty days to submit the COBRA continuation coverage election notice to the Plan, until March 2, 2021. However, pursuant to the Department of Labor and Internal Revenue Service guidance, Paul will have until the earlier of one year from the last date he was eligible to submit the COBRA continuation coverage election notice to the Plan, or sixty (60) days after the end of the Outbreak Period to timely submit COBRA continuation coverage election notice to the Plan. This means Paul would have until the earlier of March 2, 2022 (one year after the last date he could have submitted the COBRA election notice) or the end of the Outbreak Period (which is still ongoing).

2. Peter is enrolled in COBRA continuation coverage on January 1, 2021 under the Health and Welfare Plan. He made COBRA continuation coverage premiums for January 2021, but did not make COBRA premiums for February 2021. Normally, his premium payments are due the 1st of each month, and must be made within 30 days of the due date to continue coverage, here until March 3, 2021. Again, pursuant to the Department of Labor and Internal Revenue Service guidance, Peter's premiums will be considered timely for February 2021 if made by the earlier of one year from the last date he was eligible to make payment, or the 30th day after the Outbreak Period. This means Peter would have until the earlier March 3, 2022, or the end of the Outbreak Period (which is still ongoing). During the time when premiums have not yet been received by the Plan, the Plan will inform providers that Peter does not currently have coverage, but will have coverage retroactively if COBRA

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www.bac3tilebenefits.org • staff@bac3tilebenefits.org

premiums are submitted timely. Once timely COBRA premiums are received by the Plan, the Plan will pay for benefits and service provided to Peter retroactively.

If you have questions, please contact the administrative office by calling 888-208-0250 or emailing staff@bac3tilebenefits.org.