



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.¹

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 percent 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^{®2}, such as on www.HealthCare.gov, for any months that you are enrolled in COBRA continuation coverage with or without the premium assistance.

¹ 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.

² Health Insurance Marketplace is a registered service mark of the U.S. Department of Health & Human Services.

For general information on your Plan's COBRA continuation coverage, contact PEBA's Customer Service at 803.737.6800 or 888.260.9430, or 202 Arbor Lake Drive, Columbia, SC 29223.

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 PEBA's Customer Service at 803.737.6800 or 888.260.9430, or 202 Arbor Lake Drive, Columbia, SC 29223.

For more information regarding ARP premium assistance and eligibility questions, visit www.dol.gov/cobra-subsidy or contact the Department of Labor at www.askebsa.dol.gov or 866.444.EBSA (3272).

To apply for ARP Premium Assistance, if you are already enrolled in COBRA or have not yet elected COBRA continuation coverage, complete this *Request for Treatment as an Assistance Eligible Individual* form and return it to your former employer. Your former employer must verify your eligibility for the premium assistance. If you are eligible, they will assist you with completing a *COBRA Notice of Election* and submitting it to PEBA. If you do not complete this verification form and return it to your former employer 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*.

Select your plan:
 State Health Plan
 MUSC Plan

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

S.C PEBA
 202 Arbor Lake Drive
 Columbia, SC 29223

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number
	Email address

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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

Print name: _____ Relationship to employee: _____

FOR EMPLOYER 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.	<input type="checkbox"/>
2. Individual did not experience a reduction in hours.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

Employer signature: _____ Date: _____

Print name: _____ Telephone number: _____

Email address: _____

For Further Assistance, you may contact the Department of Labor's Employee Benefits Administration at 866.444.3272 or online at www.askebsa.dol.gov/WebIntake.

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name 1: _____ Date of birth: _____

Relationship to employee: _____ Social Security number: _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

Print name: _____ Relationship to employee: _____

Name 2: _____ Date of birth: _____

Relationship to employee: _____ Social Security number: _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

Print name: _____ Relationship to employee: _____

Name 3: _____ Date of birth: _____

Relationship to employee: _____ Social Security number: _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. The qualifying event was an involuntary termination or a reduction in hours.	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

Print name: _____ Relationship to employee: _____

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

Select your plan:

- State Health Plan
- MUSC Plan

PARTICIPANT NOTIFICATION

S.C. PEBA
202 Arbor Lake Drive
Columbia, SC 29223

PERSONAL INFORMATION

Name and mailing address	Telephone number
	Email address

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. Date you became eligible: _____	<input type="checkbox"/>
I am eligible for Medicare. Date you became eligible: _____	<input type="checkbox"/>

IMPORTANT

If you fail to notify your employer 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 your employer 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: _____

Print name: _____