IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND

Fund Office: Zenith American Solutions
P O BOX 670717 DALLAS TEXAS 75267 Phone: 800-527-0320

ARP GENERAL NOTICE

IMPORTANT NOTICE REGARDING COBRA CONTINUATION COVERAGE, THE ARP 100% COBRA SUBSIDY AVAILABLE FROM APRIL 1, 2021 THROUGH SEPTEMBER 30, 2021, AND OTHER HEALTH COVERAGE ALTERNATIVES

Dear COBRA Qualified Beneficiary(ies):

This notice has important information about your rights related to continued health care coverage in the [PLAN NAME] (the Plan), as well as other health coverage options that may be available to you, including coverage through Medicaid or the Health Insurance Marketplace®.

This notice also provides information to you because you may be eligible for free, fully subsidized COBRA. This new 100% COBRA subsidy program is available to certain individuals between April 1, 2021 through September 30, 2021. To elect this 100% COBRA subsidy you must read the enclosed packet, verify that you are eligble and complete and return certain forms to the Fund Office.

This notice is being provided to help navigate you through this process.

AM I ELIGIBLE FOR THE 100% COBRA SUBSIDY?

The American Rescue Plan Act of 2021 (ARP) provides temporary premium assistance ("subsidies") for continuation coverage, at no cost, for up to six months if certain eligible requirements are met. These COBRA subsidies start April 1, 2021 and end September 30, 2021. The 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 a COBRA subsidy, you need not pay any of the continuation coverage premium otherwise due to the plan. This premium assistance is available from April 1, 2021 through September 30, 2021. If you continue your COBRA continuation coverage beyond the above period, you will have to pay the full COBRA 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® (see section on "the Health Insurance Marketplace®" below).

WHY AM I GETTING THIS NOTICE?

You are getting this notice because your coverage under the Plan will end on 05/01/2021 and may be due to an end of employment (involuntary) or reduction in hours of employment.

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event," such as those listed above, that would result in a loss of coverage under an employer's plan.

HOW DO I ELECT THE SUBSIDY?

Fill out and return the enclosed: (1) COBRA Election Form; and (2) Request for Treatment as an Assistance Eligible Individual.

To qualify for the subsidy, the Fund Office must timely receive certain paperwork from you. Therefore, if you wish to elect the 100% COBRA subsidy, please:

- Read the enclosed materials carefully to determine whether you are eligible for COBRA premium assistance;
- Complete and return to the Fund Office the COBRA Continuation Coverage Election Form, AND
- Complete and return to the Fund Office the Request for Treatment as an Assistance Eligible Individual Form.

To receive the subsidy, you must return these materials to the Fund Office within 60 days of the date of the enclosed notice. This subsidized COBRA Continuation Coverage will last until September 30, 2021, as long as you are not eligible for other group health plan coverage or Medicare. If you choose to continue COBRA Continuation Coverage after September 30, 2021, you are responsible for paying required monthly premiums.

YOU MUST NOTIFY THE FUND OF OTHER GROUP OR MEDICARE COVERAGE OR YOU MAY BE SUBJECT PENALTIES

If you receive the 100% COBRA subsidy, you have a duty to notify the Fund Office if you subsequently become eligible for other group health plan coverage (like a spouse's plan) or Medicare. If you become eligible for other coverage, you are no longer eligible for the 100% COBRA subsidy. Importantly, failure to notify the Fund of your eligibility for other coverage can result in a tax penalty to you of up to 110% of the COBRA subsidy you received.

You must promptly fill out and return the enclosed Participant Notification (Premium Subsidy Ineligibility Information) to the Fund Office if you become eligible for alternative health coverage.

IF I ELECT COBRA CONTINUATION COVERAGE, WHEN WILL MY COVERAGE BEGIN AND HOW LONG WILL COVERAGE LAST?

If elected, COBRA continuation coverage will begin on 05/01/2021 and can last until 10/31/2022. If your COBRA qualifying event was due to an employee's reduction in hours or involuntary termination of employment, you may be eligible for ARP premium assistance from 05/01/2021 through September 30, 2021.

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 under another group health plan or entitled to Medicare.

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 your Plan Administrator.

If you have questions about the information in this notice or your rights to coverage, or if you want a copy of your summary plan description, contact the Fund Office ; Zenith American Solutions, Inc., P O BOX 670717 DALLAS TX 75267 telephone number 800-527-0320.

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 Employee Benefits Security Administration (EBSA) website at https://www.dol.gov/agencies/ebsa, contact them electronically at 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.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

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, the Fund's administration of the ARP premium assistance, or to notify the Fund of your inability to receive premium assistance, contact the Fund Office: Zenith American Solutions, Inc., PO BOX 670717 DALLAS TEXAS 75267, telephone number 800-527-0320.

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 reimbursement 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.

ATTENTION: *To apply for ARP premium assistance, complete this form and return it to the Fund Office, 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.*

Send the completed forms to: IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND Fund Office
c/o Zenith American Solutions, Inc., Administrator
PO BOX 670717 DALLAS TX 75267

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."

IBEW -NECA SOUTHWESTERN HEALTH AND BENEFIT FUND	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	c/o Zenith American Solutions P O BOX 670717 DALLAS TX 75267

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 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 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)

d._____

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 → _____

ATTENTION: *ONLY use this form to notify the Fund Office that you are eligible for other group health plan coverage or Medicare and therefore not eligible for premium assistance under the ARP.*

IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND	**PARTICIPANT NOTIFICATION**	c/o Zenith American Solutions P O BOX 670717 DALLAS TX 75267

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 Will not 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 your dependents you must also list their names here:

_____ _____

_____ _____

_____ _____