TEAMSTERS LOCAL UNION NO 727 HEALTH AND WELFARE FUND

COBRA SUBSIDY NOTICE TO FUND PARTICIPANTS LOSING COVERAGE AFTER MARCH 31, 2021

Please read the important information in this notice. You may be entitled to COBRA coverage without paying a premium.

If your health coverage was previously extended because you were laid off, involuntarily fired from your job or forced to reduce your hours of work on or after March 1, 2020, your health coverage will now end after March 31, 2021. In order to extend your health coverage beyond March 31, 2021, you must complete a COBRA election form and send it back to the Fund Office by the date indicated on your COBRA Continuation Coverage Election Form.

Under the recently-enacted American Rescue Plan Act of 2021, you will be entitled to "subsidized" COBRA coverage if you lose health coverage because:

- You were laid off;
- You were **involuntarily** terminated from employment; or
- Your work hours were reduced (**not by your choice**).

If these circumstances apply to you, you will NOT have to pay a premium for COBRA coverage for the period April 1, 2021 through September 30, 2021, which is the first six months of your COBRA continuation period. Please see the attached COBRA Continuation Coverage Election Notice for more information about your maximum COBRA continuation period.

IMPORTANT LIMITATIONS:

1. **You are not eligible for this subsidized COBRA coverage if you:**
   - **voluntarily terminated your employment;**
   - **voluntarily reduced your hours of employment; or**
   - **were fired for gross misconduct.**

2. **An individual who is eligible for other group health plan coverage or Medicare is not entitled to the subsidized COBRA coverage. If you become eligible for coverage under another group health plan (for example, coverage under your spouse's**

employer's health plan) or become eligible for Medicare, your subsidized COBRA coverage will end.

PENALTY: Individuals are required to notify the Fund Office if they become eligible for other group health plan coverage or Medicare and will be subject to a penalty (imposed by the Internal Revenue Service) if they fail to do so.

- **The penalty is $250 for each such failure.**
- **If the failure is due to fraud, the penalty could be up to 110% of the amount of the COBRA subsidy received after the individual became eligible for the other group health plan coverage or Medicare.**

In addition to the COBRA Continuation Coverage Election Form, please complete the additional COBRA Subsidy Form included with this Notice.

If you have any questions regarding the COBRA subsidy, please contact the Fund office at:

Teamsters Local Union No. 727 Health and Welfare Fund
1300 W. Higgins Road, Suite 103
Park Ridge, IL 60068
(773) 685-0340

If you are a Movie/Trade Show participant, please contact Elite Administration with any questions regarding the COBRA subsidy at:

Teamsters Local Union No. 727 (MTSD) Health and Welfare Fund
c/o ELITE Administration & Insurance Group, Inc.
1300 W. Higgins Road, Suite 208
Park Ridge, IL 60068
(312) 243-1265

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)

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* 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: Teamsters Local Union No. 727 Health and Welfare Fund, 1300 W. Higgins Rd., Suite 103, Park Ridge, IL 60068

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."

Teamsters Local Union No. 727 Health and Welfare Fund	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	1300 W. Higgins Rd., Suite 103, Park Ridge, IL 60068

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 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.

Teamsters Local Union No. 727 Health and Welfare Fund	**Participant Notification**	1300 W. Higgins Rd.. Suite 103, Park Ridge, IL 60068

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:

_____ _____

_____ _____