COBRA
COMPLIANCE TOOLKIT

Provided by **Benefit Team Insurance Services**

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INTRODUCTION

This toolkit is intended to provide information for employers on their compliance obligations under the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA is a federal law that generally applies to group health plans maintained by private-sector employers that have **20 or more employees**.

COBRA Overview

COBRA requires covered group health plans to offer continuation coverage to employees, spouses and dependent children when group health coverage would otherwise be lost due to certain specific events. These events, called qualifying events, include the death of a covered employee, a termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, the divorce of a covered employee and spouse, and a child's loss of dependent status under the plan.

COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect and pay for continuation coverage, and when continuation coverage may be terminated. COBRA also requires employers and health plan administrators to provide certain notices to plan participants at specific times.

COBRA Violations – Potential Consequences

Failing to comply with COBRA's requirements can trigger a number of adverse consequences for an employer, depending on the type of failure involved. Possible consequences include **excise taxes of $100 per day** for each qualified beneficiary impacted by a failure during a compliance period, **penalties of up to $110 per day** under the Employee Retirement Income Security Act (ERISA) and **lawsuits** to compel COBRA coverage where a court can award attorneys' fees, interest and other relief, such as liability for medical expenses.

What This Toolkit Covers

This toolkit provides answers to common questions regarding COBRA compliance, including the following:

- Which group health plans are subject to COBRA?
- When must COBRA continuation coverage be offered?
- What COBRA notices are required?
- How long does COBRA continuation coverage last?
- How much can group health plans charge for COBRA continuation coverage?

This toolkit also includes **sample notices** that employers may customize and use to help satisfy their COBRA compliance obligations.

Additional Resources

In addition to this toolkit, there are resources available from the Department of Labor (DOL) and Internal Revenue Service (IRS) to help employers comply with COBRA.

- **An Employer's Guide to Group Health Continuation Coverage under COBRA**, a DOL publication
- **An Employee's Guide to Health Benefits under COBRA**, a DOL publication (also available in Spanish)
- The DOL's **FAQs** on COBRA continuation coverage
- **Final regulations** on COBRA's notice and disclosure requirements
- The DOL's **webpage** on COBRA compliance, including links to the **Model General Notice** and the **Model Election Notice**

COVERED GROUP HEALTH PLANS

COBRA generally applies to group health plans maintained by private-sector employers that had at least **20 employees** on more than 50 percent of typical business days in the previous calendar year. This includes, for example, corporations, partnerships and tax-exempt organizations.

COBRA does not apply to group health plans maintained by small employers (fewer than 20 employees) or churches. There are also special coverage rules for governmental employers, although, as a practical matter, most governmental group health plans are required to offer continuation coverage.

State Continuation Coverage Laws

Many states have their own continuation coverage laws for fully insured group health plans that are similar to COBRA. These state laws, which are sometimes called mini-COBRA laws, often apply to fully insured group health plans maintained by employers with fewer than 20 employees. Thus, even if a plan is not subject to COBRA, it may nevertheless be required to provide continuation coverage under state insurance law. Self-insured health plans maintained by private-sector employers are typically not subject to state continuation coverage requirements. This toolkit does not address state continuation coverage laws. For more information on your state's continuation coverage laws, contact your Benefit Team Insurance Services representative.

Group Health Plans

A group health plan is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance, out of the employer's general assets or through any other means. Medical care broadly includes:

- Inpatient and outpatient hospital care;
- Physician care;
- Surgery and other major medical benefits;
- Prescription drugs; and
- Dental and vision care.

The following chart provides examples of common welfare benefits provided by employers and indicates whether the benefits are group health plans that are subject to COBRA.

Type of Benefit	Subject to COBRA?
Fully insured group health plans	Yes
Self-funded group health plans	Yes
Dental and vision plans	Yes
Prescription drug plans	Yes
Health Flexible Spending Accounts (FSAs)	Yes, but if a health FSA qualifies for a special exception, the employer is not required to offer COBRA coverage to certain qualified beneficiaries and may limit the duration of COBRA coverage for other qualified beneficiaries to the plan year in which the qualifying event occurs
Health reimbursement arrangements (HRAs)	Yes
Health savings accounts (HSAs)	No, but the high deductible health plans (HDHPs) offered with HSAs are subject to COBRA
Disease-specific policies, such as cancer policies	Yes, if they provide coverage for medical care
Employee assistance programs (EAPs)	Depends on the EAP's benefits—EAPs that provide medical care are likely subject to COBRA
Wellness plans	Depends on wellness plan's benefits—wellness plans that provide medical care are likely subject to COBRA
Long-term care plans	No
Accidental death and dismemberment (AD&D) plans	No (as long as there is no ancillary benefit for medical care)
Group term life insurance plans	No (as long as there is no ancillary benefit for medical care)
Long-term and short-term disability plans	No (as long as there is no ancillary benefit for medical care)

Special Rules for Health FSAs

In general, employers that offer health FSAs to their employees are required to offer COBRA coverage to qualified beneficiaries who would otherwise lose their health FSA coverage due to a qualifying event. However, this is subject to the special exception described below. Many health FSAs qualify for this special exception. Health FSAs that do not qualify for the special exception must offer COBRA coverage for the maximum coverage period applicable under COBRA. In these cases, individuals electing COBRA coverage must be allowed to re-enroll for health FSA coverage for subsequent plan years during open enrollment periods.

Special Exception

A health FSA qualifies for the special exception if it satisfies all of the following conditions:

- ✓ The **maximum annual benefit** payable to any participant under the FSA does not exceed an amount equal to twice the participant's annual salary deferral election under the FSA (or, if greater, an amount equal to the participant's annual salary deferral election under the FSA, plus $500);
- ✓ **Other group health plan coverage** is made available by the employer, other than excepted benefits under the Health Insurance Portability and Accountability Act (HIPAA); and
- ✓ The **maximum annual benefit** available under the health FSA is less than the maximum COBRA premium for a year. Often, this condition is satisfied because the COBRA premium will either equal the maximum annual benefit or will be equal to 102 percent of the maximum annual benefit.

If a health FSA qualifies for the special exception, the plan sponsor:

- Is not required to offer COBRA coverage to qualified beneficiaries who have "overspent" their FSA accounts; and
- Must offer COBRA coverage to qualified beneficiaries who have "underspent" their FSA accounts, but the COBRA coverage may terminate at the end of the year in which the qualifying event occurs.

Overspent

If the participant's maximum annual benefit minus the amount of the submitted reimbursable claims is less than the maximum COBRA premium that can be charged for the rest of the year, then the FSA is overspent.

Underspent

If the remaining annual benefit (participant's maximum annual benefit minus the amount of submitted reimbursable claims) is more than the maximum COBRA premium that can be charged for the rest of the year, then the FSA is underspent.

Exemption for Small Employers

A group health plan is NOT subject to COBRA for a calendar year if the employer maintaining the plan normally employed **fewer than 20 employees** on typical business days during the preceding calendar year.

Small employer plans are not subject to COBRA for the entire calendar year for which they qualify for this exception. This means that if a qualifying event occurs during a calendar year for which the small employer exception applies, it does not trigger COBRA rights or obligations. However, if a plan has been subject to COBRA and becomes eligible for the small employer exception, the plan remains subject to COBRA for qualifying events that occurred during the period when the plan was subject to COBRA.

> ***Example:*** An employer employs 20 or more employees on typical business days during 2017. Therefore, the employer must comply with COBRA for qualifying events occurring in 2018. Rob, an employee, terminates employment on Jan. 31, 2018, and timely elects and pays for COBRA continuation coverage. The employer employs fewer than 20 employees during 2018. Beginning in January 2019, the employer has a small-employer plan and is not required to comply with COBRA for purposes of qualifying events that occur during 2019. However, the employer must continue to make COBRA available to Rob for his maximum COBRA continuation period. The obligation would continue until Aug. 1, 2019, which is 18 months after the date of Rob's qualifying event (or longer, if Rob is eligible for a disability extension).

To help avoid benefits disputes, employers that become newly eligible for the small employer exemption due to a reduction in personnel should **notify employees** that COBRA coverage will not be available for qualifying events that occur during the relevant calendar year.

Small employers, especially those with fluctuating workforce numbers that are around the 20-employee threshold, may decide not to take advantage of the small employer exception and continue offering COBRA coverage. However, before offering COBRA coverage during a calendar year for which the small employer exception applies, the employer should consult with its health insurance issuers or stop-loss carrier.

Counting Employees

To determine whether an employer qualifies for COBRA's small employer exemption, the following employees must be counted:

- ✓ All common law employees, not just plan participants;
- ✓ Both full-time and part-time common law employees (although a part-time employee counts as a fraction of a full-time employee); and
- ✓ Common law employees working outside of the United States.

An employer may determine the number of its employees on a daily basis or on a pay period basis. The basis used by the employer must be used with respect to all employees and for the entire year for which the number of employees is being determined. Part-time employees count as a fraction of full-time employees. The fraction is equal to the number of hours that the part-time employee works divided by the number of hours that an employee must work to be considered a full-time employee.

Related Employers

All employees of any employer that is under common control with the plan sponsor must be counted in determining whether the small employer exemption applies to a group health plan. Thus, if an employer is part of a controlled group or affiliated service group (as determined under Internal Revenue Code (Code) Sections 414(b), (c), (m) or (o)), all employees of the related group must be taken into account.

Determining whether two or more organizations must be treated as a single employer under the controlled group or affiliated service group rules involves a complex analysis of ownership interests, including constructive ownership. Because these rules are so complex, an employer's controlled group or affiliated service group status should be reviewed by its legal or tax advisors.

Exemption for Churches

Church plans are **exempt** from COBRA's requirements. A church plan is any employee benefit plan established or maintained by a church or by a convention or association of churches that:

- Is exempt from tax under Code Section 501; and
- Has not made an election under Code Section 410(d) to have certain tax qualification requirements apply to it.

Determining whether the church plan exemption applies to a particular employer often involves a detailed analysis of the organization's activities and the closeness of its religious affiliation. Under some circumstances, organizations that are not churches (for example, certain hospitals or schools) may qualify for the church exemption if they are closely controlled by or associated with a church or religious denomination. Employers that are uncertain about whether they fall under the church plan exemption may want to consult with their tax or legal advisors.

Rules for Government Employers

COBRA applies to most group health plans maintained by state or local governments. If a state receives funds under the federal Public Health Service Act (PHSA), then its group health plan must comply with COBRA's continuation coverage rules. In addition, COBRA applies to group health plans maintained by local government employers, including counties, municipalities and public school districts, if they are within a state that receives PHSA funds. COBRA does not apply to plans sponsored by the governments of the District of Columbia or any territory or possession of the United States. Also, the federal government's group health plan is not subject to COBRA. However, a separate law—The Federal Employees Health Benefits Amendments Act of 1988—requires the federal government to provide continuation coverage.

OFFERING COBRA COVERAGE

A group health plan that is subject to COBRA must offer continuation coverage to **qualified beneficiaries** when health plan coverage ends (or would end) due to a **qualifying event**. Plan participants who are not qualified beneficiaries under COBRA are not entitled to continuation coverage under federal law. Also, if a qualified beneficiary's group health plan coverage ends for a reason that is not a COBRA-qualifying event, the employer is not required to offer COBRA coverage.

Qualified Beneficiaries

Who Is a Qualified Beneficiary?

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred and who is an **employee**, an employee's **spouse or former spouse**, or an employee's **dependent child**. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary.

Each qualified beneficiary has an independent right to elect COBRA. For example, if an employee and his or her spouse were covered under the health plan on the day before the qualifying event, the spouse may elect COBRA even if the employee declines coverage.

Employee

- An "employee" for COBRA purposes includes any individual who was covered under the group health plan because he or she performed services for the employer sponsoring the health plan. This definition is broader than the common law definition of "employee" and includes former employees, agents, independent contractors, directors, partners and employees who provide services under a leasing agreement, provided they are covered under the group health plan.

Spouse

- A "spouse" for COBRA purposes means a federally recognized spouse, including same-sex and opposite-sex spouses. Domestic partners are not considered spouses under federal law.

Dependent

- COBRA does not include a definition for "dependent child." The group health plan's terms determine who is eligible for coverage as a dependent child.

Also, where an employer files a proceeding in bankruptcy under Title 11, a covered employee who had retired on or before the date of substantial elimination of group coverage is a qualified beneficiary, as is any spouse, surviving spouse or dependent child of the covered employee, if on the day before the bankruptcy, the spouse, surviving spouse or dependent child were covered under the plan.

Who Is Not a Qualified Beneficiary?

A group health plan may cover individuals who are not qualified beneficiaries (for example, domestic partners, parents, siblings or other household members). Although these individuals may be covered by a group health plan, they do not have an independent right to elect COBRA continuation coverage because they are not qualified beneficiaries.

Domestic Partners

Domestic partners do not meet COBRA's definition of a spouse or dependent. Where an employer offers domestic partner benefits, even where state law recognizes domestic partners, domestic partners are not qualified beneficiaries. Therefore, employers offering domestic partner benefits should clarify within their summary plan description and COBRA notices whether they will voluntarily provide COBRA rights to domestic partners. An employer should seek approval from its insurance carrier or stop loss carrier prior to voluntarily expanding the scope of its definition of COBRA qualified beneficiary to include domestic partners.

Where a qualified beneficiary covered under COBRA adds a spouse or dependent during a health plan's open enrollment period, that spouse or dependent is not a qualified beneficiary. While the spouse or dependent is covered under COBRA, he or she does not have independent rights under COBRA. Therefore, if the employee terminates coverage prior to the end of the maximum COBRA coverage period, the non-qualified beneficiary spouse or dependents will lose coverage since they do not have an independent right to continue COBRA.

Qualifying Events

An employer must offer COBRA coverage only when group health plan coverage ends (or would end) due to a qualifying event. **Not all losses of health coverage are caused by qualifying events**. For example, a cancellation of health plan coverage—whether at the employee's request or because of the employee's failure to pay premiums—is not, by itself, a qualifying event that triggers the requirement to offer COBRA coverage. Likewise, cancelling coverage for an ineligible individual who was mistakenly covered by the health plan is not a qualifying event for COBRA purposes.

COBRA coverage must be offered to qualified beneficiaries when:

- A qualifying event occurs when the health plan is subject to COBRA; and
- The qualifying event causes a loss of coverage under the plan for a covered employee, covered spouse or covered dependent child.

Types of qualifying events

The following chart describes the events that are considered qualifying events under COBRA if they result in a loss of group health plan coverage:

QUALIFYING EVENT	DESCRIPTION OF EVENT	QUALIFYING BENEFICIARIES
Termination of employment	Termination of a covered employee's employment—whether voluntary or involuntary—for reasons other than gross misconduct. This includes retirement, voluntary quitting, employer-initiated discharges, layoffs, strikes and lockouts. COBRA does not include a definition for "gross misconduct." It is clear, however, that a termination for gross misconduct is not the same as a "for cause" termination.	Covered employee, spouse and dependent children
Reduction of hours	A reduction in hours of a covered employee's employment. If group health plan eligibility depends on the number of hours worked in a given period (such as the preceding month or quarter) and the employee fails to work the required hours, this is a reduction of hours. This includes changing positions from full time to part time, a temporary layoff or furlough, or an absence from work due to disability or for any other reason (other than FMLA leave).	Covered employee, spouse and dependent children
Divorce or legal separation	The divorce or legal separation of a covered employee from the covered employee's spouse. Many health plans are designed so that a legal separation will not trigger a loss of coverage, and, thus, will not be a qualifying event.	Spouse and dependent children *Under most plans, a divorce or legal separation will not cause a dependent child to lose coverage.
Death of covered employee	The death of a covered employee.	Spouse and dependent children
Child's loss of dependent status under plan rules	A covered employee's dependent child ceases to be a dependent under the plan's terms.	Dependent child

QUALIFYING EVENT	DESCRIPTION OF EVENT	QUALIFYING BENEFICIARIES
Entitlement to Medicare benefits	A covered employee becoming entitled to Medicare. A covered employee is entitled to Medicare when he or she is eligible for Medicare and actually enrolled in the Medicare program. An employee's Medicare entitlement will rarely cause a loss of coverage due to the Medicare secondary payer (MSP) rules. Under the MSP rules, most group health plans are prohibited in most circumstances from making Medicare entitlement an event that causes a loss of coverage. However, Medicare entitlement may cause a loss of coverage for covered retirees.	Spouse and dependent children
Employer's bankruptcy	An employer's bankruptcy can be a qualifying event for covered retirees and their covered spouses and dependent children who lose health plan coverage in connection with an employer's bankruptcy. Also, for employer bankruptcy, a loss of coverage includes a substantial elimination of coverage that occurs within the 12 months before or after the date on which bankruptcy proceedings begin.	Retiree, spouse and dependent child (if the employer or any member of its controlled group continue to offer a group health plan)

Coverage Loss in Anticipation of a Qualifying Event

Under a special rule, COBRA must also be offered if health plan coverage is **reduced or eliminated in anticipation of a qualifying event** (for example, an employee drops health plan coverage for his or her spouse in anticipation of a divorce). In this type of situation, the reduction or elimination is disregarded in determining whether there is a loss of coverage due to the qualifying event. Thus, if a covered employee eliminates coverage of his or her spouse in anticipation of their divorce, then upon receiving notice of the divorce, the group health plan must make COBRA continuation coverage available to the spouse as of the date of the divorce.

FMLA Leave

A qualifying event does not occur when an employee takes a job-protected leave under the federal Family and Medical Leave Act (FMLA). The FMLA contains its own continuation coverage rules that require covered employers to maintain group health plan benefits for an employees on FMLA leave on the same terms and conditions as if the employee had continued to work. However, a COBRA qualifying event occurs if an employee is covered under a group health plan on the day before the first day of FMLA leave (or becomes covered during the FMLA leave), the employee does not return to work at the end of the FMLA leave, and the employee would, in the absence of COBRA continuation coverage, lose coverage under the group health plan.

A COBRA qualifying event also occurs when an employee, either before starting FMLA leave or while currently on FMLA leave, notifies the employer that he or she will not be returning to work.

Retiree Health Coverage

COBRA coverage must be offered when a covered employee retirees if the termination of employment causes a loss of coverage. Employers cannot avoid their COBRA obligation by offering retiree health plan coverage.

Because retiree health plans can take many different forms, employers that offer retiree coverage should work with their advisors to determine their COBRA obligations for retirees and covered spouses and dependent children.

In many cases, employers structure their retiree coverage as an alternative to COBRA coverage. Under this type of plan design, retiring employees are given a choice between COBRA continuation coverage and the retiree health plan. Coverage under the retiree health plan may be conditioned upon the retiree waiving COBRA coverage. The COBRA waiver is not effective until the COBRA election period (typically 60 days) has ended. When the retiree health coverage expires, the employer is not required to offer COBRA again.

Example: Don is a single employee who, upon retirement, is given the opportunity to elect COBRA continuation coverage but declines it in favor of an alternative offer of 12 months of employer-paid retiree health benefits. At the end of the election period, Don ceases to be a qualified beneficiary and will not have to be given another opportunity to elect COBRA continuation coverage (at the end of those 12 months or at any other time).

However, if the retiree health coverage for covered spouses and dependent children would end due to a qualifying event (such as death, divorce, a dependent child's loss of dependent status or Medicare entitlement), COBRA coverage must be offered to these qualified beneficiaries for 36 months.

There are other design options for retiree health coverage that impact an employer's COBRA obligations. For example, if an employer offers coverage to retirees on the same basis that it is offered to active employees (including premium rules), there is no loss of coverage that would trigger an obligation to offer COBRA coverage. Under this type of design, the employer is not required to offer COBRA when the period of retiree coverage ends if the retiree coverage lasts at least as long as the maximum COBRA period. If the retiree coverage would end prior to the expiration of the maximum COBRA period, then COBRA coverage must be offered.

Because retiree health plans can take many different forms, employers that offer retiree coverage should work with their advisors to determine their COBRA obligations for retirees, as well as their covered spouses and dependent children.

COBRA NOTICES

To administer coverage under COBRA, employers and plan administrators are required to provide specific notices and disclosures to covered individuals and qualified beneficiaries. There are four main notice requirements for plan administrators under COBRA, as described in the table below:

Notice	Description	Timing
General notice	General description of COBRA rights under the plan	When health plan coverage begins
Election notice	Describes the right to elect COBRA coverage and how to make an election	After a qualifying event occurs
Notice of unavailability	Notifies individual that they are not eligible for COBRA coverage	When a request for COBRA coverage is denied
Early termination notice	Notifies individual that his or her COBRA coverage will terminate early	When a plan terminates COBRA coverage before end of maximum coverage period

Qualified beneficiaries are also subject to notice requirements under COBRA. Qualified beneficiaries are required to notify the plan administrator when certain qualifying events occur, such as a divorce or a dependent child's loss of dependent status.

General COBRA Notice

Group health plans must provide a written general notice of COBRA rights to each covered employee and spouse (if any) **within 90 days** after their health plan coverage begins. The general notice must also be sent to any spouses added to the plan after the employee's initial enrollment. In this case, the general notice must be provided within 90 days of the effective date of the spouse's coverage.

The general notice must include information about the plan coverage, a list of individuals who can become qualified beneficiaries under the plan, an explanation of the qualified beneficiaries' obligations when a qualifying event under COBRA occurs and other details.

> ***Model Notice:*** The DOL has a COBRA Model General Notice that can be used by single-employer group health plans to meet their notice obligations. Employers are not required to use the DOL's Model Notice. However, use of the Model Notice, appropriately completed, will be considered by the DOL to be good faith compliance with COBRA's coverage requirements for the general notice.

Qualifying Event Notice

Before a group health plan must offer continuation coverage, a qualifying event must occur and the group health plan must be notified of the event. Depending on the type of qualifying event, either the employer or a qualified beneficiary is required to provide this notice.

Employers are required to notify the health plan administrator when any of the following qualifying events occurs:

- Death of a covered employee;
- Termination of a covered employee's employment (for reasons other than gross misconduct);
- Reduction in the hours of a covered employee's employment;
- A covered employee's entitlement to Medicare; or
- The employer's Chapter 11 bankruptcy filing.

Who is a plan administrator?

The plan administrator is the entity that is legally responsible for compliance with many federal benefits laws. Unless a health plan's documents identify a different entity, the employer sponsoring the plan is the plan administrator.

The employer's notice to the plan administrator must be provided within **30 days** after the later of the date of the qualifying event or the date on which a qualified beneficiary would lose coverage as a result of the qualifying event.

Covered employees (or other qualified beneficiaries) are required to notify the plan when any of the following qualifying events occurs:

- The covered employee divorces or legally separates from his or her spouse; or
- A covered child loses dependent status.

Establish Reasonable Procedures

Plan administrators must establish **reasonable procedures** for covered employees or qualified beneficiaries to provide these notices. The procedures should be described within the plan's summary plan description (SPD). The SPD may require covered employees or qualified beneficiaries to use a specific form for the notices, as long as the form is readily available without cost. If a group health plan does not have reasonable procedures for providing these notices, qualified beneficiaries may give notice (either written or oral) to the person or unit that handles the employer's employee benefit matters.

Unless the group health plan provides a more generous deadline, covered employees and qualified beneficiaries must provide the notices within **at least 60 days** of the later of:

- The date of the qualifying event;
- The date on which the qualified beneficiary would lose coverage as a result of the qualifying event; or
- The date on which the qualified beneficiary was first notified of the obligation and procedures for providing notice.

COBRA Election Notice

After receiving notice of a qualifying event, the plan administrator must notify qualified beneficiaries of their right to elect continuation coverage under COBRA. The COBRA election notice must be provided no later than **14 days** after the plan's receipt of the notice of a qualifying event.

In many cases, the employer is also the plan administrator. For qualifying events where the employer is required to provide notice to the plan (for example, employee's termination or reduction in hours, death of the employee or employee becoming entitled to Medicare) and the employer is also the plan administrator, the election notice must be provided to the qualified beneficiary within **44 days** of the later of:

- The date of the qualifying event; or
- The date on which the qualified beneficiary loses coverage due to the qualifying event.

Employers that are subject to COBRA should maintain records of all COBRA-required notices, including the COBRA election notice, to document their compliance with COBRA's requirements. Maintaining complete and accurate records regarding the content and delivery of these notices will help an employer if a dispute over benefits arises.

The COBRA election notice must be written in a manner calculated to be understood by the average plan participant and contain specific information, including information about the plan, the qualifying event and each qualified beneficiary who is entitled to elect COBRA coverage. It also must include explanations of when plan coverage will otherwise end, how to elect and pay for COBRA coverage, and the duration of COBRA coverage.

Model Notice: The DOL released a COBRA Model Election Notice that can be used by single-employer group health plans to meet their notice obligations. To use the model election notice properly, a plan administrator must fill in the blanks with the appropriate plan information. Plan administrators are not required to use the model notice, but properly using it is considered good faith compliance with COBRA's notice content requirements.

Notice of COBRA Unavailability

Group health plans may deny a request for COBRA continuation coverage (or for an extension of continuation coverage) when the plan determines that the requestor is not eligible for the coverage. When a health plan decides to deny a request for COBRA continuation coverage (or a request for a coverage extension), the plan must give the individual a notice of unavailability of COBRA coverage. The notice must be provided within **14 days** after the request for COBRA continuation coverage is received, and it must explain the reason for denying the request.

Notice of Early Termination

COBRA continuation coverage must generally be made available for a maximum period of 18, 29 or 36 months. Group health plans, however, may terminate COBRA coverage early for a number of specific reasons. When a group health plan decides to terminate COBRA coverage early, the plan must give the qualified beneficiary a notice of early termination. The

notice must explain why the coverage will terminate earlier than the end of the maximum coverage period, provide the date the coverage will terminate and describe any rights the qualified beneficiary may have to elect other coverage. The notice must be provided **as soon as practicable** following the plan's decision to terminate coverage early.

COBRA ELECTIONS

Election Process

COBRA requires group health plans to give qualified beneficiaries an election period during which they can decide whether to elect continuation coverage. COBRA also gives qualified beneficiaries specific election rights.

At a minimum, each qualified beneficiary must be given **at least 60 days** to choose whether to elect COBRA coverage. This 60-day period is measured from the later of:

- The date the election notice is provided; or
- The date on which the qualified beneficiary would otherwise lose coverage under the group health plan due to the qualifying event.

Independent Election Rights

Each qualified beneficiary must be given an **independent right to elect continuation coverage**. This means that when several individuals (such as an employee, his or her spouse and their dependent children) become qualified beneficiaries due to the same qualifying event, each individual can make a different choice. However, the plan must allow the covered employee or the covered employee's spouse to elect continuation coverage on behalf of all of the other qualified beneficiaries for the same qualifying event. A parent or legal guardian of a qualified beneficiary must also be allowed to elect on behalf of a minor child.

If a qualified beneficiary waives continuation coverage during the election period, he or she must be permitted to later revoke the waiver of coverage and elect continuation coverage, as long as the revocation is done before the end of the election period. If a waiver is later revoked, however, the plan is permitted to make continuation coverage begin on the date the waiver was revoked.

Benefits Provided

Qualified beneficiaries must be offered coverage that **is identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan**. Generally, this will be the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage. A qualified beneficiary receiving COBRA coverage must receive the same benefits, choices and services that a similarly situated participant is currently receiving under the plan, such as the right during an open enrollment period to choose among available coverage options.

A qualified beneficiary is also subject to the same plan rules and limits that would apply to a similarly situated participant, such as copayment requirements, deductibles and coverage limits. The plan's rules for filing benefit claims and appealing any benefit denials also apply. Any changes made to the plan's terms that apply to similarly situated active employees and their families must also apply to a qualified beneficiary receiving COBRA continuation coverage.

Other Coverage Options

Individuals who are entitled to elect COBRA continuation coverage may have other coverage options available to them that may be more affordable. An employee or dependent who loses group health plan coverage may be able to obtain coverage under **another employer's group health plan**, even outside of that group health plan's open enrollment period, if special enrollment rights apply.

HIPAA requires group health plans and health insurance issuers to provide special enrollment opportunities outside of the plans' regular enrollment periods in certain situations. One event that triggers special enrollment is an employee or dependent losing eligibility for other health coverage. For example, an employee who loses group health coverage may be able to special enroll in a spouse's health plan. The employee or dependent must request special enrollment within **30 days** of the loss of other coverage.

Losing employment-based health coverage also gives an employee an opportunity to enroll in the Health Insurance Marketplace (Marketplace) that serves the state in which the employee resides. The employee or dependent must select Marketplace coverage within 60 days of the loss of other coverage, or will have to wait until the next open enrollment period.

If an employee or dependent chooses to elect COBRA, the employee or dependent will have another opportunity to request special enrollment in another group health plan or the Marketplace once COBRA is exhausted. In order to exhaust COBRA coverage, the individual must receive the maximum period of COBRA coverage available without early termination. An individual must request special enrollment within 30 days of the loss of COBRA coverage for coverage through another group health plan or select a plan within 60 days before or after the loss of COBRA coverage, for coverage through a Marketplace plan.

If an employee or dependent chooses to terminate COBRA coverage early with no special enrollment opportunity at that time, he or she will have to wait to enroll in other coverage until the next enrollment period for another group health plan or the Marketplace.

DURATION OF COBRA COVERAGE

COBRA requires that continuation coverage extends from the date of the qualifying event for a limited period of time of 18 or 36 months. The maximum length of time for which COBRA continuation coverage must be made available depends on the type of qualifying event that gave rise to COBRA rights. The following chart shows the maximum coverage period for each qualifying event:

Qualifying Event	Maximum Coverage Period
Termination of employment	18 months
Reduction of hours	18 months
Divorce or legal separation	36 months
Covered employee's death	36 months
Child's loss of dependent status under plan's terms	36 months
Entitlement to Medicare	36 months
Employer bankruptcy (for retirees and their dependents)	36 months

Early Termination of Coverage

A group health plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- ✓ Premiums are not paid in full on a timely basis;
- ✓ The employer ceases to maintain any group health plan;
- ✓ A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- ✓ A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- ✓ A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an **early termination notice**.

Extension of Coverage

There are two situations that can extend the 18-month maximum period of continuation coverage—the qualified beneficiary becomes disabled or a second qualifying event occurs.

Type of Extension	Length	Requirements	Who Qualifies
Disability	11-month extension (for a total of **29 months** of continuation coverage)	The Social Security Administration (SSA) determines that the qualified beneficiary is disabled before the 60th day of continuation coverage and the disability continues during the rest of the initial 18-month period of continuation coverage.	The qualified beneficiary with the disability and all of the qualified beneficiaries in the family
Second qualifying event	18-month extension (for a total of **36 months** of continuation coverage)	A second qualifying event occurs that is the death of the covered employee, the divorce or legal separation of the covered employee and spouse or loss of dependent child status under the plan. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the plan in the absence of the first qualifying event.	Qualified beneficiaries who are covered spouses and children

Disability Extension

Where a loss of coverage is a result of an employee's termination of employment (other than by reason of gross misconduct) or a reduction in hours and a qualified beneficiary is determined by the SSA to be disabled before, at or within 60 days of the date of the qualifying event, all qualified beneficiaries within that family are entitled to COBRA for a maximum period of **29 months**. The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11-month disability extension.

To be eligible for this disability extension, the disabled qualified beneficiary (or another person on his or her behalf) also must notify the plan of the SSA's determination. The plan can set a time limit for providing this notice of disability, but the time limit cannot be shorter than 60 days, starting from the latest of:

- The date on which the SSA issues the disability determination;
- The date on which the qualifying event occurs;
- The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or

A health plan's rules for how to provide a notice of disability and a notice of no longer being disabled should be described in the plan's COBRA election notice and its SPD.

- The date on which the qualified beneficiary is informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

The right to the disability extension may be terminated if the SSA determines that the qualified beneficiary is no longer disabled. The plan can require disabled qualified beneficiaries to provide notice when this type of determination is made. The plan must give the qualified beneficiaries at least 30 days after the SSA determination in which to provide this notice.

Multiple Qualifying Events

The maximum COBRA period may be extended for spouses and dependent children when a qualifying event that is a termination of a covered employee's employment or a reduction of hours (both of which trigger an 18-month maximum COBRA period) is followed by a **second qualifying event that has a 36-month maximum coverage period**. Qualifying events with a 36-month maximum coverage period include the death of the covered employee, a divorce from the covered employee or a dependent child's ceasing to be a dependent.

If a 36-month qualifying event occurs within the original 18-month maximum COBRA period (or 29-month maximum coverage period if there is a disability extension), the maximum COBRA period for the spouse and dependent children is extended from 18 months to 36 months, measured from the start of the original 18-month period. This extension for multiple qualifying events does not apply to covered employees.

Because most group health plans are prevented from terminating an employee's coverage due to his or her Medicare entitlement, Medicare entitlement will rarely constitute a second qualifying event that extends the maximum coverage period. Thus, an employee's entitlement to Medicare after terminating employment or retiring generally will not extend the maximum COBRA period for covered spouses and dependent children from 18 to 36 months.

The plan must have procedures for how a qualified beneficiary should provide notice of a second qualifying event. These rules should be described in the plan's COBRA election notice for any offer of an 18-month period of continuation coverage. The time limit for providing this notice generally cannot be shorter than 60 days from the date of the second qualifying event.

Special Rules for Medicare Beneficiaries

Although an employee's entitlement to Medicare will rarely be a COBRA qualifying event due to the Medicare secondary payer rules, it can extend the maximum COBRA coverage period for covered spouses and dependents if the employee has a termination or reduction in hours within 18 months after becoming entitled to Medicare. Under this rule, where the spouse or dependent is covered under the plan on the day before the employee's termination or reduction in hours, the spouse and dependent are entitled to COBRA coverage for the longer of:

- ✓ 18 months from the date of the employee's termination or reduction in hours; or
- ✓ 36 months from the date the employee became enrolled in Medicare.

This extension of coverage only applies to covered spouses and dependents; it does not apply to covered employees. Employees will remain eligible for 18 months of COBRA following the termination or reduction in hours.

> ***Example:*** Mary, an employee of ABC Company became entitled to Medicare on March 1, 2018. Mary retires on April 1, 2018, and elects COBRA coverage for herself and her spouse, John, under ABC Company's group health plan. Mary is entitled to 18 months of COBRA coverage from the date of her retirement. John is eligible for 36 months of COBRA coverage from the date of Mary's Medicare entitlement on March 1, 2018. Thus, Mary's maximum COBRA period would expire on Oct. 1, 2019, while John's maximum COBRA period would expire on March 1, 2021.

If the employee enrolls in Medicare after his or her termination or reduction in hours (for example, retirement), the employee loses COBRA continuation coverage. A spouse or dependent covered under the plan at the time of the termination or reduction in hours is entitled to 18 months of coverage from the date of the termination or reduction in hours.

COBRA PREMIUM RULES

Group health plans can require qualified beneficiaries to pay for COBRA continuation coverage, although plans can choose to provide continuation coverage at reduced or no cost. The maximum amount charged to qualified beneficiaries for COBRA coverage cannot exceed **102 percent of the cost to the plan for similarly situated individuals** covered under the plan who have not incurred a qualifying event.

For qualified beneficiaries receiving the 11-month disability extension, the COBRA premium for those additional months (months 19 through 29) may be increased to **150 percent** of the plan's total cost of coverage for similarly situated individuals. If the disabled qualified beneficiary is no longer covered under the plan (for example, the disabled individual becomes entitled to Medicare), the remaining qualified beneficiaries within the family are entitled to continue coverage for up to 29 months at an amount not to exceed 102 percent of the cost to the plan.

Typically, qualified beneficiaries pay for their COBRA coverage on an after-tax basis with a regular check, sent via mail to the plan sponsor. If a qualified beneficiary receives ongoing payments from an employer (such as separation pay), the qualified beneficiary may be eligible to pay for the cost of COBRA coverage on a pre-tax basis through the employer's cafeteria plan.

Determination Period

COBRA premiums must be established before a 12-month determination period. The determination period can be any 12-month period selected by the plan sponsor, but it must be applied consistently from year to year. Typically, the determination period is the plan year (for example, Jan. 1—Dec. 31 for a calendar year plan) or policy year for an insured benefit.

There cannot be a separate 12-month determination period for each qualified beneficiary. Rather, there must be a single 12-month determination period for all qualified beneficiaries who are covered under the same benefit package. An employer may apply different 12-month determination periods for different health plans or benefit packages. Different determination periods may be used, for example, if an employer has multiple medical benefit options (such as a preferred provider organization (PPO) and an HDHP) that have different renewal dates or policy years. In each situation, however, the 12-month determination period must be applied consistently from year to year.

During a determination period, COBRA premiums may only be increased in the following three cases:

1	COBRA premiums were set below the maximum amount permitted (for example, 102 percent of the plan's costs)
2	COBRA premiums increased to 150 percent of the plan's costs for a disability extension
3	The qualified beneficiary has changed his or her election (for example, from single to family coverage)

Methods for Determining Premiums

Neither COBRA nor its underlying regulations provide much guidance on how to determine the COBRA premium. Despite this lack of guidance, plan sponsors are expected to calculate COBRA premiums "in good faith compliance with a reasonable interpretation" of COBRA's requirements.

It is clear, however, that the premium is based on the total cost of coverage, which would include both the employer and employee portions. Also, if an employer offers more than one health benefit option (for example, a PPO and an HDHP) each option may have its own COBRA premium amount. The COBRA premium may also vary based on the type of coverage elected by the COBRA beneficiary—for example, self-only, employee plus spouse or family coverage—depending on the plan's rate structure for similarly situated individuals covered by the plan.

In general, the COBRA premium amount for **insured plans** is the **premium charged by the insurer**. Determining the COBRA premium amount for a self-insured plan is more difficult.

For a self-insured plan, the COBRA premium may be equal to either:

- A reasonable estimate of the cost of providing coverage, determined on an actuarial basis; or
- The cost to the plan for the preceding determination period (with a cost-of-living adjustment). This method may not be used if there has been a significant change in the coverage being offered under (or the number of employees covered by) the plan from the preceding determination period to the current determination period.

Payment Rules and Deadlines

Qualified beneficiaries must pay their COBRA premiums on a timely basis. A health plan may terminate a qualified beneficiary's COBRA coverage if premiums are not paid on time. A COBRA premium payment is made on the date that it is sent to the health plan. COBRA premiums may be paid by any third party on behalf of the qualified beneficiary. For example, a qualified beneficiary's new employer may pay COBRA premiums to the former employer on his or her behalf.

A plan sponsor must allow qualified beneficiaries to pay the required premiums on a monthly basis, and may allow payments at other intervals (for example, weekly or quarterly). Also, all of the necessary information about COBRA premiums, such as when they are due and the consequences of payment and nonpayment, should be described in the COBRA election notice.

Initial Premium Payment

Qualified beneficiaries cannot be required to pay a premium at the time they make the COBRA election. Plans must provide at least **45 days after the election** (that is, the date the qualified beneficiary mails the election form if using first-class mail) for making an initial premium payment. If a qualified beneficiary fails to make any payment before the end of the initial 45-day period, the plan can terminate the qualified beneficiary's COBRA rights.

The initial premium payment may be applied to the period of coverage beginning immediately after the date that coverage would have been lost. Also, plans can require that the initial premium cover more than one month of COBRA coverage. However, if the initial COBRA premium applies to multiple periods of COBRA coverage, plans need to make sure they are complying with the 30-day grace period rule described below.

Subsequent Premiums

Health plans may establish due dates for premiums after the initial premium payment. Typically, the due date for subsequent premiums is the first day of the month for a particular period of coverage (for example, June 1 for coverage during the month of June). Plans, however, must provide a **minimum 30-day grace period** for each payment. A premium payment does not need to be made until the end of the 30-day grace period.

A COBRA premium payment that is made at a later date is also considered timely if:

- Under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage for the period; or
- Under the terms of the arrangement with the insurance company, HMO or other entity that it pays for coverage, the employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Plans are permitted to terminate continuation coverage if full payment is not received before the end of a grace period. However, see below regarding a special rule that applies when premium payments are short by an insignificant amount. Also, a health plan is not obligated to send monthly premium notices, but it is required to provide a notice of early termination if continuation coverage is terminated early due to failure to make a timely payment.

Premium Shortfalls

A special rule applies if a qualified beneficiary makes a timely premium payment that is not significantly less than the amount that the health plan requires for a period of COBRA coverage. A COBRA premium payment is not significantly less than the plan's COBRA premium if the shortfall is not greater than the lesser of:

- ✓ $50; or
- ✓ 10 percent of the COBRA premium required by the plan.

A premium payment that is short by an insignificant amount will be deemed to satisfy the qualified beneficiary's payment obligation unless the plan notifies the qualified beneficiary of the shortfall and grants a reasonable amount of time to correct the deficiency. For this purpose, 30 days after the notice is provided is considered a reasonable amount of time.

SAMPLE NOTICES

Health plan sponsors may use the sample documents on the following pages to administer COBRA coverage and help satisfy their notice obligations under COBRA. These sample documents must be customized prior to being used. The following sample documents are provided:

- COBRA General Notice (DOL model)
- COBRA Election Notice (DOL model)
- Notice of Unavailability of COBRA Coverage
- Notice of Early Termination of COBRA Coverage and Conversion Rights

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

[*If the Plan provides retiree health coverage, add the following paragraph:*]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- [*add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE

(For use by single-employer group health plans)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

[*Enter date of notice*]

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

This notice has important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on [*enter date*] due to [*check appropriate box*]:

- ❍ End of employment
- ❍ Reduction in hours of employment
- ❍ Death of employee
- ❍ Divorce or legal separation
- ❍ Entitlement to Medicare
- ❍ Loss of dependent child status

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" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- ❍ Employee or former employee
- ❍ Spouse or former spouse

- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

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.

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.

If I 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*].

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of 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 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 continuation coverage.

For more information about extending the length of COBRA continuation coverage, visit http://www.dol.gov/ebsa/publications/cobraemployee.html.

How much does COBRA continuation coverage 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.*]

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided

to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about 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 Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa 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 Plan Administrator 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 Plan Administrator.

COBRA Continuation Coverage Election Form

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.

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'll 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. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed 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)

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

Important Information about Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact [*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due [*enter due day for each monthly payment*] for that coverage period. [*If Plan offers other payment schedules, enter with appropriate dates:* You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [*select one:* will *or* will not] send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period [*or enter longer period permitted by Plan*] to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. [*If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:* If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[*Enter appropriate payment address*]

NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

[Enter date of notice]

To: *[Identify the covered employee, qualified beneficiary or other individual]*

From: [*Plan Administrator]*

The Plan Administrator of the company's group health plan was notified on [*insert date*] of the occurrence of a COBRA qualifying event, a second COBRA qualifying event or a determination of disability by the Social Security Administration regarding a covered employee, qualified beneficiary or other individual. However, the Plan Administrator has determined that you and your dependents, if any, are NOT ENTITLED to COBRA continuation coverage of the company's group health benefits. Thus, your coverage under the company's group health benefits will terminate on [*insert date*].

The reason you are not entitled to COBRA continuation coverage is as follows:

[*Describe reason*]

If any of the individuals listed above does not reside at this same address, please immediately notify the Plan Administrator so that we may provide a copy of this notice to that individual.

Appeal Procedure

You may appeal this decision to deny your COBRA coverage if you believe your rights to COBRA continuation coverage have been improperly denied. The procedures to appeal this decision are as follows:

[*Describe appeal procedure for plan*.]

Other Coverage Options

You may have other coverage options available to you. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. More information on the Marketplace is available at: www.healthcare.gov. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Additional Information

Please contact the Plan Administrator immediately if you have questions about this notice or your COBRA rights. The Plan Administrator can be reached at [*insert contact information*].

NOTICE OF EARLY TERMINATION OF COBRA COVERAGE AND CONVERSION RIGHTS

[Enter date of notice]

To: *[Identify the qualified beneficiary]*

From: [*Plan Administrator]*

Effective [*insert date*], COBRA continuation coverage of your group health benefits will terminate. This termination is earlier than the end of the maximum period of COBRA continuation coverage that applies to your original qualifying event.

If any of the individuals listed above does not reside at this same address, please immediately notify the Plan Administrator so that we may provide a copy of this notice to that individual.

Reason for Early Termination of COBRA Coverage

Your COBRA continuation coverage is terminating before the end of the maximum coverage period due to [*check appropriate box*]:

- ☐ Coverage under another group health plan that does not limit or exclude pre-existing conditions of the individual
- ☐ Failure to pay required premium on time
- ☐ Termination of all company group health plans
- ☐ Eligibility for Medicare
- ☐ During a 29-month maximum coverage period based on disability, the Social Security Administration made a determination that the individual is no longer disabled
- ☐ Other [*describe other event*]

Conversion Rights

You may have the right to convert your group health benefits under COBRA to an alternative group or individual health insurance policy. The Plan Administrator can provide you eligibility information, enrollment forms and other information on your conversion rights. If you qualify for a conversion policy, you will have [*insert number of days*] to submit your insurance application and first premium once your COBRA coverage ends.

Appeal Procedure

Please notify the Plan Administrator as soon as possible if you believe the termination date of your COBRA coverage is inaccurate. You may request a review of this decision. The procedures to appeal this decision are as follows: [*Describe appeal procedure for plan*.]

Additional Information

Please contact the Plan Administrator immediately if you have questions about this notice or your COBRA rights. The Plan Administrator can be reached at [insert contact information].