



Important information for employers who have former employees on fully insured state continuation or may have individuals eligible for state continuation.

The American Rescue Plan Act (ARPA) of 2021 was signed into law on March 11, 2021. ARPA provides temporary premium assistance for some state continuation coverage. The premium assistance is available for the period beginning April 1, 2021, or prospectively from the date of the qualifying event if the qualifying event is after April 1, 2021, through September 30, 2021 or the end of the qualified beneficiary's eligibility period, whichever is earlier. The premium assistance may end earlier if the assistance eligible individual (AEI) becomes eligible for another group health plan or Medicare. The premium assistance is available to certain assistance eligible individuals who are eligible for fully insured state continuation coverage.

To be eligible for the premium assistance, a qualified beneficiary **must meet all the following requirements:**

- **MUST** have a qualifying event that is a reduction in hours or an involuntary termination of a covered employee's employment.
- **MUST** elect state continuation coverage with effective dates between April 1, 2021 and September 30, 2021 or were enrolled in state continuation coverage as of March 31, 2021 and are still eligible April 1, 2021.
- **MUST NOT** be eligible for Medicare.
- **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.

AEIs with a state continuation election in place shall be treated for purposes of any state continuation provision as having paid in full the amount of the premium for the period for which they are eligible for the premium assistance.

For fully insured state continuation, the insurer, not the employer, is responsible for advancing the premium for AEIs and taking a tax credit. **If you are an employer who has employees that are or may be covered under state continuation coverage provided by UnitedHealthcare between April 1, 2021 and September 30, 2021, read this closely and take appropriate actions.**

The Department of Labor (DOL) has issued model notices related to ARPA and regulations regarding the provision of these notices.

- *Summary of the COBRA Premium Assistance Provision* under the American Rescue Plan Act of 2021: Must be sent with the *Alternative Notice*.

<https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/cobra/premium-subsidy/summary-of-provisions.pdf>

- The *Alternative Notice*: Notice for all qualified beneficiaries who have experienced any qualifying event at any time from April 1, 2021 through September 30, 2021 under state law.

<https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/cobra/premium-subsidy/model-alternative-election-notice.pdf>



- *Notice of Expiration of Period of Premium Assistance*: This notice must be provided 15 to 45 days before the date of expiration of premium assistance. This notice is not required to be provided if eligibility for the premium assistance ends because the individual has become eligible for another group health plan or if the individual has become eligible for Medicare.
<https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/cobra/premium-subsidy/notice-of-premium-assistance-expiration-premium.pdf>
- Qualified beneficiaries who believe they are eligible for the premium assistance will need to submit the *Request for Treatment as an Assistance Eligible Individual* form which is included in the notices. If the qualified beneficiary does not have an election in effect, they will also have to apply for state continuation.

IMPORTANT – If UnitedHealthcare Benefit Services (UHCBS) is your state continuation administrator or if your plan is situated out of CA, FL, KS, KY, MA, MS, NH, OK, OR, RI or WV, the following lists UnitedHealthcare and employer group responsibilities.

UnitedHealthcare Responsibilities

- Will send the Summary of Provisions to any currently enrolled members who may qualify as an AEI from 4/1/21 – 9/30/21.
- Review of *Requests for Treatment as an Assistance Eligible Individual* form.
- Request verification from employer of involuntary termination or reduction in hours for qualified beneficiaries who request premium assistance.
- Mail denial letter to individuals who request Treatment as an Assistance Eligible Individual who are not eligible for the subsidy, when applicable.
- Update the system for individuals who qualify as AEIs.
- Communicate eligibility changes to enrollment due to qualified beneficiaries qualifying as AEIs
- Mail the *Notice of Expiration of Period of Premium Assistance* prior to the expiration of premium assistance.
- Issue a refund for an individual who has met the requirements to be treated as an Assistance Eligible Individual (AEI) and who paid in full for periods of continuation coverage beginning on or after April 1, 2021 through September 30, 2021. The refund will be issued within 60 days of determination of Assistance Eligible status, to the group or individual as appropriate.

Employer Responsibilities

- Provide verification upon request from UnitedHealthcare of involuntary termination for qualified beneficiaries who request premium assistance and were sent their *COBRA Election Notice* after the initial list of qualified beneficiaries is identified.
- Review employees that qualify for state continuation between 4/1/2021 and 9/30/2021 and identify if they are potential AEIs and communicate to UnitedHealthcare.
- If the premium has been remitted to the employer by UHCBS already, issue a refund to an individual who has met the AEI requirements and who paid in full for periods of continuation coverage beginning on or after April 1, 2021 through September 30, 2021. The refund will be issued within 60 days of determination of Assistance Eligible status.



IMPORTANT – UnitedHealthcare and Employer responsibilities for states where UnitedHealthcare does not administer state continuation coverage.

Employer Responsibilities

- Review employees that qualify for State Continuation between 4/1/2021 and 9/30/2021 and identify if they are potential AEIs
- Distribute the *Summary of the COBRA Premium Assistance Provision*, which includes the [Request for Treatment as Assistance Eligible Individual form](#) to any currently enrolled members who may qualify as an AEI from 4/1/21 – 9/30/21.
- Distribute the *Alternative Notice* and the *Summary of the COBRA Premium Assistance Provision*, which includes the [Request for Treatment as Assistance Eligible Individual form](#) under the American Rescue Plan Act of 2021 to the potential AEI who becomes eligible for State Continuation coverage between 4/1/2021 and 9/30/2021.
- Advise employees that want to be considered for premium subsidy to send employer *Requests for Treatment as an Assistance Eligible Individual*, contained in the Summary of the COBRA Premium Assistance Provision sent by their employer. Remind employees that they have up to 60 days to respond to the employer after the notices are provided to them.
- Provide the *Summary of the COBRA Premium Assistance Provision* form to an AEI to report a change in status that makes them no longer eligible for premium subsidy.
- **Review, approve, and sign** the *Requests for Treatment as an Assistance Eligible Individual* to make sure they are complete and that the individual does qualify for the subsidy, including the information shown in the sample below.
- Complete the *Employer Verification* form, which is attached to this communication.
- Submit the *Employer Verification* form and all [Requests for Treatment as an Assistance Eligible Individual](#) forms for individuals listed on the *Employer Verification* form to UnitedHealthcare. Use mailing information at the end of this letter.

Note: *Please submit 1 Employer Verification form (attached) together with 1 [Request for Treatment as Assistance Eligible Individual form](#) for each individual. If submitting via fax, do one submission at a time.*

- Mail the *Notice of Expiration of Period of Premium Assistance* to AEIs.

UnitedHealthcare Responsibilities

- Review *Requests for Treatment as an Assistance Eligible Individual* and *Employer Verification* form. Both forms are required.
- Communicate to the employer if we see something that would not allow us to accept the individual's request for Treatment as an Assistance Eligible Individual.
- Update system for individuals who qualify as AEIs.
- In cases where the employer has already paid, provide a credit for premium paid for AEIs during time period during which they qualify for subsidy

Please Note: Initially there may be a delay for requests and adjustments to be processed as systems are set up.



Requests for Treatment as an Assistance Eligible Individual Sample (1 of 2 Required forms):

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: [Enter Name and Address]

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."

[Insert Plan Name] **REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL** [Insert Plan Mailing Address]

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. | <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 →
 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 involuntary. | <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"/> |

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 →



To allow more efficient processing, please clearly write the employer name, phone number and policy number as shown by the arrow on the form to the left. The shaded area is difficult to read after processing.

Mailing Information

UHCBS including CA, FL, KS, KY, MA, MS, NH, OK, OR, RI, and WV plans

- cobra@uhcervices.com
- P.O. Box 740221
Atlanta, GA 30374-0221

UnitedHealthcare and UHC plans that are not Oxford

- UnitedHealthcare
PO Box 30964
Salt Lake City, UT 84130-0964
- Fax: 248-733-6062 or 248-733-6063

Oxford Plans

- UnitedHealthcare Commercial Enrollment Department
Attn: Enrollment Department
P.O. Box 29142
Hot Springs, AR 71903
- Fax: 888-454-0386



Employer Verification Form (2 of 2 Required forms)

Important: Please submit 1 Employer Verification form together with 1 [Request for Treatment as Assistance Eligible Individual](#) form for each individual. If submitting via fax, do one submission at a time.

To report a change in Premium Eligibility, please submit 1 Employer Verification form together with 1 [Eligible for Other Group Health Plan Coverage or Medicare form](#) for each individual. If submitting via fax, do one submission at a time.

For state continuation, please complete the following fields listed below. This information below is needed in addition to the [Treatment Assistance Eligible Individual](#) form. Once complete return the Employer Verification form and other forms to UnitedHealthcare at the following address (print/type information clearly).

1. **Name of Employer/Company** _____
2. **Employer Contact Name/Phone/Email** _____
3. **Group/Customer Number** _____
4. **Employee Policy Number** _____
5. **Employee Name** _____
6. **Employee SSN** _____
7. **Date of Birth** _____

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