

**Model COBRA Continuation Coverage Notice in Connection with  
Extended Election Periods**

**(For use by group health plans for qualified beneficiaries currently enrolled in COBRA continuation coverage, due to a reduction in hours or involuntary termination (Assistance Eligible Individuals), as well as those who would currently be Assistance Eligible Individuals if they had elected and/or maintained COBRA continuation coverage)**

**Instructions**

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage extended election notice that the Plan may use to provide the election notice to qualified beneficiaries currently enrolled in COBRA continuation coverage due to reduction in hours or involuntary termination (Assistance Eligible Individuals), as well as those who would be Assistance Eligible Individuals, if they had elected and/or maintained COBRA continuation coverage.

To use this model extended election notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers appropriate use of the model extended election notice to be good faith compliance with the election notice content requirements of COBRA. You don't have to use the model notice, but it may help you comply with the applicable notice requirements. When distributing, the Plan Administrator should also include the attachment *Summary of COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021*, which contains information on the American Rescue Plan (ARP), and forms to elect premium assistance, in order to satisfy the ARP's notice requirements.

**NOTE:** Plans do *not* need to include this instruction page with the model election notice.

**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 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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-XXXX.

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

<b>Notice Type</b>	<b>Estimated Average Time</b>
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

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**(For use by group health plans for qualified beneficiaries currently enrolled in COBRA continuation coverage, due to a reduction in hours or involuntary termination (Assistance Eligible Individuals), as well as those who would currently be Assistance Eligible Individuals if they had elected and/or maintained COBRA continuation coverage)**

**IMPORTANT INFORMATION: COBRA Continuation Coverage, other Health Coverage Alternatives, and Extended Election Periods under the American Rescue Plan Act of 2021 (ARP)**

[Enter date of notice]

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

**This notice has important information about your new rights related to continued health care coverage in the [enter name of group health plan] (the Plan).**

The American Rescue Plan Act of 2021 (ARP) provides temporary premium assistance for COBRA 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 COBRA 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 do not need to pay any of the COBRA premium otherwise due to the plan for the months when you are eligible for premium assistance. This premium assistance is available from April 1, 2021 through September 30, 2021. If you choose to continue your COBRA continuation coverage beyond that date, you may have to pay the full COBRA premium amount due. However, when your premium assistance ends, you may qualify for a special enrollment period to enroll in coverage through the Health Insurance Marketplace<sup>®1</sup> (see section on “other coverage options” below).

You are receiving this notice because you experienced a qualifying event that may have been a reduction in hours or an involuntary termination of employment and you have not reached the maximum period for your COBRA continuation coverage or did not elect COBRA continuation coverage when it was first offered.

To help determine whether you can get the ARP premium assistance, you should read this notice and the attached documents carefully. In particular, review the “Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan of 2021” with details regarding eligibility, restrictions, and obligations and the “Request for Treatment as an Assistance Eligible Individual.”

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<sup>1</sup> Health Insurance Marketplace<sup>®</sup> is a registered service mark of the U.S. Department of Health & Human Services.

**If you believe you meet the criteria for the premium assistance, complete the “Request for Treatment as an Assistance Eligible Individual” (provided in the Summary of COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021 as an attachment to this notice) and return it with your completed Election Form, or separately, if you are currently enrolled in COBRA continuation coverage.**

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

**If I did not have COBRA continuation coverage and now elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?**

If elected, COBRA 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 COBRA continuation coverage: [list available coverage options].]

[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, 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 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]. The different coverage must cost the same or less than the coverage you 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, or a health flexible spending arrangement.”]

COBRA continuation coverage may end before the date noted above in certain circumstances, including for failure to pay premiums, for fraud, or if you become covered by another group health plan.

Note, due to the COVID-19 National Emergency, the Department of Labor, the Department of the Treasury, and the Internal Revenue Service issued a Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak (“Joint Notice”).<sup>2</sup> This notice provided relief for certain actions related to employee benefit plans required or permitted under Title I of ERISA and the Code, including the 60-day initial election period for COBRA continuation coverage. The Department of Labor’s Employee Benefits Security Administration (EBSA) provided further guidance on this relief in EBSA Disaster Relief Notice 2021-01.<sup>3</sup> The extended deadline relief provided in the Joint Notice and Notice 2021-01 does not apply, however, to the 60-day election period related to COBRA premium assistance under the ARP. Potential Assistance Eligible Individuals therefore

<sup>2</sup> 85 FR 26351 (May 4, 2020).

<sup>3</sup> Available at <https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01.pdf>.

must elect COBRA continuation coverage within 60 days of receipt of the relevant notice or forfeit their right to elect COBRA continuation coverage with premium assistance.

However, a potential Assistance Eligible Individual has the choice of electing COBRA continuation coverage beginning April 1, 2021 or after (or beginning prospectively from the date of your qualifying event if your qualifying event is after April 1, 2021), or electing COBRA continuation coverage commencing from an earlier qualifying event if you are eligible to make that election, including under the extended time frames provided by the Joint Notice. The election period for COBRA continuation coverage with premium assistance does not cut off an individual's preexisting right to elect COBRA continuation coverage, including under the extended timeframes provided by the Joint Notice and EBSA Disaster Relief Notice 2021-01.

### **Can I now extend the length of COBRA continuation coverage?**

If you now elect COBRA continuation coverage, you may be able to extend the length of COBRA continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify *[enter name of party responsible for COBRA administration]* of a disability or a second qualifying event within a certain time period to extend the period of COBRA continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of COBRA continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf>.

### **How much does COBRA continuation coverage now cost?**

COBRA 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.]* The ARP reduces the COBRA premium to zero for certain individuals. Premium assistance is available to certain individuals who are eligible for COBRA 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 COBRA premium otherwise due to the plan. This premium assistance is available from April 1, 2021 through September 30, 2021. If you choose to continue your COBRA continuation coverage beyond that date, you may have to pay the full amount due. See the attached "Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan of 2021" for more details, restrictions, and obligations as well as the form to complete to establish eligibility.

If you qualify as an "Assistance Eligible Individual" this monthly premium cost will be zero from April 1, 2021 through September 30, 2021 and you do not have to send any payment with the election form.

The Plan will send you additional payment information after receiving the election form.

## **Are there other coverage options besides COBRA 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 a special enrollment period. Additionally, you may apply for and, if eligible, 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 COBRA continuation coverage. If you are eligible for other group health plan coverage, such as through a new employer's plan or a spouse's plan (not including excepted benefits, a qualified small employer health reimbursement arrangement, or a health flexible spending arrangement), 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 COBRA continuation coverage. Note, however, that you will not be eligible for a premium tax credit, or advance payments of the premium tax credit, for your Marketplace coverage for months that you are enrolled in COBRA continuation coverage and you may not be eligible 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 COBRA 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 COBRA, because the new coverage may impose a new deductible. Also, keep in mind that if you elect COBRA 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 tax credit if you end your COBRA 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 COBRA 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 doesn't fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact *[enter name of party responsible for COBRA administration for the Plan, with telephone number and address]*.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's EBSA website at

<https://www.dol.gov/agencies/ebsa>, go to [www.askebsa.dol.gov](http://www.askebsa.dol.gov), or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace®, and to locate an assister in your area who you can talk to about the different options, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep Your Plan Informed of Address Changes**

To protect your and your family's rights, still keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also still keep a copy of any notices you send to the Plan Administrator.

COBRA Continuation Coverage Election Form (for individuals not currently on COBRA)

**Instructions:** To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan, unless you are entitled to additional time under a federal policy or program. For example, you may be entitled to more time because of a national emergency. However, if you fail to elect COBRA continuation coverage and the premium assistance within 60 days of receipt of this form, you may be ineligible for the premium assistance and the additional COBRA election period under the ARP.

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 don't submit a completed Election Form by the due date shown above, you may lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date.

Read the important information about your rights included in the pages after the Election Form.

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

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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a. \_\_\_\_\_  
[Add if appropriate: Coverage option elected: \_\_\_\_\_]

b. \_\_\_\_\_  
[Add if appropriate: Coverage option elected: \_\_\_\_\_]

c. \_\_\_\_\_  
[Add if appropriate: Coverage option elected: \_\_\_\_\_]

\_\_\_\_\_  
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 COBRA Continuation Coverage Benefit Options**

**Instructions:** To change the benefit option(s) for your COBRA continuation coverage to something different than what you or the participating employee 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 COBRA CONTINUATION COVERAGE.**

I (We) would like to change the COBRA 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)
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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

*[Attach Summary of COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021 in order to satisfy ARP requirements]*