# OptumHealth Financial Services, Inc. (OHFS) COBRA and Retiree Administrative Services

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Chapter 1 - Introduction

## Welcome to OptumHealth Financial Services, Inc. (OHFS) COBRA & Direct Bill Operations

Nearly every employer is faced with the need to provide continuation of benefits under COBRA. With OHFS COBRA administration services, we provide our customers with the expertise, superior customer service and vital tools needed to make COBRA compliance simple, easy and cost effective.

With more than twenty years of exceptional COBRA administration experience, OHFS is well versed in COBRA statute and regulations and successfully implementing revisions resulting from regulatory changes—saving our customers time and preventing unnecessary costs. According to the Employee Benefits Institute of America (EBIA), nine out of 10 employers are out of compliance with COBRA regulations with fines and penalties of up to $110 per day per infraction. Customers utilizing OHFS's COBRA services benefit from our sound practices and gatekeeper activities that mitigate risk of financial loss for non-compliance of COBRA laws.

OHFS's COBRA offering includes an easy-to-navigate Web site and issuance of all required notifications via first-class mail and proof of mailing per Department of Labor guidance. We assume all gatekeeper activities of processing enrollments and payments, allowing our customers to focus on their active population. Premiums are invoiced monthly, and payments can be made via check, money order, reoccurring automated clearinghouse (ACH) debit from a checking or savings account or a one-time payment via our Web site. Plans are updated weekly using "paid through" dates whenever possible, which curbs access to coverage when premiums are in arrears. Finally, our Web site provides customer access to reports, correspondence and participant look-up for an easy inquiry into COBRA activities.

OHFS is furnishing this guide to provide your organization with detailed, in-depth reference material to assist you with the compliance of the many facets of COBRA administration. We are confident you will find this manual a useful tool in working with us on your COBRA and Direct Bill administration.

Part of our effort to provide superior client support is to offer informative tools that assist you in utilizing our services. This document details how to fully leverage the depth of our services.

Sincerely,

Marlene Gordon

Marlene Gordon
Director, COBRA / Direct Bill Operations

Please Note:

- This Guide is for informational purposes only and does not bind OHFS to provide any specific services, absent an executed services agreement to that effect.
- This material is proprietary and is only offered to provide information regarding potential services. ***It should not be distributed***.
- OHFS retains the discretion to modify these policies and procedures as it deems appropriate.
- This GUIDE is not intended to provide legal advice. Customers should consult their own legal counsel.
- Nothing in this GUIDE should be construed as obligating OHFS to assume liability relating to an employer's obligations under applicable law.

## *Background and Summary of COBRA Law*

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires employers to offer certain individuals the right to continue group health coverage for a specific period at applicable group rates. These individuals have experienced a Qualifying Event, as defined in this handbook.

COBRA was signed into law on April 7, 1986, and allows eligible individuals the opportunity to pay for group health coverage for a specified period at applicable group rates when this coverage would otherwise end due to certain Qualifying Events. COBRA continuation coverage enables former Employees, and their families, who were covered under the group plan, to have continued access to the employer-sponsored health care during interim periods between jobs or coverage under another plan.

COBRA legislation amended the Internal Revenue Code (IRC), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHSA) to include provisions that require the continuation of health coverage. After the original enactment of COBRA, subsequent technical corrections and revisions were issued to amend and clarify the law.

Modifications to COBRA have been made through legislation, regulations, rulings, notices, procedures, and court cases, including but not limited to:

- Omnibus Budget Reconciliation Act of 1986 (OBRA ’86)
- Tax Reform Act of 1986 (TRA)
- Technical and Miscellaneous Revenue Act of 1988 (TAMRA)
- Omnibus Budget Reconciliation Act of 1989 (OBRA ’89)
- Omnibus Budget Reconciliation Act of 1990 (OBRA ’90)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA ’96)
- Small Business Job Protection Act of 1996 (SBJPA)
- IRS Proposed Regulations of 1998
- IRS Final Regulations of 1999
- IRS Proposed Regulations of 1999
- IRS Final Regulations of 2001
- IRS Final Regulations of 2002
- Trade Act of 2002
- IRS Final Regulations of 2004
- The American Recovery and Reinvestment Act of 2009 (ARRA)
- TAA Health Coverage Improvement Act of 2009

## *Summary of Requirements*

Generally, COBRA law requires employers to offer continuation of group health plans to individuals who lose coverage as a result of certain "Qualifying Events" (e.g., termination of employment, reduction in work hours, divorce, legal separation, Employee death, Employee Medicare entitlement, and loss of dependent status). The law defines a "group health plan" as any plan maintained by an employer or Employee organization to provide health care to individuals who have an employment-related connection to the Employee or Employee organization or to their families.

This includes any employer-sponsored medical, dental, vision or prescription drug program. In addition, group health plans subject to COBRA include certain health flexible spending accounts, mental health plans, drug or alcohol treatment programs, employee assistance plans (EAPs) intended to relieve or alleviate a physical condition or health problem, chiropractic programs and any self-insured arrangements that provide similar benefits. One or more individual insurance policies may constitute a group health plan if the arrangement involves the provision of health care to two or more Employees.

Individuals eligible for COBRA continuation coverage are referred to as "Qualified Beneficiaries." An Employee, spouse or child can become a Qualified Beneficiary by virtue of participating in the group health plan on the day before a Qualifying Event. In addition, any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation is a Qualified Beneficiary when added within the designated period allowed by the plan.

Employers must offer Qualified Beneficiaries the opportunity to have separate election rights and be allowed to pay for the same coverage they had prior to the event. Qualified Beneficiaries must be given essentially the same rights as active Employees with respect to Annual/Open enrollment periods, plan or benefit changes, and adding or deleting Dependents, if and when such rights are afforded to active Employees.

## Employers Subject to COBRA

An employer is subject to COBRA if it maintains a group health plan for a calendar year and employed 20 or more employees on at least 50 percent of the typical business days in the previous calendar year. Employers must determine what their typical business days are for COBRA purposes. Church plans, governmental plans and small employer plans (see "Small Employer Exception" below) are exempt from COBRA.

Both full-time and part-time employees are considered "Employees" for purposes of this rule regardless of whether they are eligible for coverage under the employer's group health plan. However, under the 1999 final IRS regulations, an employer is only required to count common-law employees when determining whether they meet the 20-employee requirement. Thus, for

purposes of the small employer exception only, self-employed individuals, agents, independent contractors (i.e., "1099 employees") and corporate directors are not treated as employees and need not be counted. Employers must, however, still aggregate employees from all divisions, subsidiaries and any other entities that make up a controlled group of corporations. In general, a controlled group of corporations may consist of a parent-subsidiary controlled group, brother-sister controlled group, or a combined group as defined under Internal Revenue Code Section 414b.

In addition, under the 2001 final IRS rules, a part-time employee may be counted as a fraction of a full-time employee, with the fraction equal to the number of hours the part-time employee works divided by the number of hours an employee must work in order to be considered a full-time employee, not to exceed 40 hours per week. Under these same rules, employers are also permitted to use daily or pay period methods of counting.

## *Small Employer Exception*

Small employer plans are not subject to COBRA. An employer meets COBRA's "small employer" exception if it maintains a group health plan for a calendar year and normally employed fewer than 20 employees during the preceding calendar year.

Based on the employee count of the previous calendar year, a company retains the status of being exempt from or subject to COBRA for the duration of 12 months beginning January 1. For example, to determine COBRA status for 2012, a company would review its employee work force data during the "look back" period of calendar year 2011. If it was determined that the plan is exempt from COBRA, continuation coverage would not need to be offered for Qualifying Events that occur for 12 months beginning January 1, 2012.

However, if a plan that has been subject to COBRA (that is, was not a small employer plan) becomes a small employer plan, the plan must honor its continuation coverage obligations for Qualifying Events that occurred during the period when the plan was subject to COBRA. The employer is required to continue COBRA coverage for these Qualified Beneficiaries until the end of the entire coverage period (18, 29, or 36 months), including any applicable extensions (e.g., secondary Qualifying Events, Social Security disability, etc.)

Due to the variables involved with calculating group size and aggregating employees under common ownership, OHFS is not responsible for annually monitoring the company's need for COBRA compliance.

## *Penalties for Non-Compliance*

Federal agencies responsible for enforcing COBRA provisions are the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services.

Penalties for COBRA noncompliance are extremely severe. Non-compliance penalties are summarized as follows:

1. The penalty for failure to comply with COBRA is a $110 excise tax per day of non-compliance per individual (or $200 per day per family, maximum). The period of non-compliance begins on the date the failure first occurred and ends on the earlier of:
   A. The date the failure is corrected, or
   B. The date six months after the employer's responsibility to provide continuation of coverage ended.
2. This penalty would be waived if the violation were proven to be unintentional and corrected within 30 days.
3. Violations discovered by the Internal Revenue Service that are not corrected before the employer receives notice of an IRS audit are subject to the lesser of:
   A. A $2,500 penalty per affected beneficiary, or
   B. The excise tax (described above) that would be due based on the length of the violation.
4. For violations discovered by the IRS considered more than "de minims" (i.e., more than trivial), employers are subject to a $15,000 fine instead of $2,500.
5. The maximum annual penalty is the lesser of:
   A. $500,000, or
   B. 10% of the employer's prior-year health care costs.
6. In addition to the IRS penalties above, ERISA penalties also apply. Because Employees, Qualified Beneficiaries, or the Secretary of Labor may sue to enforce under ERISA, Plan Administrators may be subject to a $110 per day penalty for refusal to comply with a request for information regarding coverage requirements (i.e., failure to provide notice of COBRA rights).

## *COBRA Lawsuits*

Perhaps what is more likely than an IRS audit is the threat of lawsuits filed against employers by former employees and dependents. The number of COBRA lawsuits increases every year. These court cases often bring insight and clarity to ambiguous COBRA issues, but not without great costs to the company being sued. Judgments in favor of Qualified Beneficiaries have left employers responsible for huge sums in unpaid medical expenses and attorney fees.

# Chapter 2: COBRA continuation Coverage Guidelines

## *Introduction*

COBRA continuation coverage involves both statutes and regulations. At a minimum, you should be familiar with general COBRA provisions and concepts in order to understand OHFS's administrative procedures.

This section provides a brief explanation of who is entitled to COBRA continuation, what events trigger COBRA eligibility and how long an individual can maintain COBRA continuation coverage.

## *Qualified Beneficiaries*

In general, an individual is considered a Qualified Beneficiary eligible for COBRA continuation coverage if he or she was covered under an employer-sponsored group health plan on the day before a Qualifying Event. A Qualified Beneficiary can be a covered Employee, spouse or a child of the covered Employee. In addition, any child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage is also considered a Qualified Beneficiary when added within the designated period allowed by the plan.

### Employees

An Employee can be a Qualified Beneficiary if he or she had group health plan coverage, by virtue of employment with the employer, on the day before a Qualifying Event. In addition, a retiree or former Employee may also be a Qualified Beneficiary if this individual has coverage with a group health plan that results in whole or in part from his or her previous employment.

An Employee who declines group health coverage when he or she is eligible for plan participation or an Employee who voluntarily requests coverage termination from the plan, in effect, waives any COBRA continuation rights upon a subsequent Qualifying Event.

### Spouses

A covered spouse can be a Qualified Beneficiary if he or she is married to a covered Employee on the day before a Qualifying Event.

In contrast, an individual who marries a Qualified Beneficiary after a Qualifying Event and is

added to COBRA continuation coverage as a new spouse is not considered a Qualified Beneficiary. This individual may receive COBRA continuation coverage only as a covered dependent.

NOTE: A covered spouse whose coverage is voluntarily terminated at Annual/Open enrollment does not experience a COBRA Qualifying Event and need not be offered continuation coverage.

## Dependents

A covered child can be a Qualified Beneficiary if he or she is a covered child of a covered Employee on the day before a Qualifying Event. In addition, a child born to or placed for adoption with a covered Employee during a period of COBRA continuation is deemed to be a Qualified Beneficiary. In such case, the newborn or adopted child must be added as a dependent within the period allowed by the plan and is entitled to COBRA continuation for the remainder of the applicable coverage period measured from the date of the original Qualifying Event.

## Individuals who have other coverage

An individual covered under another group health plan or Medicare at the time he or she elects COBRA is a Qualified Beneficiary and cannot be denied COBRA continuation coverage. These Qualified Beneficiaries may choose COBRA as long as the other group health plan coverage existed prior to their COBRA election date.

## Domestic Partners and Domiciled Adults

COBRA law is clear in its definition of “Qualified Beneficiary” that entitlement to continuation coverage is limited to covered Employees, their spouses and children. However, some employers design their group health plans to enable domestic partners and/or domiciled adults (non-minor individuals, usually an elderly parent, who resides with the covered Employee) to be covered under the plan. When these individuals are eligible for coverage under an employer’s group health plan, the question arises as to whether they should also have COBRA continuation coverage rights.

Federal statute does not recognize a domestic partner as a “spouse of the covered Employee” or a domiciled adult as a “Dependent child of an Employee.” Therefore, COBRA continuation coverage is not required under federal law for these individuals. If the plan wishes to offer non-COBRA continuation coverage that would extend coverage for domestic partners or domiciled adults beyond the time when coverage would otherwise end (i.e., due to employment termination, Employee death, etc.), we suggest you consult your legal counsel.

## *Qualified Events*

A Qualifying Event is any of a set of specified events that occurs while a group health plan is subject to COBRA and that causes a covered Employee (or the spouse or child of the covered Employee) to lose coverage under the plan. There are Qualifying Events that affect Employees, spouses and dependents.

### Employees

For a covered Employee, Qualifying Events include:

- The voluntary or involuntary termination of employment with the company, except for reasons of gross misconduct (see "Gross Misconduct" below),
- A reduction in hours of employment resulting in a loss of group health benefits (e.g., strikes, layoffs, workers compensation, leaves of absence**).

** Please see "Employer Paid Alternative Coverage" and "Family Medical Leave Act (FMLA)".

### Spouses

For a covered spouse, Qualifying Events include:

- The voluntary or involuntary termination of the Employee's employment with the company, except for reasons of gross misconduct (see "Gross Misconduct" below),
- A reduction in hours of the Employee's employment resulting in a loss of group health benefits (e.g.,
- Death of covered employee
- Divorce or legal separation between the covered employee and spouse
- Employee's entitlement to Medicare benefits

### Dependents

- The voluntary or involuntary termination of the Employee's employment with the company, except for reasons of gross misconduct (see "Gross Misconduct" below),
- A reduction in hours of the Employee's employment resulting in a loss of group health benefits (e.g.,
- Death of covered employee
- Divorce or legal separation between the covered employee and spouse
- Employee's entitlement to Medicare benefits
- Loss of dependent child status as defined by the plan

## *Life Events*

A Life Event is an event that causes coverage (active or COBRA) to change. The Participant's Life Events must also be communicated to OHFS. The following Life Events can cause active or COBRA coverage to change:

- Birth/Adoption
- Marriage
- Divorce/Legal Separation (where legally recognized)
- Dropping/Adding Coverage
- Death of Dependent
- Change in Employee's employment status

## *Gross Misconduct*

COBRA provides that employers are not obligated to offer continuation coverage when an Employee is terminated for reasons of gross misconduct. However, there are several reasons why employers should use extreme caution before exercising this provision of the law. .

Please consult your legal counsel for guidance if the company plans to exercise the gross misconduct rule under COBRA.

## *Plans and Benefits Subject to COBRA*

Under the final regulations, a "group health plan" subject to COBRA is any plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employee or employee organization or to their families. This includes any employer-sponsored medical, dental, vision or prescription drug program.

In addition, group health plans subject to COBRA include certain health flexible spending arrangements (FSA), health reimbursement arrangements (HRA), mental health plans, drug or alcohol treatment programs, employee assistance plans (EAPs) intended to relieve or alleviate a physical condition or health problem, chiropractic programs and any self-insured arrangements that provide similar benefits. One or more individual insurance policies may constitute a group health plan if the arrangement involves the provision of health care to two or more employees.

### *Election Period*

When a Qualifying Event occurs, a Qualified Beneficiary has a 60-day election period during which continuation coverage can be chosen. This election period begins on the later of: (1) the date coverage is lost due to the Qualifying Event (2) the date the COBRA election notification is provided to the Qualified Beneficiary, or (3) the date on which the Qualified Beneficiary is informed of his or her obligation to provide notice.

### *Other Coverage Prior to COBRA Election*

The final regulations provide that a Qualified Beneficiary retains COBRA rights when other group health coverage or Medicare exists, so long as the individual had that coverage before the COBRA election date.

### Separate Election Rights

A group health plan must offer each Qualified Beneficiary the opportunity to make an independent election to receive COBRA continuation. This requirement also applies to any child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. (An election for a minor child may be made by the child's parent or legal guardian.)

Thus, if there is a choice among types of coverage under the plan, each Qualified Beneficiary is entitled to make a separate election among such types of coverage. For example, if an Employee had family medical and dental coverage as an active Employee, upon a COBRA Qualifying Event he may decline COBRA for himself and elect continuation coverage for only his spouse. Moreover, Qualified Beneficiaries have the same rights as active Employees with respect to Annual/Open enrollment, plan or benefit changes, and adding or deleting Dependents.

### Duration of Continuation Coverage Periods

In general, a Qualified Beneficiary may continue group health coverage under COBRA for up to 36 months unless the Qualifying Event is due to employment termination or a reduction in hours of employment. In such case, the maximum continuation coverage period is 18 months. Qualified Beneficiaries for this purpose include the terminated Employee and the Employee's spouse and Dependent children who were covered on the plan on the day before the termination, and children born to or placed for adoption with a covered Employee during the Continuation Period.

## *18-Month Qualifying Events*

- Voluntary termination of employment, including retirement
- Reduction in hours
- Layoff
- Involuntary termination (except for termination due to gross misconduct)
- Bankruptcy (Retirees Only)

## *Extension of Continuation Coverage Periods*

An 18-month COBRA continuation coverage period may be extended to 29 or 36 months, respectively, if a Qualified Beneficiary: (1) is disabled (as determined by Social Security Administration) at any time during the first 60 days of COBRA continuation coverage, or (2) has a secondary Qualifying Event during an original 18-month continuation coverage period or 29-month disability extension period.

### Social Security Disability Extension

As amended by HIPAA, COBRA continuation coverage can be extended from 18 to 29 months if an individual was determined (under Title II or XVI of the Social Security Act) to have been disabled at any time during the first 60 days of COBRA continuation coverage. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption.

The disabled individual may be any Qualified Beneficiary (former Employee, spouse or Dependent) who became eligible for COBRA continuation due to an Employee's termination or reduction in hours of employment. Furthermore, the disability extension applies to each Qualified Beneficiary who is not disabled as well as to the disabled Qualified Beneficiary.

To qualify for the extension, written notice in the form of a copy of the Social Security Administration determination letter must be provided to OHFS within 60 days after the date the determination is issued and before the end of the original 18-month continuation coverage period.

The statute does not specifically address circumstances when a Social Security disability determination is obtained prior to a COBRA Qualifying Event date. When this occurs, it is OHFS policy to accept notification of the disability if it is made by the end of the COBRA Election Period. Of course, any disability notification requirement on the part of a Qualified Beneficiary can only be enforced if the individual has been previously so advised through written materials such as the Initial COBRA Rights Notification (General Notice) and COBRA

Election Notice.

The 29-month disability extension can be further expanded to a period of up to 36 months (measured from the original Qualifying Event or loss of coverage date) when a secondary Qualifying Event occurs such as Employee death, divorce or legal separation, Medicare entitlement or cessation of Dependent status (see below). The timing of the second Qualifying Event, in relationship to the disability extension, can affect the applicable premium that may be charged to a Qualified Beneficiary or family unit (see "Premiums during Disability Extension" below). Additionally, the Plan Administrator must be notified within 30 days after the individual is determined to be no longer disabled. In such case, coverage for all Qualified Beneficiaries ends with the first month beginning more than 30 days after the Social Security Administration determination or, if later, at the end of 18 months of continuation coverage.

## *Process: Disability Extension*

Description: Following is the process followed when Participants request to continue coverage after initial COBRA eligibility period ends due to a disability extension.

### Secondary Qualifying Event Extension

The length of continuation coverage may be expanded from 18 (or 29 months for disability extensions) to 36 months if a second Qualifying Event (e.g., divorce, legal separation, Employee death, Employee Medicare entitlement, loss of Dependent child status) occurs during the original continuation coverage period. An expanded 36-month continuation coverage period is measured from the original Qualifying Event and applies to any spouse or Dependent who is a Qualified Beneficiary.

To receive the extension, a Qualified Beneficiary must notify OHFS in writing within 60 days of the second Qualifying Event and within the original 18- or 29- month coverage period.

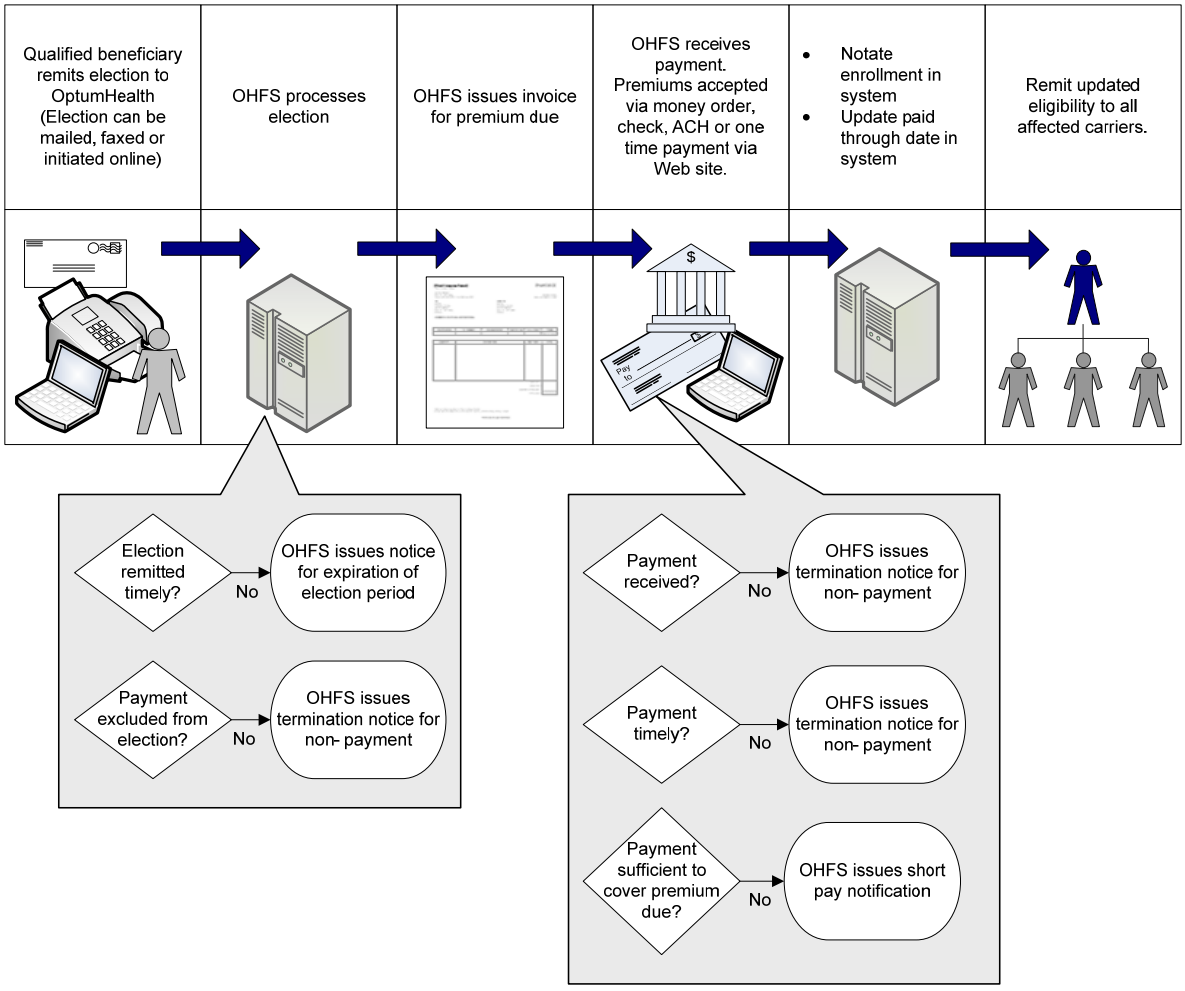
In no event does COBRA continuation coverage last beyond three years from the date of the event that originally made a Qualified Beneficiary eligible to elect coverage. The final regulations stipulate that an Employee who obtains COBRA coverage due to a reduction in hours cannot subsequently be entitled to extend this coverage to 36 months if the individual is later formally terminated or officially resigns from the company. Thus, a reduction in hours followed by termination of employment is not a secondary Qualifying Event for COBRA purposes.

Pursuant to I.R.S. Rev. Rul. 2004-22, the Medicare entitlement of a covered Employee is not a second Qualifying Event unless, in the absence of the first Qualifying Event, the 36-month event would result in a loss of coverage for the Qualified Beneficiary under the plan within the maximum coverage period.

## Premiums for Continuation Coverage

During a standard 18 or 36-month continuation coverage period, COBRA allows an employer to charge up to 102% of the "applicable premium." For purposes of COBRA, the "applicable premium" is the cost to offer the plan to a similarly situated non-COBRA Participant.

A Qualified Beneficiary has the right to pay for COBRA continuation coverage in monthly installments. The first payment for COBRA continuation coverage cannot be applied prospectively. Instead, it is applied to the period of coverage beginning immediately after the date that coverage under the plan would have been lost due to the Qualifying Event.




## Premium Due Dates

A Qualified Beneficiary has 45 days after the date on which the Qualified Beneficiary elected COBRA to make an initial payment. Thereafter, group health plans must allow Qualified

Beneficiaries to make monthly premium payments. Semi-annual, quarterly, and weekly payments are permissible, but not required. COBRA premiums are subject to a 30-day Grace Period, but plans may be more lenient.

In the event that a Qualified Beneficiary makes a premium payment that is short by the lesser of $50 or 10% of the required premium amount, the final regulations require that the Qualified Beneficiary be allowed a 30-day safe harbor period to pay the required premium. For example, if the required COBRA premium payment is $510, and the payment received is deficient by $51 (exactly ten percent of the premium), the Qualified Beneficiary would not be entitled to the 30-day safe harbor period because the shortfall exceeds the stipulated $50 cutoff by one dollar, even though the premium shortfall is within 10% of the premium. Our system generates these premium shortfall notifications to Qualified Beneficiaries on a daily basis to keep the length of the payment period to a minimum.

Description: Process followed should a Participant remit an insignificant premium payment.

| | Step | Timing | Responsible Party | | | |
|---|---|---|---|---|---|---|
| | | | EE | OHFS | Client | Carrier |
| 1. | Participant remits premium that is short by an “insignificant” amount. | | √ | | | |
| 2. | OHFS processes payment | Within 48 hours of receipt | | √ | | |
| 3. | A notice is mailed to the participant explaining the balance due and due date by which to pay | Within 48 hours of processing the payment | | √ | | |
| 4. | If the remaining balance is not received by the end of the grace period, the participant is cancelled retroactively back to the most current paid-thru date | 30 days from the due date | | √ | | |
| 5. | OHFS sends a cancellation notice to the participant’s last know address | Within 48 hours of processing the termination | | √ | | |

If the payment meets the 90%/$50 rule, OHFS will mark the payment as acceptable. If the payment does not meet the 90% / $50 rule, the Participant may remit remaining payment if they are still in their Grace Period.

## Premiums during Disability Extension

In the case of a disability extension, the plan can charge up to 150% of the "applicable premium" during the 11 months of the extension (months 19 through 29) when the disabled individual is part of the coverage group. If only non-disabled Qualified Beneficiaries are in the coverage group, 102% of the applicable premium would apply.

A disability extension coupled with a secondary Qualifying Event can affect COBRA premiums differently depending upon the timing of the second Qualifying Event in relationship to the original 18-month COBRA continuation coverage period.

For example, assume that an Employee, spouse and disabled child obtain 18 months of COBRA coverage due to employment termination. Assume further that the family becomes entitled to a disability extension due to the child's disability. (Timely notification of the disability is made to the plan.) Within the original 18 months of COBRA coverage, the Employee and spouse are divorced. (The law allows the spouse and Dependent child to expand COBRA coverage for a total of 36 months.) The plan cannot require more than 102% of the applicable premium for the entire COBRA continuation coverage period, regardless of the disability.

In contrast, suppose the divorce occurred during the 24th month of COBRA coverage (applied toward the period of disability extension). The spouse and disabled child are still entitled to expand COBRA continuation from 29 to 36 months due to the second Qualifying Event. However, as long as the disabled child remains on the plan, the Qualified Beneficiaries may be charged up to 150% of the applicable premium from months 19 through 36 of COBRA coverage

## Third Party Premium Payments

As discussed above, the employer can require payment for continuation coverage. However, the law does not require premium payments to be made only by the Qualified Beneficiary covered by the plan. In fact, the 1999 final regulations intentionally exclude any reference as to who must make a required premium payment. Thus, it can be implied that any person (or entity) may make a COBRA payment on behalf of a Qualified Beneficiary.

An active Employee, hospital or health care provider, new employer, or state Medicaid program are each a potential source for third party payment of COBRA premiums on behalf of a Qualified Beneficiary. For example, a divorce decree may require an active Employee to

provide health care coverage for a specified period to his or her ex-spouse. It is also possible that a hospital or health care provider may choose to pay for COBRA premiums to make certain that coverage exists for a Qualified Beneficiary's medical expenses. Additionally, it is feasible that a Qualified Beneficiary may negotiate a new employer to pay for COBRA premiums during a probationary or eligibility period required by the new plan. Furthermore, a Qualified Beneficiary may be entitled to certain state-run programs in which Medicaid agencies pay for the cost to maintain COBRA premiums.

In any of these examples, it is important to stress that the Qualified Beneficiary has ultimate responsibility for maintaining desired COBRA continuation coverage, even if a third party fails to make a timely payment. Therefore, unless a Qualified Beneficiary is in regular contact with its designated third party to assure that timely payment has been made, it is possible for a COBRA Participant's coverage to end unknowingly and without recourse. Qualified Beneficiaries should be mindful of these risks when arrangements for third party COBRA premiums are made.

## Determination Period

By law, an employer must establish a 12-month determination period to be applied consistently from year to year. Generally, the applicable premium must be calculated and fixed by a group health plan before the 12-month determination period begins. The determination period is a single period for any benefit package. During a determination period, a plan can increase the amount it requires for continuation coverage only in the following three cases:

1. The plan has previously charged less than the maximum amount permitted and the increased amount required to be paid doesn't exceed the maximum amount permitted; or
2. The increase occurs during a disability extension and the increased amount required to be paid does not exceed the maximum amount permitted; or
3. A Qualified Beneficiary changes the coverage being received.

Whenever a plan allows a similarly situated active Employee to change coverage (such as during Annual/Open enrollment or under special enrollment rules), the plan must allow each Qualified Beneficiary to change coverage on the same terms as similarly situated active Employees. As a result of certain changes to coverage, the applicable premium may be affected. For example, a shift from one benefit package to another benefit package, or adding or eliminating family members from the plan, may cause the applicable premium to be increased or decreased. The statutory guidelines allow for changes in premium related to a change in coverage to be passed on to Qualified Beneficiaries without regard to any determination period.

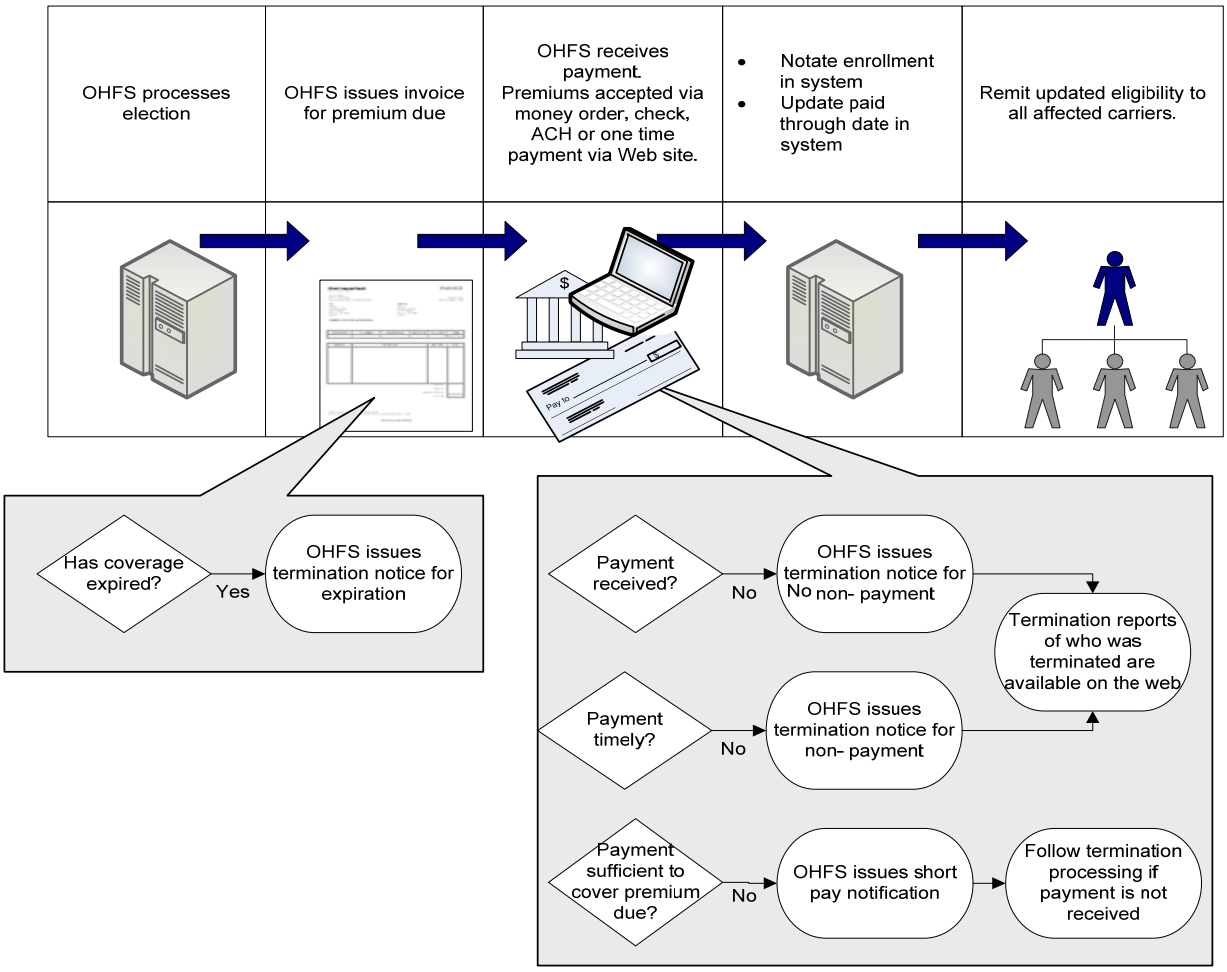
## Retiree Coverage

### Enrollment in Retiree Coverage

Eligibility for enrollment into retiree coverage is determined and managed by OHFS. OHFS is notified of the enrollment and eligibility for retiree coverage. Once the enrollment is processed, the participant is sent an invoice for the premium due on a monthly basis.

If the payment is not received when due or if the payment received does not pay the invoice in full, a late payment notice or partial payment notice is sent to the participant notifying them of the potential of termination if payment is not received in a timely basis.

If the late payment or the balance of the payment due is not received by the end of the established grace period, the termination processing will be invoked.



## Termination of Retiree Continuation

The Client provides approval for Retiree continuation coverage can be terminated or canceled upon the earlier of:

- A written request for termination made by the participant,
- Late or non-payment of premium,
- Employer elimination of group health benefits (including successor plans),
- Participant obtains other group health coverage, after the date of Retiree election or,
- Participant becomes entitled to Medicare, after the date of Retiree election.

Description: Termination of coverage due auto-term for non-payment.

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | Monthly invoices sent to the participant including any amount due. | 10th of each month | | √ | | |
| 2. | Participant receives the invoice but no payment is made within the 30 grace period | By end of 30 day grace period | √ | | | |
| 3. | Waiting period for mail time | 6 mail days are allowed to receive payment post marked within grace period | | √ | | |
| 4. | If no payment was received, system will automatically terminate coverages, retroactively to previous paid date | 7th mail day | | √ | | |
| 5. | Termination notification is sent to the carrier | Daily for UnitedHealthcare<br><br>Based on pre agreed upon schedule for all other carriers | | √ | | √ |
| 6. | Termination notification sent to participant advising of retroactive termination | 7th mail day | √ | √ | | |

Description: Employer elimination of group health benefits (including successor plans) or Participant obtains other group health coverage, after the date of Retiree election

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | Monthly invoices sent to the participant including any amount due. | 10th of each month | | √ | | |
| 2. | Participant receives the invoice | Payment to be received by end of 30 day grace period | √ | | | |
| 3. | Participants receives an end of eligibility notice | 60 prior to end of eligibility | √ | √ | | |
| 4. | Termination notification sent to participant advising of termination | Last day of coverage | √ | √ | | |
| 5. | Termination notification is sent to the carrier | Daily for UnitedHealthcare<br><br>Based on pre agreed upon schedule for all other carriers | | √ | | √ |

Description: Termination of coverage due to request.

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | Monthly invoices sent to the participant including any amount due. | 10th of each month | | √ | | |
| 2. | Participant receives the invoice | Payment to be received by end of 30 day grace period | √ | | | |
| 3. | Participant request in writing to be terminated from coverage(s) | Processed within 5 business days | √ | √ | | |
| 4. | Termination notification sent to participant advising of termination | Last day of coverage | √ | √ | | |

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 5. | Termination notification is sent to the carrier | Daily for UnitedHealthcare<br><br>Based on pre agreed upon schedule for all other carriers | | √ | | √ |

Description: Termination of coverage due Qualified Beneficiary becomes entitled to Medicare, after the date of Retiree election requested termination.

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | Monthly invoices sent to the participant including any amount due. | 10th of each month | | √ | | |
| 2. | Participant receives the invoice | Payment to be received by end of 30 day grace period | √ | | | |
| 3. | Participant request in writing to be terminated from coverage(s) | Processed within 5 business days | √ | √ | | |
| 4. | Termination notification sent to participant advising of termination | Last day of coverage | √ | √ | | |
| 5. | Termination notification is sent to the carrier | Daily for UnitedHealthcare<br><br>Based on pre agreed upon schedule for all other carriers | | √ | | √ |

## Reinstatement of Retiree Coverage

Description: Process if a Participant requests reinstatement of coverage due to cancellation.

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | The Participant sends in a written request to appeal for reinstatement coverage. | Within 180 days from original termination date. | √ | | | |
| 2. | Upon receipt, the document is date stamped and scanned into the Participant's record. | Within 48 hours of receipt | | √ | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3. | The request is sent to The Client for review. | Within 48 hours of receipt | | √ | √ | |
| 4. | An appeal review is completed based on Participant's written request and the information in the system | Within 72 hours of receipt | | | √ | |
| 5. | If there was not an administrative error and all information was processed correctly, a denial letter is sent to the participant | Within 10 business days. | | | √ | |
| 6. | If the appeal is approved the Participants account is reinstated with an appeals extension date for payment. | Within 10 business days | | | √ | |
| 7. | The Participant is sent an approval notice that includes the amount the Participant owes | Within 10 business days | √ | | √ | |

## *Employer Paid Alternative Coverage*

Alternative coverage is any coverage made available to an individual concurrently or in place of COBRA continuation coverage. In general, a (non-FMLA) leave of absence is treated as a COBRA Qualifying Event due to an Employee's reduction in hours of employment. If elected, COBRA continuation begins on the date coverage is lost following commencement of any leave. However, some employers are mandated by industry practice, a collective bargaining agreement or company policy to contribute toward health coverage during a leave of absence or severance agreement. (See also "Severance Agreement Arrangements" below.)

As a rule, if alternative coverage being offered is less than that which the Employee had prior to the leave of absence (or other reduction in hours situation), the Employee should be offered the opportunity to elect COBRA continuation at the same time. If the Employee chooses the lesser alternative coverage instead of COBRA continuation, the employer need not offer COBRA continuation again at the end of that alternative coverage.

However, if alternative coverage being offered is identical to or better than that which the Employee had prior to the leave, the law allows the employer to either:

- Apply the period of identical alternative coverage toward part of the COBRA continuation coverage period, or
- Treat the period of identical alternative coverage separately from COBRA continuation coverage.

An employer that chooses the latter would in effect extend the length of time an individual remains on the group health plan by starting the COBRA coverage period after alternative coverage. In either case, it is prudent to clearly describe the alternative coverage policy in the Summary Plan Description (SPD) and to notify the insurance Carrier any time alternative coverage begins to achieve full disclosure with the plan.

Please note that OHFS can assume billing and collection responsibilities only when the period of alternative coverage is applied toward the period of COBRA continuation coverage.

### Severance Agreement Arrangements

Generally, individuals who receive group health plan benefits as part of a severance agreement arrangement are no longer active Employees with the company. As a provision of many benefit contracts, insurance companies stipulate that as a condition for eligibility, covered individuals must be affiliated with the employer by virtue of active employment or through COBRA continuation coverage.

Failure to properly disclose individuals who have separated from service with the company and remain on the plan could result in undesirable complications with the plan. For this reason, it should be standard procedure in a severance agreement situation for employers to make both the former Employee and insurance Carrier aware of whether the severance agreement arrangement is to be made a part of or separate from COBRA continuation coverage.

Where the severance agreement arrangement and COBRA continuation coverage run concurrently, the Qualified Beneficiary should be provided a COBRA election notice. Of course, the terms of the severance agreement arrangement would govern the method and form of premium payments (e.g., employer-subsidized premiums) for the period of severance.

Different rules apply for leaves defined under the Family and Medical Leave Act of 1993 (see “The Family and Medical Leave Act (FMLA)” in Chapter 3).

## *Voluntary Termination of Health Coverage*

An Employee with family coverage can request plan coverage to be terminated for his or her spouse or Dependent. This request could be due to financial necessity or a result of the spouse or Dependent obtaining other health coverage. Typically, this is a voluntary action on the part of the Employee to end coverage and is not in connection with a COBRA Qualifying Event. Therefore, the employer is generally not required to offer continuation coverage when plan coverage ends because of a voluntary request. However, under HIPAA requirements, this loss of coverage would trigger a Certificate of Creditable Coverage to be issued by the plan.

(Remember that, in general, COBRA continuation must only be offered to Qualified Beneficiaries who were covered on the day before a Qualifying Event.)

Consequently, the possibility exists that an Employee could intentionally request coverage to be terminated for a spouse in anticipation of a future Qualifying Event such as divorce or legal separation. In such a case, termination of coverage could occur without knowledge or consent of the spouse (or Dependent) whose coverage is affected. Similarly, an employer may intentionally reduce or terminate plan coverage from an Employee in anticipation of the employment termination. In both examples, the Qualified Beneficiary would technically cease to have COBRA rights because he or she was not covered "on the day before the Qualifying Event." However, a provision of COBRA law protects continuation coverage rights when coverage is lost or reduced "in anticipation of" a future Qualifying Event.

As with the 1987 proposed regulations, the 2001 final regulations provide that any reduction or elimination of coverage in anticipation of an event is "disregarded in determining whether the event results in a loss of coverage." In other words, a plan is required to make COBRA continuation coverage available, effective on the date of the Qualifying Event (e.g., termination, divorce or legal separation), but not for any period before the Qualifying Event date. Of course, continuation coverage is conditioned upon a Qualified Beneficiary's timely notification of the Qualifying Event (by law, the later of, 60 days from the loss of coverage, 60 days from the Qualifying Event date, or 60 days from the date on which the Qualified Beneficiary is informed of his or her obligation to provide notice) to the employer.

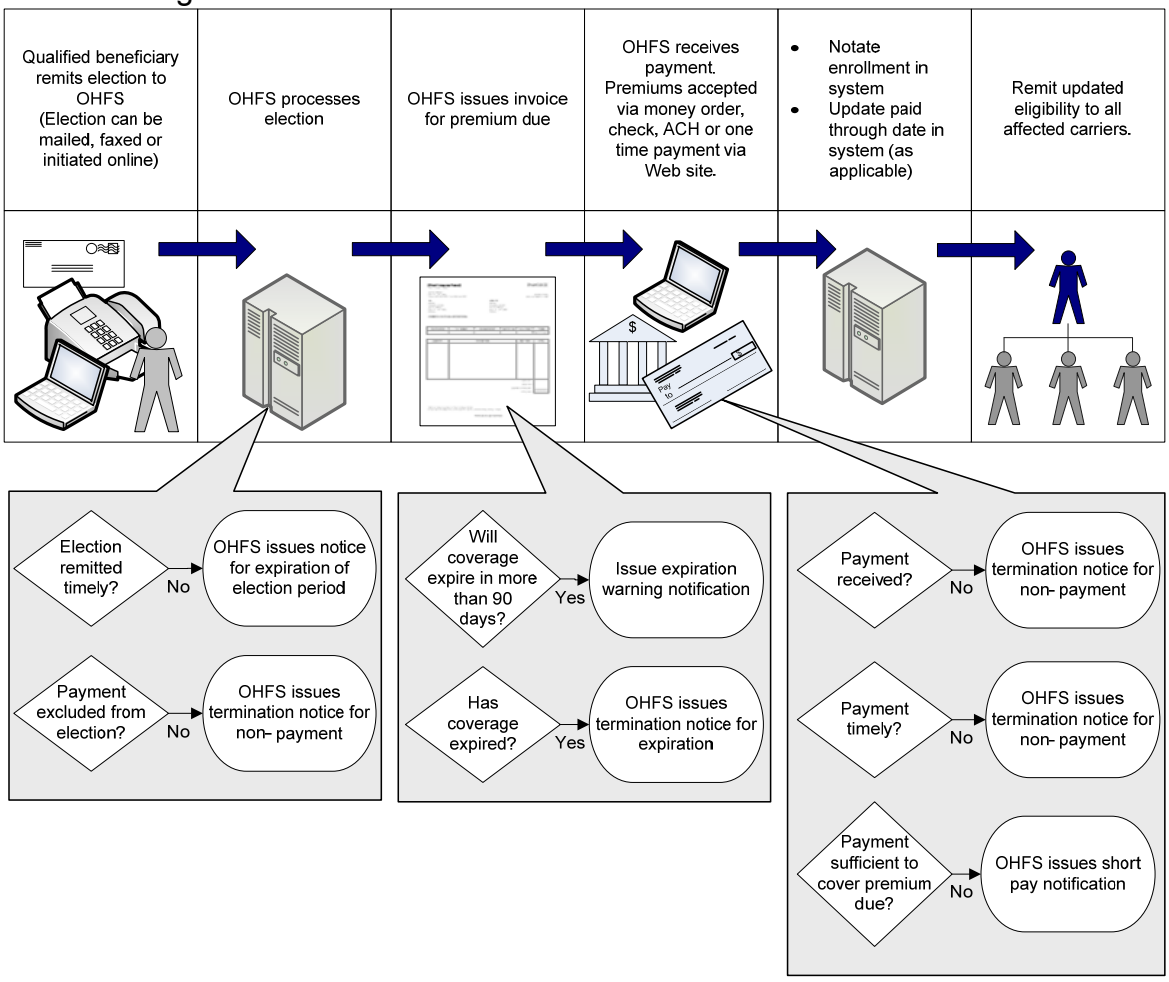
The regulations do not address obstacles that exist when a gap in coverage is present between the time an Employee requests termination of coverage for his or her spouse, and the actual Qualifying Event (i.e., the date of employment termination, divorce or legal separation). The regulations also do not provide guidance as to the appropriate interval for determining when an action is no longer considered "in anticipation of" a Qualifying Event (e.g., 3 months vs. 12 months between spouse coverage termination and divorce). In the absence of statutory guidance, it is advisable to seek legal counsel on these issues.

OHFS does not perform any administrative duties related to a voluntary request for coverage termination. When an Employee requests termination of plan coverage for a spouse or Dependent, the employer must provide a Certificate of Creditable Coverage to the individual(s) losing coverage. In addition, it is advisable to send a confirmation letter that informs the spouse or Dependent that health coverage has or will end at the Employee's request. If contracted to do so, OHFS will send the Certificate of Creditable Coverage to the individual(s) losing coverage.

## Termination of COBRA Continuation

The law provides that COBRA continuation coverage can be terminated or canceled upon the earlier of:

- A written request for termination made by the Qualified Beneficiary,
- Late or non-payment of premium,
- Completion of 18-, 29-, 36-month continuation coverage period,
- Employer elimination of group health benefits (including successor plans),
- Qualified Beneficiary obtains other group health coverage, after the date of COBRA election, that does not include an applicable exclusion or limitation for any Preexisting Condition,
- Qualified Beneficiary becomes entitled to Medicare, after the date of COBRA election,
- For cause, on the same basis that the plan terminates for cause of similarly situated non-COBRA beneficiaries, or
- For an 11-month disability extension, a final determination is made that the individual is no longer disabled.



***Appeals Processing***

## Overview

There are multiply ways an appeal can be received from the participant:

- Consumer Affairs
- Escalation Unit
- Directly from the participant/spouse via mail or fax
- Directly from the participant/spouse via email to the operations email box
- Directly from the participant/spouse as a walk in to the office

**NOTE:** The only difference in the process and timing is the initial receipt. All other steps are followed.

## Initial Receipt

Receive the appeal request from the participant (which could come in from consumer affairs, escalation unit, or directly from the participant via email, mail or fax.)

| If… | Then… |
|---|---|
| Appeal was received from **Consumer Affairs**, | The notification will come directly to OHFS from Consumer Affairs. Within 4 hours of receipt, each email will be evaluation to determine if the appeal belongs to our area. If the appeal does not belong to the COBRA, an email response is sent to not delay the process. |
| Appeal was received from the **Escalation Unit,** | The notification will come directly to OHFS from the Escalation Unit. Within 4 hours of receipt, each email will be evaluation to determine if the appeal belongs to our area. If the appeal does not belong to the COBRA, an email response is sent to not delay the process. |
| Appeal was received from the **participant or spouse via mail or fax or walk in,** | Within 48 hours of receipt, the document is date stamped and scanned into the Participant's record. Management is made aware of the appeal. All reviews will be made within 4 hours of the notification of the review. |
| Appeal was received from the **participant or spouse via email to operations mailbox,** | Within 4 business days of receipt, Management is made aware of the appeal. All reviews will be made within 4 hours of the notification of the review. |

## Review

The information in the appeal is reviewed to determine if there was an administrative error which gives the appeal merit. Documentation is gathered by OHFS to make the determination. Within 48 hours, the information gathered is documented and the determination is made to

grant or deny the appeal. It is possible more research is required, refer to the Research Section.

## Denial

Within 48 hours of the receipt or notification of the receipt, if the review determined that an administrative error did not occur, a denial letter is sent to the party in the same manner in which it was received.

| If… | Then… |
|---|---|
| Appeal was received from **Consumer Affairs**, | The information gathered and the determination is sent to Consumer Affairs for notification of the denial to the participant. |
| Appeal was received from the **Escalation Unit,** | The information gathered and the determination is sent to the Escalation Unit for notification of the denial to the participant. |
| Appeal was received from the **participant or spouse via mail or fax,** | The denial letter is sent to the participant via mail advising the participant that the request for appeal has been denied with the supporting reasoning. The participant is given a management phone number to call if they have questions. |
| Appeal was received from the **participant or spouse via email to operations mailbox,** | The denial letter is sent to the participant via email advising the participant that the request for appeal has been denied with the supporting reasoning. The participant is given a management phone number to call if they have questions. |

## Approval

Within 48 hours of the receipt or notification of the receipt, if the review determined that an administrative error did occur, an approval letter is sent to the party in the same manner in which it was received.

| If… | Then… |
|---|---|
| Appeal was received from **Consumer Affairs**, | The information gathered and the determination is sent to Consumer Affairs for notification including supporting documentation, i.e. reinstatement notification, invoice for premium due, etc. Consumer Affairs will notify the participant. |
| Appeal was received from the **Escalation Unit,** | The information gathered and the determination is sent to the Escalation Unit for notification including supporting documentation, i.e. reinstatement notification, invoice for premium due, etc. The Escalation Unit will notify the participant. |
| Appeal was received from the **participant or spouse via mail or fax,** | The approval letter is sent to the participant via mail advising the participant that the request for appeal has been approved with the supporting documentation, i.e. reinstatement notification, invoice for premium due, etc. |

| | |
|---|---|
| Appeal was received from the **participant or spouse via email to operations mailbox,** | The approval letter is sent to the participant via email advising the participant that the request for appeal has been approved with the supporting documentation, i.e. reinstatement notification, invoice for premium due, etc. |

## Research

If additional research is needed, within 48 hours of the notification a letter or email is sent to the receiving party to acknowledge the request and inform them of the extended timeframe needed.

## Department of Labor or Department of Insurance

If the Department of Labor or the Department of Insurance is involved in the appeal process or if another governmental agency (i.e. governor, senator, representative), the employer is notified of the appeal and determination.

## Second Request

If there is a second request for the appeal, the same process and timing is followed. The employer is notified of the previous denial and the determination of the second request. If this is an ASO client and they choose to overturn the denial and allow the reinstatement, they are informed of potential discrimination if all appeals are not handled identically. OHFS will follow the ASO client direction.

## Standing procedures

All appeals will be validated against employer specific procedures as some ASO employers will automatically allow:

- Reinstatements
- Allow one reinstatement
- Allow reinstatements where the requests are made within 60 days of the termination

## Reinstatement of benefits

If the appeal is approved the participant is notified of the approval. The documentation sent to the participant includes an invoice for premiums due. This documentation advises them of the options of making payments through the normal process and the option of paying over the phone. If they elect to make the payment at the time of notification over the phone, the benefits are updated through the urgent update process; otherwise the reinstatement of benefits follows the standard processing. There is an extension for payment of 30 days from the approval date of the appeal.

## Call Center Support

If the participant calls to request an appeal, they are informed that all appeals or requests for review must be made in writing with reasons for the request. They are provided the mailing address, fax number and email address so that the participant has multiple choices of the notification.

## *COBRA and Health Maintenance Organization*

A Health Maintenance Organization (HMO) is a managed health care system designed to provide region-specific benefits to its Plan Participants. Participating providers in this type of health care delivery system agree to perform certain health maintenance and treatment services for a predetermined periodic payment based on the number of Plan Participants assigned with the provider. In contrast to indemnity, fee-for service, or major medical plans, HMOs restrict coverage to Plan Participants who reside within limited service areas.

HMOs can create difficult administrative challenges for employers with respect to COBRA continuation coverage. First, most HMOs utilize a "prepayment" billing practice that directly conflicts with the premium Grace Period allowed under COBRA. Out of necessity, many employers must pre-fund their Qualified Beneficiaries' COBRA premiums in order to remain in good standing with the HMO for its active Employees. Second, problems can arise when an employer cancels its indemnity plan in favor of an HMO that cannot service a Qualified Beneficiary who resides outside of the service area. Third, employers are confused as to what their COBRA obligations are when a Qualified Beneficiary moves out of an HMO service area and can no longer receive services or treatment.

In an attempt to address the latter, the 2001 final regulations state that a Qualified Beneficiary need only be given an opportunity to continue the coverage that she or he was receiving immediately before the Qualifying Event. This is true regardless of whether the coverage ceases to be of value if the Qualified Beneficiary relocates out of an HMO's service region.

However, the final regulations also stipulate that the Qualified Beneficiary must be given an opportunity to elect alternative coverage that the employer makes available to similarly situated non-Qualified Beneficiaries or its active Employees. This availability cannot be conditioned upon the employer having covered Employees where the Qualified Beneficiary has relocated. Instead, the relocating Qualified Beneficiary must have access to any alternative coverage made available to other Employees (similarly situated or not) as long as the other coverage would provide coverage to that area.

Pursuant to the 2001 final regulations, such an offer for alternative coverage must be made on the date of the relocation or, if later, on the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage. If the HMO is the sole plan made available to its Employees, the employer is not required to make any other coverage available to the relocating Qualified Beneficiary.

## *Michelle's Law Affecting Student Eligibility Under Group Health Plans*

On October 9, 2008, President Bush signed into federal law a new statute known as "Michelle's Law" (H.R. 2851). The law amends ERISA, the Public Health Service Act, and the Internal Revenue Code. Michelle's law generally requires group health plans, which provide coverage for dependent children who are postsecondary school students, to continue such coverage if the student loses the required student status because he or she must take a leave of absence from studies due to a serious illness or injury. The law applies to fully insured and self-funded group health plans and will be effective for an employer's plan on the first plan year on or after October 9, 2009.

**What the Law Requires**

Continuation Requirement:
Michelle's Law requires that a self-insured group health plan, or insurer of an insured group health plan ("Plan"), shall not terminate coverage of a student "dependent child" who must take a "medically necessary leave of absence", before the earlier of:

(1) one year after the leave of absence begins; or
(2) the date on which the child's coverage under the Plan would otherwise terminate.

Key Definitions:

- "Dependent child" means an eligible dependent under the Plan, who is enrolled for coverage based on his or her student status at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence. Although Michelle's Law is generally described as protecting college students, it actually applies more broadly to any student enrolled in a school after high school.
- "Medically necessary leave of absence" means a leave of absence from a postsecondary school, or any other change in enrollment at the school, that:
  (1) begins while the child is suffering from a serious illness or injury;
  (2) is medically necessary; and
  (3) causes the child to lose student status and therefore coverage under the Plan.

Physician Certification:
A Plan is only required to comply with the continuation requirement if it receives written certification from the child's treating physician stating that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment, such as a change from a full-time to part-time student) is medically necessary. There is no definition of medically necessary and it appears that the physician's determination in this regard is controlling.

Notice Requirement:
A Plan must include notice of the continuation coverage under the law with any notice addressing certification of student status required by the Plan for dependent coverage. The notice must be written to be understandable to the typical Plan participant.

Benefits Applicable to Leave:

- When a dependent child is receiving the continued coverage required by Michelle's Law during a medically necessary leave of absence, the benefits shall be the same as if the child remained a covered student and was not on the leave of absence. In other words, the benefits provided to the child shall be the same as those provided to dependent children who are maintaining their required student status.
- When a dependent child is receiving the continued coverage required by Michelle's Law during a medically necessary leave of absence, and the coverage level for dependent children changes (e.g., change in benefit Plan due to change in Plan sponsor's benefit program or change in insurers), the new coverage level will apply for the remainder of the continuation period.

Effective Date:
The requirements of Michelle's law apply to an employer's group health plan on the first plan year on or after October 9, 2009, and to medically necessary leaves of absence beginning during such plan year. For calendar year plans, the effective date is January 1, 2010.

**Impacts on Group Health Plans**

The main impacts on group health plans will be developing procedures to maintain eligibility of dependent children protected by the law during a medically necessary leave of absence, updating SPD language to reflect the new requirements, and complying with the notice requirement when requesting certification of student status. A thorough regulatory/operational review will be done to uncover any additional impacts.

Michelle's Law applies to all self-insured and insured group health plans, including HMO plans. Affected plans include employer-sponsored ERISA plans, church plans and governmental plans. However, non-federal governmental plans (e.g., employer-sponsored plans of states, municipalities and other political subdivisions) may exclude themselves from the law by following federal opt-out requirements.

Group health plans within the scope of the law are plans providing medical benefits. Exceptions applicable to other federal group health reforms, such as preexisting conditions limits, mothers' and newborns' health protection, and women's' health and cancer rights, also apply to Michelle's law. Thus, the following types of coverage are excluded from the scope of the law:

- Accident only coverage (e.g., AD&D),
- Disability income coverage,
- Workers' compensation,

- Limited scope dental and vision coverage (if offered separately from the group health plan),
- Long term care coverage (if offered separately from the group health plan),
- Coverage for only a specified disease or illness (e.g., cancer-only policies), or hospital indemnity or other fixed indemnity coverage that pays a fixed dollar amount per day regardless of expenses incurred (if offered separately from, and not coordinated with, the group health plan),
- Medicare supplemental insurance (i.e., Medigap or MedSupp insurance as defined under the Social Security Act) and TRICARE supplemental insurance

# Chapter 3: HIPAA and FMLA

## *Introduction*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family and Medical Leave Act of 1993 (FMLA) are two important laws, which affect COBRA compliance. This section describes HIPAA and FMLA and how they relate to continuation coverage.

## *The Health Insurance Portability and Accountability Act of 1996*

In August 1996, “The Health Insurance Portability and Accountability Act of 1996" (HIPAA) [Public Law 104191] were signed into law. This legislation amends and clarifies certain COBRA continuation rules and establishes additional administrative guidelines that affect all group health plans. The following is a summary of HIPAA provisions as they pertain to COBRA continuation coverage.

### *Certificate of Creditable Coverage Requirements*

Under HIPAA, employers are required to provide Plan Participants with a written certificate of creditable coverage that certifies any period of prior coverage. This certificate must be provided:

1. when the individual loses coverage under the plan, for any reason (including due to a COBRA Qualifying Event),
2. when the individual ceases to be covered under COBRA continuation, and
3. upon request, if requested within 24 months after coverage under the plan ends.

Certificates of creditable coverage must include:

1. the period of creditable coverage under the plan (e.g., active Employee coverage) and (if any) the period of coverage under COBRA, and
2. if any, the Waiting Period (and affiliation period, if applicable) imposed under the plan. Each family member within the plan may need a separate certificate of creditable coverage since it is possible that coverage may begin or end at different times for different family members. It is highly recommended that you begin tracking and archiving this information immediately because you may be responsible for reporting creditable coverage information back to July 1, 1996.

A plan may not impose a 12-month Preexisting Condition exclusion if a Plan Participant is able to provide certification that he or she had 12 months of prior continuous creditable coverage. This prior coverage can be one or any combination of group or individual plan coverage, COBRA continuation, Social Security, public health plans or similar programs. Any coverage prior to a 63-day or more breaks in coverage (excluding any waiting/affiliation periods) must be disregarded for purposes of calculating creditable coverage.

Plans or issuers must automatically provide a Certificate of Creditable Coverage to:

Note: You are responsible for providing a Certificate of Creditable Coverage for all loss of coverage situations that are NOT related to a COBRA Qualifying Event. For example, if an Employee requests plan termination because he is enrolling in his wife's employer group health plan; this is not a COBRA Qualifying Event. However, it is a loss of coverage event in which a Certificate of Creditable Coverage must be issued to the Employee.

a leave taken under the FMLA is not considered a COBRA Qualifying Event, despite the fact that an Employee experiences a reduction in hours of employment due to the leave. A leave described under the Act is considered a COBRA Qualifying Event if the Employee fails to return to work following an FMLA leave. In such case, COBRA continuation coverage is measured from the earlier of the date the employer is notified the Employee will not return to work or the last day of FMLA leave.

It is the Plan Sponsor's responsibility to identify and track FMLA leaves within the company and, when necessary, report to OHFS that a COBRA Qualifying Event has occurred.

# Chapter 4: COBRA Administrative Service

## *Introduction*

The following sections describe the reporting responsibilities with OHFS and the services that we perform to maintain the company's COBRA compliance.

## *Plan Sponsor Role as the COBRA Plan Administrator*

While OHFS performs necessary functions of COBRA administration, as the employer and Plan Sponsor, we rely on you to properly communicate information to OHFS, to carry out OHFS instructions regarding Plan Participant coverage and, in general, to conform to all COBRA guidelines.

## *Initial COBRA Rights Notification to Active Employees*

Even prior to a Qualifying Event, COBRA law requires an initial notification of COBRA rights to be sent to each insured Employee and covered spouse. OHFS refers to this notice as the "General Notice". This notice must be sent first class mail to all covered Employees and spouses when a company first becomes subject to COBRA. Additionally, on an on-going basis, a General Notice must be provided whenever an individual is added to the plan such as:

(1) a new hire that becomes covered under the group health plan,
(2) an Employee and/or spouse that becomes covered under the group health plan at Annual/Open enrollment, or
(3) an Employee who marries and adds his/her spouse to the plan.

New hires and newly eligible are the same thing when it comes to the General Notice. Unless the participant enrolls (newly eligible) there is not a general notice requirement.

The General Notice is a critical document because it discloses important continuation coverage rights and responsibilities. Specifically, this notice gives details of the COBRA provisions including eligibility requirements, Qualifying Events, the responsibility of notification, and a timeline for notification and payments. It also informs Employees and spouses of their explicit responsibility to notify the employer when they have a change of address, become legally separated or divorced, or lose Dependent child status under the plan.

## *Process: Newly Covered On COBRA Eligible Plan (General Notice)*

## *Plan Sponsor Responsibility*

When the company first became subject to COBRA, a General Notice should have been sent to each insured Employee and covered spouse. In addition, on an on-going basis, the company should currently be providing to any Employee and/or spouse who become covered under the group health plan.

The standard approach is for a plan sponsor to print the General Notice from adminservices.optumhealthfinancial.com and distribute to the employee and/or family members. For large companies, OHFS provides an optional service to perform the requirement on the company's behalf (see "OHFS Optional Administration Service" below). Unless OHFS is otherwise advised, the company is responsible for distributing to the active insured Employees and their covered spouses.

A sample entitled, "Important Notice of Continuation Coverage Benefits" is shown in this guide. However, please be advised that OHFS is not responsible for developing; maintaining or updating the contents of the General Notice when you choose to self-administer this important COBRA requirement.

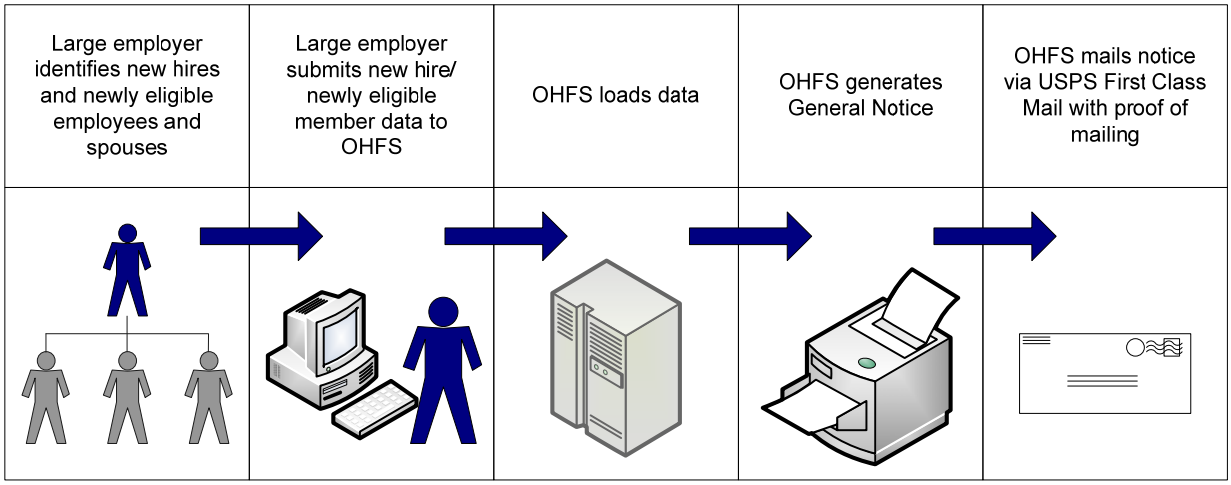
## *Guidelines for Distributing General Notices:*

The law requires companies subject to COBRA to distribute a General Notice to each Employee and spouse covered under the group health plan. Thus, employers are discouraged from distribution in person or as a payroll stuffer because these methods do not serve to inform a covered spouse of his/her COBRA rights. Similarly, simply posting the notice on a company bulletin board does not satisfy good faith COBRA compliance. Instead, good faith compliance requires that you address the General Notice to the last known mailing address of each insured Employee and covered spouse and send the notice via first class mail. If the Employee and spouse reside at the same address, one notice addressed to both individuals will suffice. If the Employee and spouse live at different addresses, mail a separate notice to both addresses.

For documentation purposes, a copy of this notification should be kept on file or be readily available along with a record or log of when, where and to whom the notifications were sent.

## *OHFS COBRA Optional Administration Service:*

The standard approach is for a plan sponsor to print the General Notice from adminservices.optumhealthfinancial.com and distribute to the employee and/or family members.
As an optional service, OHFS will perform the distribution of General Notices on the behalf of the Plan Sponsor. This option is available to companies who have large numbers of employees. Note that separate General Notices must be sent to family members who reside at a different mailing address from the Employee. Contact OHFS is you wish to use this service.




## *When a Qualifying Event Occurs*

In the case of a divorce, legal separation, a child losing Dependent status under the plan, occurrence of a second Qualifying Event and notice of a disability or recovery from a disability as determined by the Social Security Administration, the Employee or Qualified Beneficiary must notify the Plan Administrator generally within, 60 days after the date of the Qualifying Event, 60 days from the date on which the Qualified Beneficiary would lose coverage because of the Qualifying Event, or 60 days from the date on which the Qualified Beneficiary is informed of his or her obligation to provide notice, whichever is later. Timely notification from either the Employee or a Qualified Beneficiary would satisfy the notice requirement to report a Qualifying Event. In the event that timely notification is not made, COBRA continuation need not be offered. However, be aware that this 60-day notification requirement to inform the Plan Administrator of a Qualifying Event may not be enforced if the employer failed to provide a General Notice to the Employee and/or spouse upon plan coverage.

The employer is also responsible for identifying and communicating certain Qualifying Events to the Plan Administrator, such as the covered Employee's death, termination of employment (other than by reason if gross misconduct), reduction in hours of employment, Medicare entitlement, or a bankruptcy proceeding with respect to the employer of a retiree. Notification must be made within 30 days of a Qualifying Event or the loss of coverage date.

OHFS advises you to communicate Qualifying Events to us immediately, preferably within 14 days of the event, so that COBRA periods can begin promptly. Once notified, OHFS will provide a COBRA election notice to the Qualified Beneficiary(ies) within 14 days. This notification provides detailed information about COBRA continuation coverage and includes specific instructions for electing continuation coverage, lists available group health benefits and discusses premium guidelines.

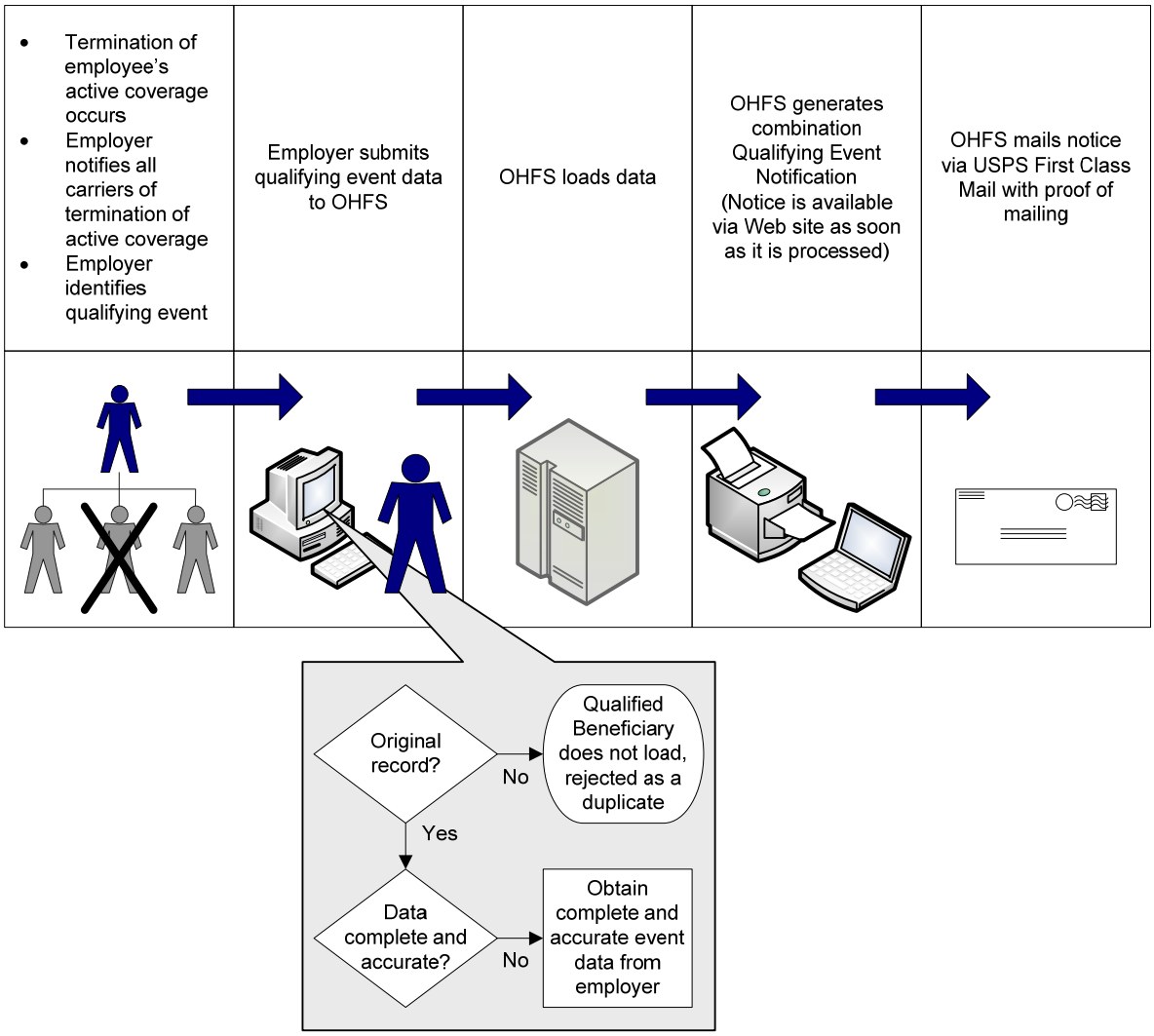
## *Plan Sponsor Responsibility*

Perform one of the following actions immediately after a Qualifying Event:

Website Notification- Immediately following a Qualifying Event, access https://adminservices.optumhealthfinancial.com/

- and submit a Qualifying Event. The confirmation page may be printed and kept with the Employee records for future reference.
- File Transfer Notification – Immediately following a Qualifying Event, process the termination as appropriate in the companies HRIS/Payroll system. A file should be sent to OHFS on at least a weekly basis. The file will be processed and appropriate notices mailed to Qualified Beneficiaries. It is important to review the processing report in a timely and thorough manner.

## *OHFS Qualifying Event Process*




Note: Documents queued are generally batched and printed on the same business day. The file is a record for the USPS of which notices have been mailed. Notice is available via web is available after batch processing.

OHFS is required to make a complete response to any inquiry from a health care provider (e.g., a physician, hospital or pharmacy) regarding a Qualified Beneficiary's right to plan coverage during the 60-day COBRA Election Period. Similar requirements exist to provide the status of COBRA coverage when health care provider inquiries are made during applicable monthly premium Grace Periods.

## *Process: COBRA Non-Response Time*

Description: Process followed in the event the Participant does not return their COBRA Notice and Plan Alternative

Notes: If the election notice is received after the account has been cancelled and the postmark date is on or before the expiration, the account will be reinstated and the election will be processed (see election processing).

## *Certificate of Mailing*

All OHFS legal communication notifications are sent to Plan Participants via certificate of mailing through the USPS. OHFS uses a batch processing which logs process for queuing and tracking notices required by COBRA and HIPAA law.

OHFS queues each of its notices on a variety of criteria, which vary depending on the notice type. Once a notice is queued, it goes into our notice queue pending printing. Notices can also be manually queued by OHFS.

## *Optional Participant Notification Services*

OHFS generally batches and prints everything on the same business day that it is queued. The document server creates a print batch of all the queued notices by form type. For each form it then prints a proof of mail document, prints each notice to an image file that is attached to the Participant's record, and prints a copy to the printer.

OHFS then takes the batch of documents with its corresponding ASN document and performs a quality review. The notices, along with any appropriate inserts, are then automatically stuffed into envelopes and run through a postal meter for postage. These batches of notices are taken to the post office the same day. The post office stamps the ASN document, confirming that the notices were indeed received by them. Upon return of the ASN sheets, the batch in the system that was mailed is then compared to the ASN and marked as mailed. The ASN document is retained by OHFS in batch number order for future retrieval.

## *When a Qualified Beneficiary Elects and pays for COBRA Continuation*

When COBRA continuation coverage is elected, OHFS will send the Qualified Beneficiary 6-month invoice. A Qualified Beneficiary has 45-days from the postmarked date of the election by which to remit the initial premium.

## *Process: Electronic Eligibility Feed for COBRA*

Description: This is a description of the electronic eligibility feed process COBRA Participants.

| | Step | Timing | Responsible Party | | |
|---|---|---|---|---|---|
| | | | EE | Client | OHFS |
| 1. | Eligibility codes are programmed in the OHFS system for a specific Carrier which include plan names, plan numbers, plan types, etc. | | | | √ |
| 2. | The Data Exchange parameters are set up in the OHFS system. The encryption policy – PGP, WinZip with password, or Static password is set up and the FTP server site, User ID and password is set up. | | | | √ |
| 3. | The Delivery parameters are set up in the OHFS system as Weekly, or Daily scheduled eligibility reports. | | | | √ |
| 4. | The OHFS system will generate the electronic eligibility report based on the frequency chosen in Step 3, with the first report starting from the date the Delivery parameters are set up. | | | | √ |
| 5. | The OHFS sends reports based on the time each report is received into the queue. | | | | √ |

## *Process: Urgent Eligibility Updates*

| | Step | Timing | Responsible Party | | |
|---|---|---|---|---|---|
| | | | EE | Carrier | OHFS |
| 1. | Participant calls requiring an urgent eligibility update. The CCP will advise eligibility will be updated within 48 hours. CCP will submit an urgent update to the urgent eligibility team | Immediately during the phone call. | √ | | √ |
| 2. | Issue record is assigned to the urgent eligibility team for updating all carriers for plans the participant is enrolled in | Within 48 hours | | √ | √ |
| 3. | Urgent eligibility team confirms with carrier eligibility was updated - timing is contingent on carrier. | Within 48 hours | | √ | √ |
| 4. | Participant is notified of the update | | √ | | √ |

## *Premium Collection*

By law, COBRA Qualified Beneficiaries may pay for continuation coverage on a monthly basis. However, other payment intervals such as weekly installments are permissible at the discretion of the group health plan. As a policy, OHFS enforces the standard monthly payment interval. COBRA premium payments are due on the first day of the month for the month of coverage with a 30-day Grace Period. These guidelines are adhered to strictly.

Qualified Beneficiaries must remit premiums directly to OHFS where they are collected throughout the month and deposited into a trust account.

Each month, a Premium Statement and check (if applicable) will be sent to the specified contact person in the system. The total represents the total premiums received from the Qualified Beneficiaries for the previous month.

When a premium payment received is not significantly less than the amount due, OHFS will notify the Qualified Beneficiary and allow 30 days to pay the deficit as mandated by the final regulations.

PLEASE NOTE: Clients utilizing our optional Carrier Remittance Service will receive a separate summary report with their Monthly Activity Report, which lists COBRA Participants' names and Carriers to whom premiums have been forwarded.

By law, Qualified Beneficiaries are entitled to a 30-day Grace Period measured from the premium due date. OHFS sends the premium reimbursement on approximately the 15th business day of the month for the prior month's premiums. Therefore, when continuation coverage is established for a COBRA Participant (i.e., the Qualified Beneficiary has elected, paid initial COBRA premiums and is reinstated on the plan), and if OHFS does not provide premium remittance services, the company will need to advance premium funds on behalf of its Qualified Beneficiary(ies) each month to avoid a lapse in coverage. Advancing funds for COBRA Participants' premiums is a logistical necessity for many clients who want their active Employees' premiums to be sent, received and posted by the Carrier on time without delay due to their COBRA Participant's 30-day grace period.

PLEASE NOTE: Clients utilizing our optional Carrier Remittance Service will receive a separate summary report with their Monthly Activity Report, which lists COBRA Participants' names and Carriers to whom premiums have been forwarded.

## *OHFS Administration Services*

For each Qualified Beneficiary on COBRA continuation coverage, OHFS will:

- Send Monthly invoices which include any past due amounts
  - Initial invoices are sent within 2-business day of enrollment into COBRA.
  - Invoices are sent on the eighth business day of the month prior to the due date to allow for approximately 3 weeks payment window.
- Respond to verbal and written requests
- Enforce payment due dates and grace periods
- Verify timeliness of postmark dates and process premium payments.
- Administer corrective procedures for checks returned due to non-sufficient funds.

### *Termination of COBRA Continuation*

OHFS will do the following when Qualified Beneficiary's COBRA continuation coverage should be terminated or cancelled:

- Prepare and send a termination letter to the Qualified Beneficiary(ies) indicating the reason for termination and last date of coverage.
- Address written appeals from Qualified Beneficiaries.

- Notify Qualified Beneficiaries of their conversion option rights within the required period for COBRA Participants who have completed the maximum coverage period (18-, 29- or 36- months).
- Report to employer, via the eligibility report, the demographic information of Qualified Beneficiaries for whom continuation coverage should be terminated or canceled.
- Remit a HIPAA Certificate of Creditable Coverage to all appropriate parties

The law provides that COBRA continuation coverage can be terminated or canceled upon the earlier of:

- A written request for termination made by the Qualified Beneficiary,
- Late or non-payment of premium,
- Completion of 18, 29, or 36 months continuation coverage period,
- Employer elimination of group health benefits (including successor plans),
- Qualified Beneficiary obtains other group health coverage, after the date of COBRA election, which does not include an applicable exclusion or limitation for any pre-existing condition.
- Qualified Beneficiary becomes entitled to Medicare, after the date of COBRA election. Pursuant to I.R.S. Rev. Rul. 2004-22, the Medicare entitlement of a covered Employee is not a second Qualifying Event unless, in the absence of the first Qualifying Event, the 36-month event would result in a loss of coverage for the Qualified Beneficiary under the plan within the maximum coverage period.
- For cause, on the same basis that the plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, or -For an 11-month disability extension, a final determination is made that the individual is no longer disabled.

For protection of the plan, it is important that COBRA coverage is promptly terminated as soon as possible.

Description: Termination of coverage due auto-term for non-payment.

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | Monthly invoices sent to the participant including any amount due. | 10th of each month | | √ | | |
| 2. | Participant receives the invoice but no payment is made within the 30 grace period | By end of 30 day grace period | √ | | | |
| 3. | Waiting period for mail time | 6 mail days are allowed to receive payment post marked within grace period | | √ | | |

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 4. | If no payment was received, system will automatically terminate coverages, retroactively to previous paid date | 7th mail day | | √ | | |
| 5. | Termination notification is sent to the carrier | Daily for UnitedHealthcare<br><br>Based on pre agreed upon schedule for all other carriers | | √ | | √ |
| 6. | Termination notification sent to participant advising of retroactive termination | 7th mail day | √ | √ | | |

Description: Termination of coverage due to end of eligibility.

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | Monthly invoices sent to the participant including any amount due. | 10th of each month | | √ | | |
| 2. | Participant receives the invoice | Payment to be received by end of 30 day grace period | √ | | | |
| 3. | Participants receives an end of COBRA eligibility | 180 prior to end of COBRA eligibility | √ | √ | | |
| 4. | Termination notification sent to participant advising of termination | Last day of coverage | √ | √ | | |
| 5. | Termination notification is sent to the carrier | Daily for UnitedHealthcare<br><br>Based on pre agreed upon schedule for all other carriers | | √ | | √ |

Description: Termination of coverage due to request.

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | Monthly invoices sent to the participant including any amount due. | 10th of each month | | √ | | |

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 2. | Participant receives the invoice | Payment to be received by end of 30 day grace period | √ | | | |
| 3. | Participant request in writing to be terminated from coverage(s) | Processed within 5 business days | √ | √ | | |
| 4. | Termination notification sent to participant advising of termination | Last day of coverage | √ | √ | | |
| 5. | Termination notification is sent to the carrier | Daily for UnitedHealthcare<br><br>Based on pre agreed upon schedule for all other carriers | | √ | | √ |

Description: Termination of coverage due Qualified Beneficiary becomes entitled to Medicare, after the date of COBRA election requested termination.

| | Step | Timing | EE | OHFS | Client | Carrier |
|---|---|---|---|---|---|---|
| 1. | Monthly invoices sent to the participant including any amount due. | 10th of each month | | √ | | |
| 2. | Participant receives the invoice | Payment to be received by end of 30 day grace period | √ | | | |
| 3. | Participant request in writing to be terminated from coverage(s) | Processed within 5 business days | √ | √ | | |
| 4. | Termination notification sent to participant advising of termination | Last day of coverage | √ | √ | | |
| 5. | Termination notification is sent to the carrier | Daily for UnitedHealthcare<br><br>Based on pre agreed upon schedule for all other carriers | | √ | | √ |

## *Benefit & Coverage Changes or Annual / Open Enrollment*

Any benefit or coverage changes that affect the employer's group health plan must be communicated to COBRA Participants by the employer group. Benefit changes may include changes to the deductible, stop-loss, or co-payment. Plan or coverage changes can include Carrier changes, or a new plan being offered in addition to plan options already available. Similarly, as defined by COBRA, an annual/open enrollment period is a period during which a covered Employee can choose to be covered under another group health plan or under another benefit package within the same plan, or to add or eliminate coverage of family members. COBRA requires open enrollment rights to be extended to Qualified Beneficiaries in any case in which they are extended to similarly situated active Employees. Accordingly, when benefits and/or coverage change or the company offers open enrollment rights to active Employees, you must also provide the opportunity for COBRA Qualified Beneficiaries to make changes or modifications to their group health plan.

During open enrollment, it is possible for a Qualified Beneficiary to add coverage for a family member who may have declined or was not entitled to continuation coverage during the original COBRA Election Period. Note that this individual, when added to the plan after the COBRA Election Period, is not considered a Qualified Beneficiary.

COBRA law dictates that individuals currently receiving COBRA benefits must receive the same plan options and information as your active employees during your open enrollment period. For most benefit teams, orchestrating open enrollment for the active population utilizes all available resources and leaves limited or no ability to comply with COBRA open enrollment requirements. With help from OHFS, your administrative load is lightened considerably.

We provide election forms and distribute all necessary plan information to your current COBRA participants. Our enrollment options go beyond paper-based, passive enrollment and extend to the choice of active enrollment through our easy-to-use Web capabilities. Unlike many COBRA administrators in the marketplace, OHFS has introduced an online enrollment tool through https://adminservices.optumhealthfinancial.com/ to simplify the enrollment process for participants.
Upon receipt of their enrollment materials, participants can log on to https://adminservices.optumhealthfinancial.com/ to enter their enrollment selections. Any coverage adjustments made are then automatically communicated to the customer and the appropriate carriers as open enrollment information is processed.

Our standard services include notification to COBRA Participants of rate changes for existing plans. In general, you are responsible for duties related to Carrier changes or other plan benefit modifications

*COBRA and the Summary Plan Description*
A Summary Plan Description (SPD) is a written document required by ERISA, which employers must distribute to Employees who participate in company health, and welfare

benefit plans. An SPD is intended to provide Employees with non-technical answers to general questions pertaining to Employee benefits, company policies and COBRA continuation coverage. An explanation of COBRA in an SPD informs Employees of their continuation coverage rights within the same context as other Employee benefits matters and must be included as mandated by regulations issued by the Department of Labor (DOL).

It is strongly suggested to consult legal counsel to ensure that information communicated in the SPD is accurate and consistent with other COBRA written materials.

## *Reporting*

Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/. Some reports include user defined date parameters.

- Eligibility – This series of reports will allow the client to view waiting periods, continuants and cancelled participants.
- Activity – This section provides a way for the client to monitor the activity on their account. Searches can be done by user, division or activity type for a specified date.
- Employees – This report will allow the client to select the employees to include in the report, optionally include addresses and dependents and sort by various criteria.
- COBRA Continuation Pending Report – This report lists employees that have had a qualifying event processed, have not elected to continue COBRA coverage and are still in their 60-day election period.
- Status of COBRA Continuants – This report contains participant records of those that are currently on COBRA. Details include date of qualifying event, reason, eligibility end date, etc.
- Cancelled Eligible Employees and Continuants – This report lists participants for whom COBRA coverage has expired or has never been elected, participants that have requested cancellation or participants who had coverage cancelled for non-payment of premium. Participant records remain on this report for 120 days.
- Covered Participants by Plan – This report provides a listing of participants by plan.
- Standard Eligibility Communication with Qualifying Events – In addition to standard COBRA eligibility information, this report details employees that have lost coverage due to COBRA qualifying events. Although these will be included on the report, it is recommended that the client continue to notify carriers immediately of dropped coverage situations when employees have a coverage loss.
- Qualifying Events Report – This report only includes those individuals who have had qualifying events processed and who have not, as of the run date of the report, elected and paid.

## Disbursement processing

**Disbursement Processing**

| Time Frame | Participant | OHFS | Carrier |
|---|---|---|---|
| Monthly | Participant remits monthly premiums by due date / grace period | | |
| On the 6th business day of each month | | OHFS runs disbursements through the 1st of the current month | |
| On the 9th business day of each month | | OHFS completes the review and sends to fulfillment for mailing | |
| On the 11th business day of each month | | OHFS – The fulfillment center mails all disbursement checks and reports | |
| Upon mail delivery | | | Receives all payments based on premiums collected and disbursement set up |

Supplemental reporting is available upon request. The disbursement reporting provided in the mailing process is available via excel spreadsheet.

## Disbursement Processing

| Time Frame | Participant | OHFS | Client | Carrier |
|---|---|---|---|---|
| Monthly | Participant remits monthly premiums by due date / grace period | | | |
| On the 6th business day of each month | | OHFS runs disbursements through the 1st of the current month | | |
| On the 9th business day of each month | | OHFS CSC has available databases to create electronic reporting | | |
| On the 11th business day of each month | | OHFS – Base on request, CSC delivers the electronic version of disbursement reporting | | |

## Sample Reporting

Report layout:

Paid to: PAYEE NAME (if paid to carrier, should be carrier name. If paid to account, should be account number and description.)

| Company No | Company Name | Division | Carrier Code | Carrier | Coverage Code | Coverage | Coverage Date | Disbursement Date | Name | Amount | Admin Fee | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $385.03 | | $385.03 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $249.07 | $5.84 | $254.91 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | | -$5.21 | -$5.21 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $87.18 | $2.04 | $89.22 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $33.53 | $0.79 | $34.32 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $53.64 | $1.26 | $54.90 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $87.18 | $2.04 | $89.22 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $249.07 | $5.84 | $254.91 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $249.07 | $5.84 | $254.91 |
| | | | 00890089:01 | CH + PS1 H S A 501A Cobra w/ RX | 01 | PARTICIPANT ONLY | 1/1/2009 | 2/8/2009 | Last Name, First Name | $249.07 | $5.84 | $254.91 |
| | | | | | | | | | | $1,652.84 | $24.28 | $1,677.12 |

## COBRA NOTICE TIMING/DELIVERY CHART

| DOL regulations for timing and delivery of COBRA notices | | | |
|---|---|---|---|
| **Notice** | **Description** | **Timing** | **Delivery methods** |
| General Notice | Plan administrator sends information to help participants understand their basic rights and responsibilities under COBRA. | No later than 90 days, after the Coverage begins for the group health plan.<br>If employee or spouse has QE during 90-day period, general notice obligation is satisfied when plan administrator provides timely election notice. | Send to covered employee and spouse (may send single notice if same address).<br>First class mail, hand delivery (for employee only; spouse must be separately notified), SPD, or electronically. |
| Employer notice to Plan Administrator | Employer notifies Plan Administrator of these QEs: employee termination, reduction in hours of employment, death, enrollment in Medicare; employer bankruptcy. | No later than 30 days after QE (or loss of coverage, if applicable*). | As desired by employer and Plan Administrator. |
| Election Form | Plan Administrator notifies QBs of COBRA rights and election information after a QE occurs. | No later than 14 days after Plan Administrator receives employer notice (for multi-employer plans, at the end of the period specified in the plan). | All potential QBs must receive the notice.<br>Same as delivery rules for general notice. |

## COBRA NOTICES TIMING/DELIVERY CHART

### DOL regulations for timing and delivery of COBRA notices

| Description | Timing | Delivery methods |
|---|---|---|
| COBRA Continuation of Coverage Election Notice | Within 14 calendar days of receipt of notification from employer | Certificate of mailing |
| Monthly Invoice | Printed on the 8th business day of each month | Bulk Mailing |
| General Notice | Sent within 14 days of receipt | First class mailing |
| Welcome Letter | Daily based on enrollment into COBRA | First class mailing |

### Reports - Timing/Delivery Chart

| Description | Timing | Delivery methods |
|---|---|---|
| Disbursement Reporting | Mailed on the 11th business day of each month | First class mailing |
| Electronic Disbursement Reporting – special request | Emailed on the 11th business day of each month | Email |
| Eligibility - This series of reports will allow the client to view waiting periods, continuants and cancelled participants. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |
| Activity – This section provides a way for The client to monitor the activity on their account. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |

| Description | Timing | Delivery methods |
|---|---|---|
| Employees – This report will allow The client to select the employees to include in the report, optionally include addresses and dependents and sort by various criteria. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |
| COBRA Continuation Pending Report – This report lists employees that have had a qualifying event processed, have not elected to continue COBRA coverage and are still in their 60-day election period. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |
| Status of COBRA Continuants – This report contains participant records of those that are currently on COBRA. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |
| Cancelled Eligible Employees and Continuants – This report lists participants for whom COBRA coverage has expired or has never been elected, participants that have requested cancellation or participants who had coverage cancelled for non-payment of premium. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |

| Description | Timing | Delivery methods |
|---|---|---|
| Covered Participants by Plan – This report provides a listing of participants by plan. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |
| Standard Eligibility Communication with Qualifying Events – In addition to standard COBRA eligibility information, this report details employees that have lost coverage due to COBRA qualifying events. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |
| Qualifying Events Report – This report only includes those individuals who have had qualifying events processed and who have not, as of the run date of the report, elected and paid. | Available on the web 24 x 7 at https://adminservices.optumhealthfinancial.com/ | Web pick up |

OptumHealth
Financial Services, Inc.

September 13, 2012

**OPTUMHEALTH FINANCIAL SERVICES, INC. - COBRA Administration**

«First_Name» «Last_Name»
«Address»
«City», «State» «Zip_Code»

Dear «First_Name»

OptumHealth Financial Services, Inc. would like to welcome you and provide our contact information should you have any questions or concerns during your continuation period. We would like to remind you that you need to return your enrollment form even if you have a severance agreement in place in order to continue your coverages.

Also included in this package is a list of contact information for easy reference should you have any questions. An ACH enrollment form is attached if you wish to have your premiums automatically deducted from your checking account on the first of each month. OptumHealth Financial Services, Inc. will be responsible for reporting your continued eligibility for benefits to carriers. Eligibility will only be reported if your premiums are paid.

We look forward to serving you in this administrative capacity. Please feel free to call us at (866) 301-6681 if you have any questions or concerns.

Sincerely,
OptumHealth Financial Services, Inc.
Telephone: (866) 301-6681

## Important contact information for OptumHealth Financial Services, Inc.

| | Important Details | Contact Information |
|---|---|---|
| **Payment Address** | All premium payments will continue to be due on the 1st of each month to avoid the termination of the policy for non-payment.<br><br>Your payment must be accompanied by an invoice. If you do not have an invoice, a copy is available for you to print at https://adminservices.optumhealthfinancial.com/ | OptumHealth Financial Services, Inc.<br>PO Box 713082<br>Cincinnati, OH 45271-3082 |
| **Web Site Address** | Our web site offers eligibility, payment status and account information 24 hours a day. **You will be required to register as a new user on the site.** | https://adminservices.optumhealthfinancial.com/ |
| **Customer Service Phone Number** | Our customer service number is: | (866) 301-6681 |
| **Email Address** | Customer service email address: | OperationsAdminServices@optum.com |
| **Mailing Address For Routine Correspondence** | New mailing address for all correspondence, **other than premium payments** | OptumHealth Financial Services, Inc.<br>PO Box 221709<br>Louisville, KY 40252 |
| **Fax Number** | Our Fax number is: | 866-525-1740 |

Want a fast and easy way to enroll?

Log into https://adminservices.optumhealthfinancial.com/ and select the option to enroll. You can enroll in your benefits and make your payments online.

Need to make a change or have a question?

Log into https://adminservices.optumhealthfinancial.com/ and select the option “request for edit”. This will allow you to request your enrollment, change your address, drop coverage, or ask a question. With this option you will receive an email confirmation back on your response when completed or answer to your question.

OptumHealth Financial Services, Inc. is committed to meeting your service needs. Please contact our Customer Service Center at **(866) 301-6681** if you have any questions. We look forward to serving you.

Sincerely,
OptumHealth Financial Services, Inc.

OptumHealth
Financial Services, Inc.

## AUTOMATIC WITHDRAWAL OF INSURANCE PREMIUMS

If you are a participant you can conveniently have your premium payments automatically deducted from your checking or savings account. Simply complete this form and return it to UHCServices. Allow *up to 10 business days* from the date received for processing of this form.

***If you have outstanding premium payments due, you may include a check made payable to OptumHealth Financial Services, Inc. in the amount of the outstanding premium payments along with this form.***

☐ **I hereby authorize** OptumHealth Financial Services, Inc. to electronically withdraw the amount of my Billing insurance premium payments from the designated checking or savings account listed below. I also authorize the financial institution indicated to debit such account.

☐ I understand withdrawals will be made on the 1st of the month for which the payment is due (or on the next banking day if the 1st is a non-banking day). I further understand that this form may take up to 10 business days from the date received to process. If I am mailing this form close to the 1st of the month for which the premium payment is due, I will include a check for the premium payment due on the 1st. Automatic withdrawals will then commence on the following premium payment due date.

☐ **I understand** that if my automatic withdrawal is rejected by my bank due to insufficient funds or other circumstances, OptumHealth Financial Services, Inc. may, but is not required to, attempt to resubmit the automatic withdrawal. Any automatic withdrawal not honored by my bank will be considered not paid and could result in cancellation of the corresponding insurance coverages. Additionally, the Automatic Withdrawal of Insurance Premiums will automatically be discontinued. Future premium payments must be made via personal check or money order.

☐ **I understand** that automatic withdrawals will continue as the premiums come due until such time that I either cancel this agreement by completing a new form or the corresponding coverages expire.

**Employer Name:** _____

**Your Name:** **«First_Name» «Last_Name»**

**Soc. Sec. #:** - - _____

**E-mail Address:** _____

**Bank Name:** _____

**EFT Effective Date:** _____

**Account Type:** **__ Checking __ Savings**

**Is this request:** **__ New __ Change __ Cancel**

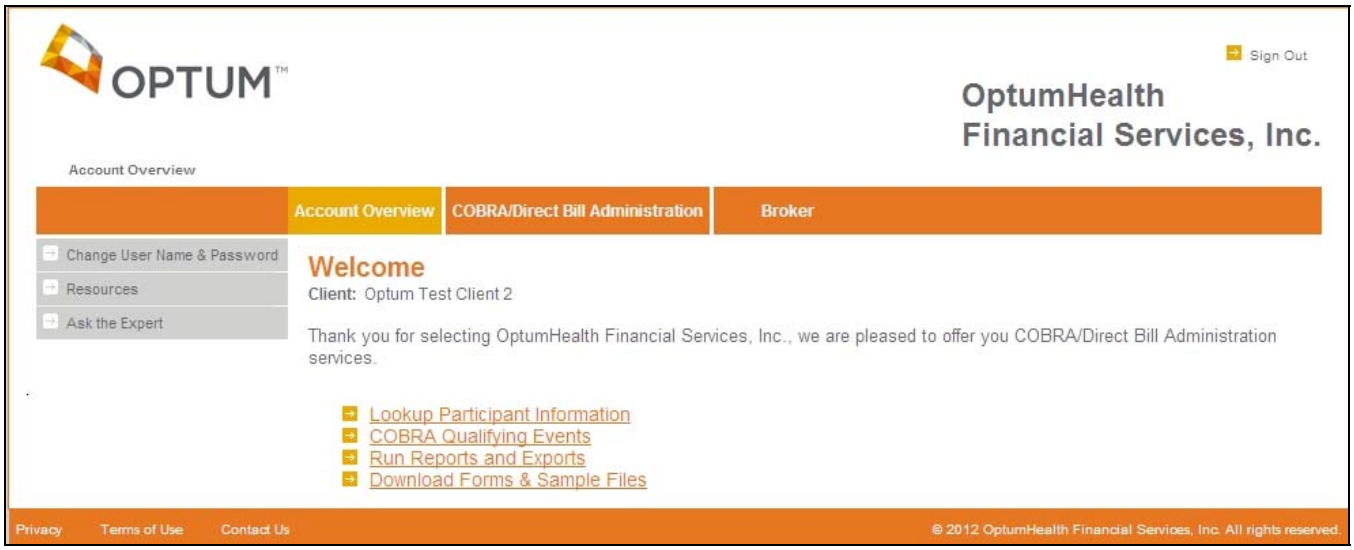
**Your Signature:** _____

**Date:** _____

# Chapter 5 – https://adminservices.optumhealthfinancial.com/

## *Web Services Employer*

- Login and Navigation
- Ease of Use




Functions Available

- Lookup or search participant information
- Individual report of transactions
- View forms / Letters sent to participant
- Summary participant information
- Summary payment information
- Run Reports and Exports
- Download forms / Files
- Submit a Qualifying Event Notification Request
- Print a General Notice or Initial Notice

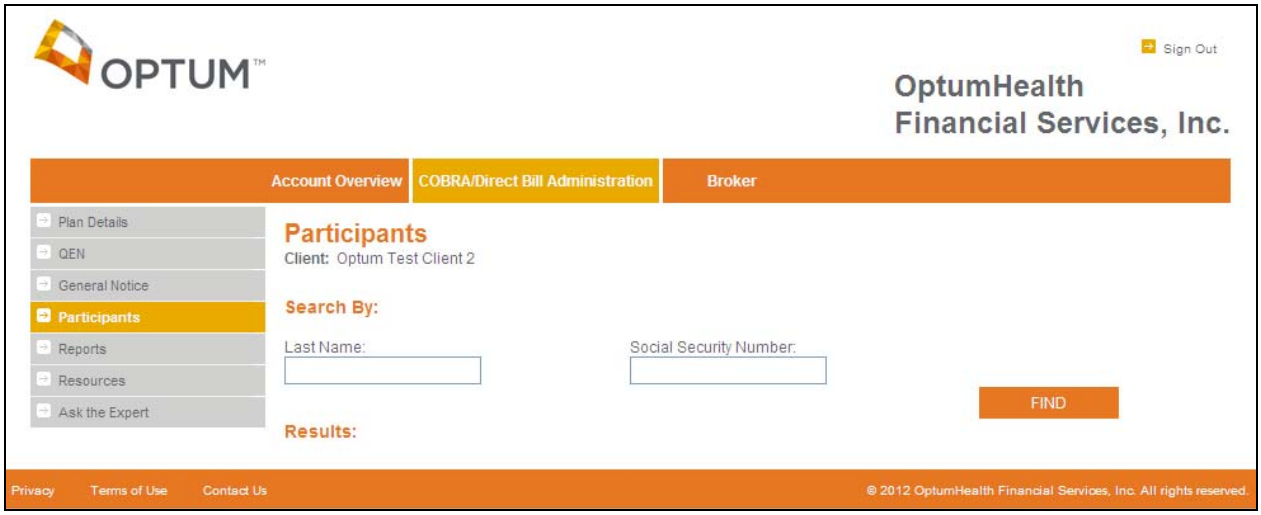
What is accessible on the client website?

- Entry of a new Qualified Beneficiary
- Participants and Dependents which are enrolled
- Payments received by participant
- Amount due by participant
- Who has terminated
- Who is in notified status
- New features scheduled for release this quarter

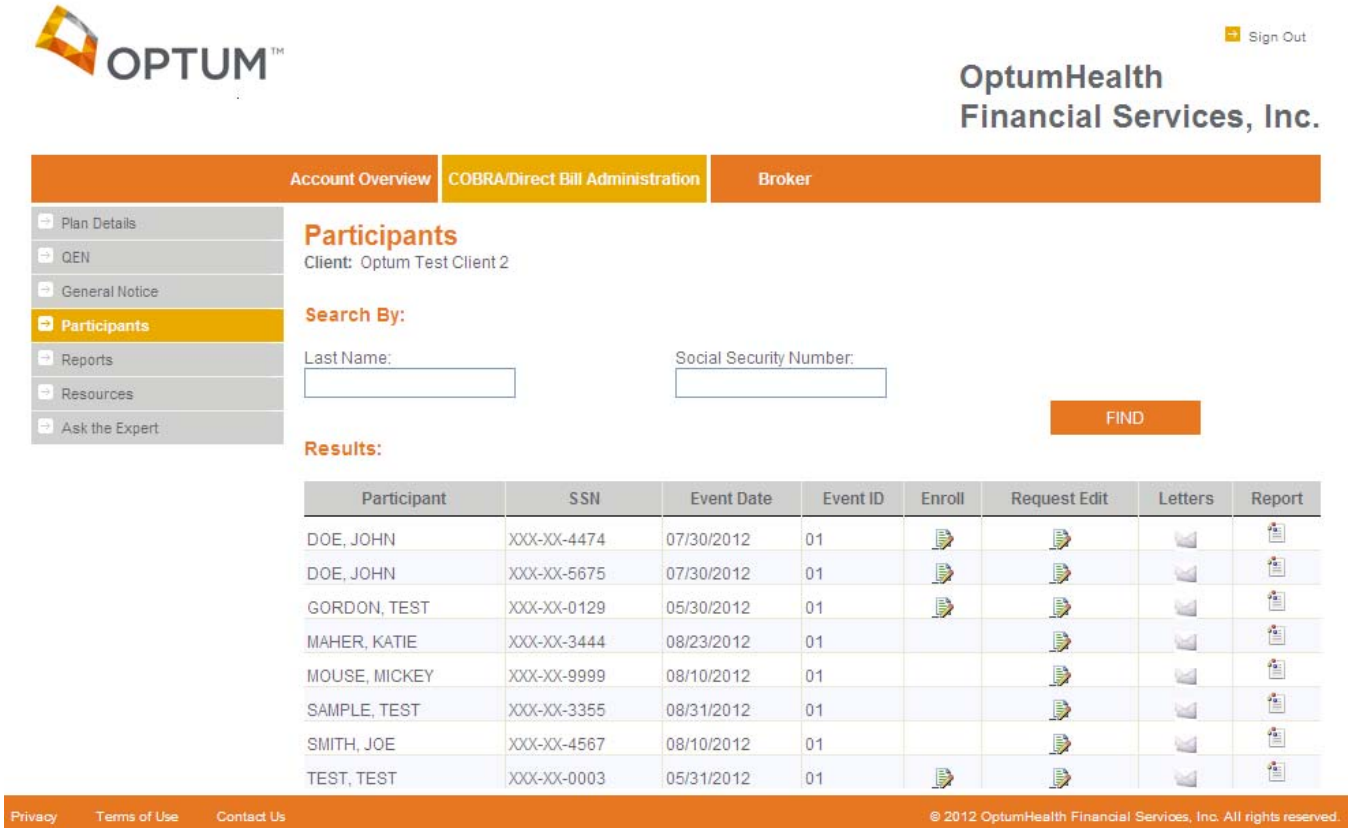
- Participant demographic information
- Dependent demographic information
- Invoice / Payment history
- All forms previously sent to a participant, viewable and printable
- Notes on participant's account
- Printable status sheet per participant
- Expanded security features

## *Look-up Participant Information*

The participant lookup provides two options to find both current and previous enrolled or notified participants. Enter either the Last Name (all or part of the last name) or Social Security Number (all or part) to locate the participants matching the search criteria.
To return all participants (active and terminated) press FIND.



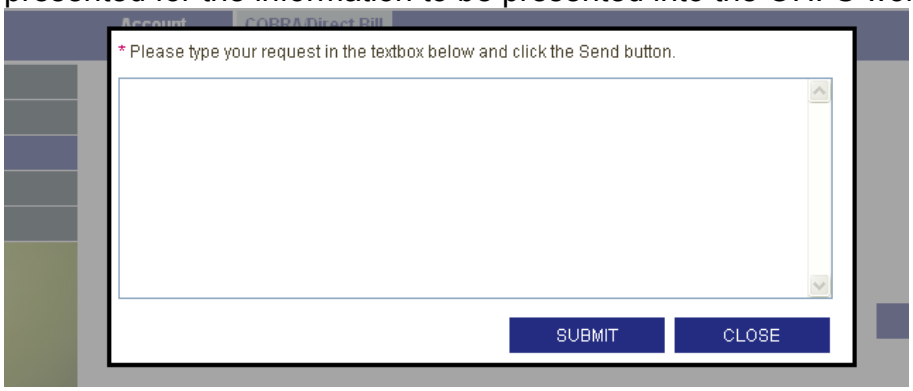
The results of the search will be displayed along with the options available for the participant.



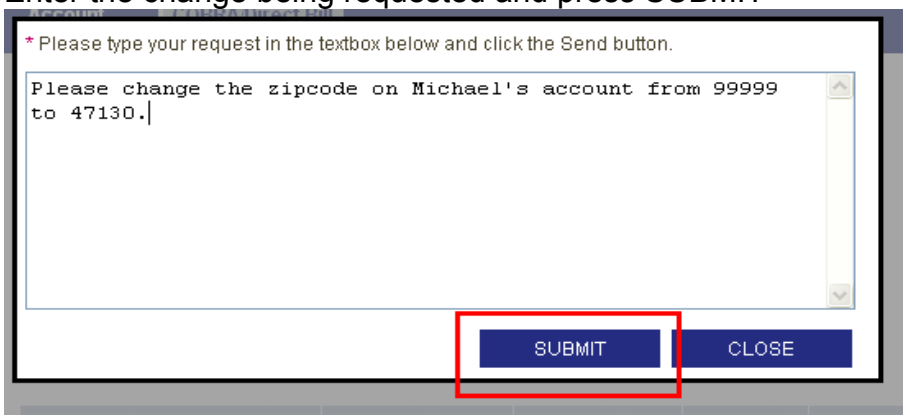

- Participant – Last Name, First Name of the participant
- SSN – Social Security Number of the participant. The information is masked for security reasons
- Event Date – For COBRA this will be the date of event, i.e. termination, divorce, date the child left college or reached maximum age of coverage. For a Direct Bill Participant the event date could be the retirement date or the date the coverage was lost or to be offered.
- Request Edit – will allow for a submission of a change to the record, i.e. address change, notification of termination, information provided by the participant or notification of death.
- Letters – any letter printed for the participant as of 09/01/2012 or the date the participant was added to the system which ever is greater
- Report – the report is a personal report for the participant selected which includes demographic, dependents, coverage's, and payments.

## *Requesting a change*

To request an edit press on the paper image under Request Edit. There will be a request form presented for the information to be presented into the OHFS work flow.

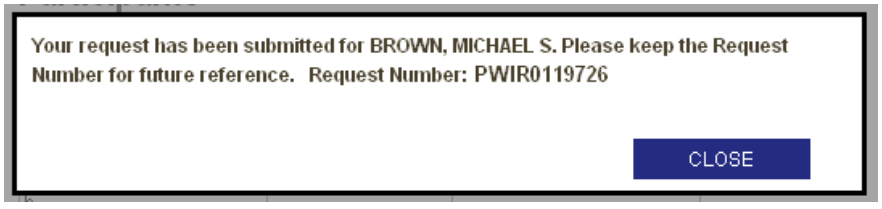



Enter the change being requested and press SUBMIT



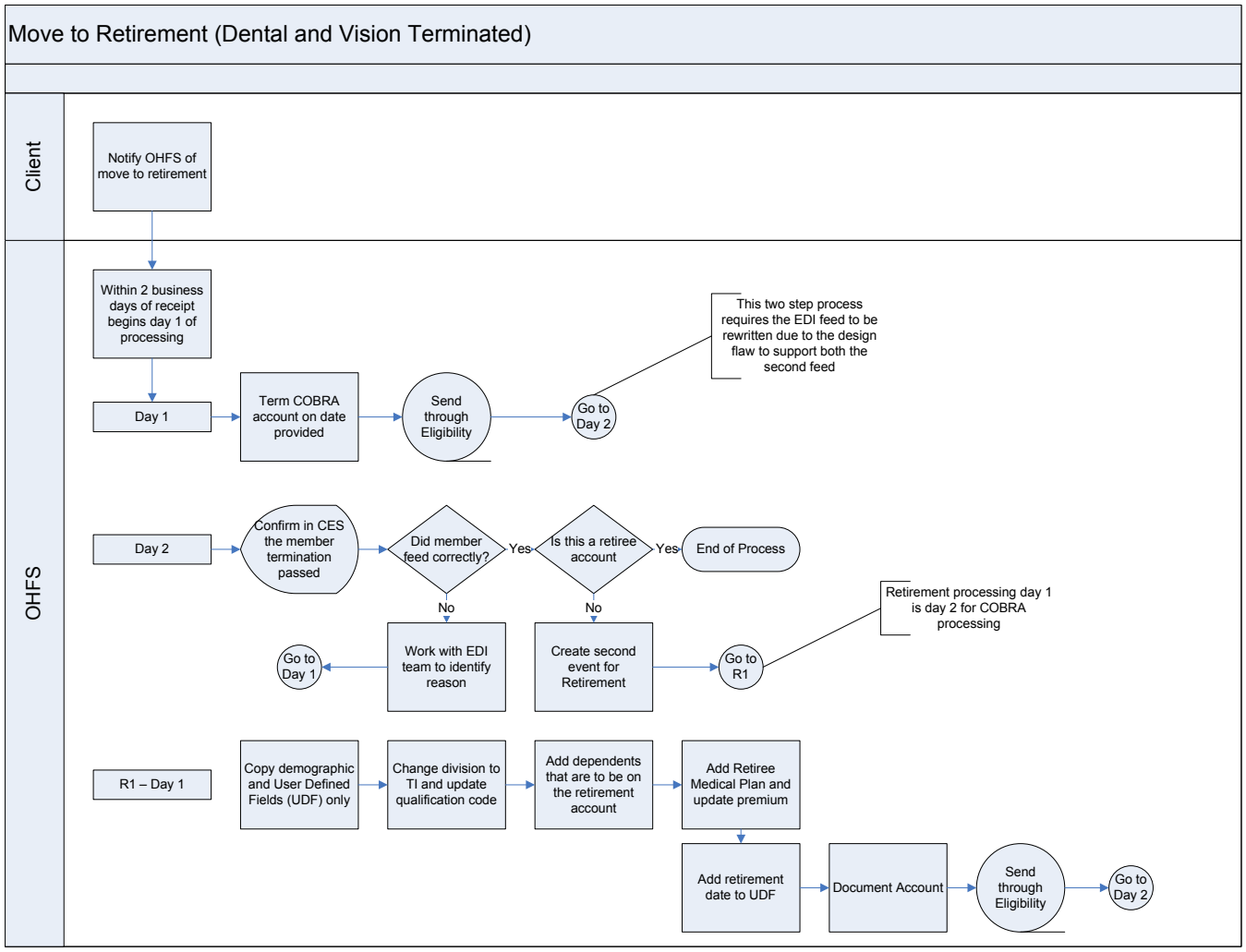

Once submitted a tracking or request number is provided for future questions or reference if needed.

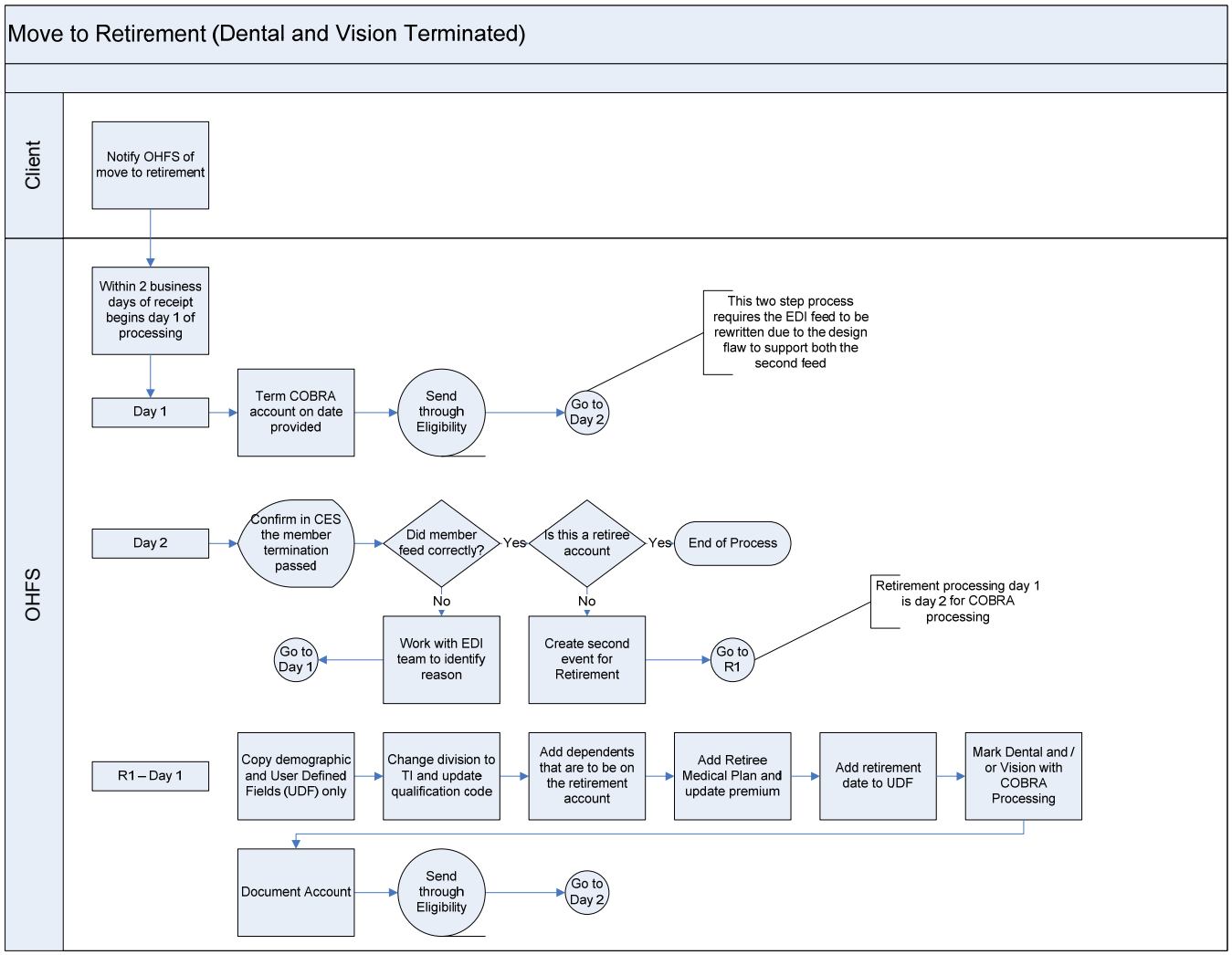
After the request has been processed you will receive an email confirmation the change was completed



# Chapter 6 – Direct Bill Continuation

Direct bill continuation is offered as a service by OHFS.




Move to Retirement (Dental and Vision Terminated)
Client
OHFS
Notify OHFS of move to retirement
Within 2 business days of receipt begins day 1 of processing
Day 1
Term COBRA account on date provided
Send through Eligibility
Go to Day 2
This two step process requires the EDI feed to be rewritten due to the design flaw to support both the second feed
Day 2
Confirm in CES the member termination passed
Did member feed correctly?
Yes
Is this a retiree account
Yes
End of Process
No
No
Go to Day 1
Work with EDI team to identify reason
Create second event for Retirement
Go to R1
Retirement processing day 1 is day 2 for COBRA processing
R1 – Day 1
Copy demographic and User Defined Fields (UDF) only
Change division to TI and update qualification code
Add dependents that are to be on the retirement account
Add Retiree Medical Plan and update premium
Add retirement date to UDF
Mark Dental and / or Vision with COBRA Processing
Document Account
Send through Eligibility
Go to Day 2

# Chapter 7 - State Continuation Laws

OHFS is contracted by the company to administer the federal mandates of COBRA continuation coverage. However, certain state laws are closely related to but are not technically part of COBRA.
At the outset, it should be clearly understood that state continuation laws apply to insured group health plans. As a result, state continuation law requirements typically apply to insurers, not to employers. Thus, the applicable state Department of Insurance has jurisdiction over that state's continuation laws.

State continuation laws can be classified into two basic categories. First, most continuation laws apply only to insurance policies for small employers who fall below the 20-employee threshold for COBRA. These are often referred to as 2-19 continuation laws. Second, states may apply to groups with 20 or more employees. If a plan is subject to COBRA, the federal law and the state continuation both apply to the plan. If a plan is not subject to COBRA, only the state continuation would apply. While many of the state continuation laws apply to the employer, some state continuation laws are the responsibility of the insurer.

# Appendix

## Section 1 – Terminology

### *After-Acquired Dependent:*
An individual who was not covered under the medical plan when coverage terminate, but who later becomes covered under the plan as a dependent of a qualified beneficiary. An after-acquired dependent may be a spouse or child. These are non-qualified beneficiaries and their eligibility for continuation is limited to the eligibility of the original COBRA participant.

### *Carrier:*
Any commercial insurance company, i.e. UnitedHealthcare, Delta Dental, etc. or other underwriter that provides insurance protection, such as medical, dental, vision, life, disability, for employer benefit plans.

### *COBRA:*
(Consolidated Omnibus Budget Reconciliation Act of 1985): This federal law amended the Internal Revenue Code, ERISA, and the Public Health Services Act to require most employers maintaining group health plans to offer Employees, their spouse, and their Dependents the opportunity to elect continuation coverage, on a self-pay basis, for 18, 29, or 36 months, depending on the Qualifying Event.

### *Continuation Period:*
The period of time during which a Qualified Beneficiary may continue his or her coverage under the employer's plan.

### *Continuee or COBRA Continuee:*
Any persons entitled to receive continuation of coverage that has elected to do so.

### *Conversion Privilege:*
A contractual right of a terminating employee to convert from group coverage to an individual policy without providing evidence of insurability.

### *Coverage Begin Date (Effective Date):*
First Date of active coverage on a Health Plan.

### *Dependent:*
Any person who is BOTH eligible for coverage and covered as a Dependent spouse or child under the Plan Sponsor's health plan on the day before a Qualifying Event.

### *Disability:*
The inability to perform all or some portion of the duties of one's occupation or, alternatively, any occupation as a result of a physical or mental impairment. Extension of COBRA benefits is limited to only Social Security disabled Participants.

### *Election Period:*
The time period in which a Qualified Beneficiary must elect COBRA coverage. The time period is 60 days from the loss of coverage, 60 days from the Qualifying Event date, or 60 days from the date they were notified of continuation rights, whichever is latest.

### *Enrollment Date:*
The first day of coverage or the first day of the Waiting Period (typically the employment date).

### *Employee:*
Any person who is both eligible for coverage and covered as an Employee under the Plan Sponsor's health benefit plan on the day before the Qualifying Event.

### *Grace Period:*
A period that follows the due date of the premium after which the policy continuation is enforced.

### *HIPAA:*
Health Insurance Portability and Accountability Act of 1996: This federal law enacted portability, accessibility, and accountability requirements for group health plans and health insurance issuers. The new requirements make it easier in certain respects for an individual to obtain and/or maintain health insurance coverage.

### *HIPAA Certificate of Creditable Coverage:*
A certificate should be given to the Employee and/or Dependents that lose coverage. The Certificate identifies the Carrier and time the Participant had coverage.

### *General Notice:*
This notice explains the opportunity to continue the group insurance benefits should the Employee become ineligible for participation in the plan. It specifies "Qualifying Events" that may make them eligible for COBRA continuation and explains the responsibilities and time frames that must be followed to participate in this continuation privilege.

### *Medicaid:*
A medical benefits program for low-income people paid for jointly by the federal government and the applicable state and administered by the applicable state. Medicaid provides medical benefits to persons who meet certain criteria and whose incomes fall below specified maximums.

### *Medicare:*
A federal program of medical and hospital benefits, generally for those over age 65.

### *Paid Participant:*
An Elected Participant whose continuation health plan coverage premium has been timely received and who remains eligible for such continuation coverage.

### *Plan Administrator:*
The person specifically so designated by the terms of the instrument under which the plan is operated, or if an administrator is not so designated, the Plan Sponsor. OHFS is not the Plan Administrator, and they do not operate in a fiduciary capacity. In most cases, the employer will be the Plan Administrator. Please refer to your administrative services agreement (ASA) for more information on the role of OHFS.

### *Plan Sponsor:*
The employer or employee organization in the case of a plan established or maintained by an employee organization. OHFS is not the Plan Sponsor, and they do not operate in a fiduciary capacity. In most cases, the employer will be the Plan Sponsor. Please refer to your administrative services agreement (ASA) for more information on the role of OHFS.

### *Qualified Beneficiary:*
A Participant who became eligible for COBRA continuation because of a Qualifying Event. The Participant must be covered on the health plan one day prior to the Qualifying Event. Beneficiary wording in this agreement is both singular and plural.

### *Qualifying Event:*
The occurrence of any of the following specific events that result in a loss of coverage by a Participant under the Plan(s):

a.) Death of a covered Employee or covered retiree;
b.) Termination of employment of a covered Employee (for reasons other than gross misconduct) or reduction in Employee's hours;
c.) Divorce and/or legal separation from the covered Employee;
d.) Covered Employee/retiree becoming entitled to Medicare;
e.) Dependent children who cease to be eligible as "Dependents" under provision(s) of the Plan(s);

f.) Client filing for bankruptcy whereby loss or substantial elimination of benefits under Plans(s) within one year before or after the commencement of bankruptcy proceeding; and
g.) Any other event resulting in a covered Employee and/or Dependent becoming qualified to continue coverage under the provisions of COBRA.

### *Qualifying Event Notification:*

This notice is sent when a Plan Participant (covered Employee or Dependent) loses insurance benefits because of one of the specified COBRA Qualifying Events; they will be notified of their opportunity to continue the coverage if this service has been selected. Each Participant has an opportunity to make a separate continuation decision. The continuation time is determined by the Qualifying Event.

### *Special Enrollee:*

Individuals who become dependents through marriage, birth, adoption, or placement for adoption are allowed to enroll during special enrollment periods without having to wait for the Plan's regular Annual/Open enrollment season.

# Section 2 – Timing of COBRA Processing

## *Clarification of Dates:*

1. All timings below assume all calendar days and not business days

2. All timings assume no holidays.

    a. If a holiday does fall within the timeframes, the number of days for the holiday(s) would be subtracted from the time. i.e. if the Qualifying Event Notice was sent on November 15th, Thanksgiving, day after Thanksgiving, Christmas and New Year's day would not be included in the 60 day window (the holidays are based on OHFS's holiday schedule)

## *Notification of Termination*

1. If a client has outsourced their COBRA administration, the client has 30 days to provide the COBRA termination to the TPA. In the realm of COBRA administration, OHFS is considered a TPA.

2. The TPA has 14 calendar days to mail the Qualifying Event Notification to the participant

3. If a client self-administers their COBRA, they have 14 days to send out the Qualifying Event Notification to the participant

## *Participant Timing*

1. The participant has 60 days from the mail date of the Qualifying Event Notification or the loss of coverage date, whichever is greater, to elect COBRA

2. At any time during the 60 days the Qualified Beneficiary can choose to elect or decline coverage

3. If the participant declines coverage, they can then enroll at any time as long as they are still within the 60-day window. If the participant has formally declined coverage, the effective date of the plan is the date of the election and is not the actual COBRA

effective date. The client / carrier can elect to be more generous and allow the retro election date.

## *Election Timing*

1. OHFS has a standard 3 day turn around timing for processing the enrollment

2. The participant can enroll via

    a. Web at https://adminservices.optumhealthfinancial.com/

    b. Mailing the enrollment form to OHFS

    c. Faxing the enrollment to OHFS

    d. Emailing a scanned copy of the enrollment form

    e. Emailing a letter of request to enroll

3. Once the processing is complete an initial invoice is mailed to the participant for payment

4. The participant has the option to make a payment at the time of the election, if so the initial payment process is skipped.

## *Payment Process*

Initial Payment Process

1. The participant has 45 days from the election date, which is defined as, the postmark if the election is mailed, the fax date if faxed, the election date if on the web, the email date if emailed to make the first payment, which include all retro months to the current month.

2. If the COBRA benefit date is the day following the event, the initial invoice will include moving the invoice date to the first of the month.

Ongoing Payment Process

1. The ongoing payment is due each month on the first of the month
2. The participant has a 30 days grace period to pay the invoice
3. If the invoice is due on September 1, the invoice is produced and mailed to the participant on or around August 8.
4. The invoice due date is marked as September 1st
5. The grace period would be through September 30th
6. If the invoice is due on February 1, the invoice is produced and mailed to the participant on or around January 8th
7. The invoice due date is marked as February 1st
8. The grace period would be through March 2nd

## *Eligibility Notification*

1. Once the payment is received, OHFS's standard process is to send the election information to the carrier for reinstatement of benefits
2. All notices and information provided to the participant state that benefits may not be paid until the payment is received

## *Termination Processing / Eligibility Processing*

1. Non-Payment Processing
    a. Initial Payment
        i. The participant has 45 days to make their first payment. If the

payment is not made within the stated period, the participant is retro termed to the day prior to the COBRA effective date. (OHFS allows a 7-day mail handling timeframe. The payment must be postmarked by the end of the grace period. The only reason for the mail period is for the payment to be received and processed. It does not extend the timeframe for the payment.)

ii. A termination notice is sent to the participant notifying them of the non-payment termination

iii. Since nothing has been sent to the carrier, the carrier will not be notified

b. Ongoing Payment

i. The ongoing payment for COBRA benefits is due on the first of each month. There is a 30-day grace period. If the payment is not received within the 30-day window, the participant's benefit/s are retro termed to the last date paid. (OHFS allows a 7-day mail handling timeframe for the payment to be received. The payment must be postmarked by the end of the grace period. The only reason for the mail period is for the payment to be received and processed. It does not extend the timeframe for the payment.)

ii. A termination notice is sent to the participant notifying them of the non-payment termination

iii. Eligibility is sent weekly to the carrier making notification of the retro termination to the last period paid.

2. Participant requested termination processing

a. Termination is processed at the end of the month requested

b. Eligibility is sent weekly to the carrier making notification of the retro termination

c. If the participant requests a retro term, the participant must show proof of

other coverage. If the proof is provided, we will retro term no greater than 60 days or 2 months including the current month.

i. Example, if the participant requests a retro term on September 10 to June 30, we would allow the retro termination to July 31.

*Please note that the information contained herein is provided to readers for informational purposes only and you may not rely on this information as legal or any other advice. You should consult with your own legal counsel to ensure compliance with applicable law.*