UnitedHealthcare
Benefit Services COBRA and Retiree Administrative Services

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UnitedHealthcare Benefit Services

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Chapter 1 - Introduction

Welcome to UnitedHealthcare Benefit Services

Nearly every employer is faced with the need to provide continuation of benefits under COBRA. With UnitedHealthcare 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.

Unlike many other carriers, UnitedHealthcare manages its COBRA services internally, not through a carrier/third-party administrator arrangement. This means our sole focus is on providing comprehensive, efficient COBRA services to meet the unique needs of UnitedHealthcare customers, including serving all lines of coverage, even where ancillary lines are provided by another carrier

UnitedHealthcare has been providing COBRA services since 1999. With ten years of exceptional COBRA administration experience, we are well versed in COBRA regulations, case law 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 UnitedHealthcare's COBRA services benefit from our sound practices and gatekeeper activities that mitigate risk of financial loss for non-compliance of COBRA laws.

UnitedHealthcare'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 and mitigate claim exposure. 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. To further illustrate our ownership of the COBRA member service experience, we save our clients the responsibility of eligibility updating as we update COBRA eligibility for them on UnitedHealthcare plans daily. All non-UnitedHealthcare 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.

UnitedHealthcare 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 process documents details how to fully leverage the depth of our services.

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Please Note:

- This Guide is for informational purposes only and does not bind UnitedHealthcare 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.
- UnitedHealthcare 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 UnitedHealthcare to assume liability relating to an employer's obligations under applicable law.

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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, retirees and their families to have access to 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

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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 child 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 dependent 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,

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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 2000, a company would review its employee work force data during the "look back" period of calendar year 1999. 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, 2000.

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, UnitedHealthcare 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:

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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 minimis" (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. UnitedHealthcare Benefit Services' expert COBRA management system, coupled with our meticulous documentation and record keeping policies, is unmatched in the employee benefits industry. As your professional COBRA administrator, UnitedHealthcare Benefit Services monitors pertinent court cases, analyzes the results and integrates any necessary changes into our administrative forms and procedures. We perform compliance duties with exacting detail and precision to minimize the exposure to lawsuits and COBRA non-compliance penalties.

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Chapter 2: COBRA continuation Coverage Guidelines

Introduction

COBRA continuation coverage involves numerous statutory rules and regulations. At a minimum, you should be familiar with general COBRA provisions and concepts in order to understand UnitedHealthcare'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, the spouse of the covered Employee or a Dependent 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.

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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 Dependent child can be a Qualified Beneficiary if he or she is a covered Dependent 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 Dependent 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

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employment termination, Employee death, etc.), we suggest that 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 Dependent 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
- The employer's commencement of a bankruptcy proceeding under Title 11 of the United States Code

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.,

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- Death of covered employee
- Divorce or legal separation between the covered employee and spouse
- Employee's entitlement to Medicare benefits
- The employer's commencement of a bankruptcy proceeding under Title 11 of the United States Code
- 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 UnitedHealthcare. 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.

First, an employer cannot invoke the gross misconduct rule if an Employee resigns before being terminated by the employer. Therefore, an Employee involved in a gross misconduct situation can voluntarily resign, thereby preserving his or her COBRA rights, even if employer termination was imminent.

Second, gross misconduct is not defined within the COBRA statute. The absence of a statutory definition results in subjective and inconsistent interpretations of what constitutes gross misconduct. One employer's perception of gross misconduct may be unacceptable to a judge in a courtroom.

Third, some courts have ruled that the intent of the gross misconduct rule was to inhibit an Employee's ability to receive continuation coverage, not hinder his or her spouse and Dependents' access to COBRA. Hence, even in a verifiable gross misconduct situation, an employer may still have an obligation to offer COBRA to the Employee's eligible Dependents. In turn, the Dependents who are Qualified Beneficiaries could then add the Employee to the plan at the next Annual/Open enrollment.

The ambiguity associated with the gross misconduct rule leaves many to question whether it is

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wise to exercise this provision at all when it risks exposure to possible litigation. Most employers conclude that there is little to lose by offering COBRA continuation, even in circumstances of gross misconduct. 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 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.

Health Flexible Spending Accounts under COBRA

Employers who maintain health flexible spending accounts (FSAs) must follow the 2001 final regulations, which permit certain qualifying health FSAs to either deny COBRA altogether, where the Employee has overspent his account or limit the COBRA coverage period, with respect to the health FSA, to the end of the year in which a Qualifying Event occurs.

Specifically, the 2001 final regulations provide two limited exceptions from COBRA for health FSAs. The first exception applies if a health FSA satisfies two conditions. With this exception, the health FSA need not make COBRA coverage available to a Qualified Beneficiary for any plan year after the plan year in which the Qualifying Event occurs.

- The first condition is that the health FSA must not be subject to HIPAA portability provisions. A health FSA is not subject to HIPAA portability provisions if the employer also provides another group health plan, the benefits under the other plan are not limited to excepted benefits (e.g., limited scope dental and vision), and the maximum reimbursement under the health FSA is not greater than two times the Employee's salary reduction election (or if greater, the Employee's salary reduction election plus five hundred dollars).

- The second condition is that in the plan year in which the Qualifying Event occurs, the maximum amount that the health FSA could require to be paid for a full plan year of COBRA coverage equals or exceeds the maximum benefit available under the

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health FSA for the year. This is typically met by most health FSAs. For example, if a health FSA limits reimbursements to Employees' salary reduction amounts, this condition is always met because the maximum amount that the health FSA could require as payment for the full plan year of COBRA (102% of salary reduction) always exceeds the maximum benefit for the year (100% of salary reduction).

The second health FSA exception under the 2001 final IRS rules provides that COBRA need not be offered to a Qualified Beneficiary who has overspent his or her account as of the Qualifying Event date. For example, if an Employee has to pay $600 (plus 2%) for the second half of the year of the Qualifying Event ($100 per month) and will only be eligible for $200 of reimbursements (because the individual was already reimbursed $1,000), COBRA coverage does not have to be offered at all.

The practical effect of these COBRA rules is that many employers who maintain HIPAA-excepted FSAs may find it easier simply to always offer COBRA coverage for the rest of the year in which a Qualifying Event occurred. That way, the employer will not have to decide which of the two FSA exceptions applies.

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.)

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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.

Claims Incurred During Election Period

The 2001 final regulations state that for indemnity or reimbursement plans that terminate a Qualified Beneficiary's coverage upon a Qualifying Event and allow retroactive reinstatement, the plan is not required to process payment for claims incurred by a Qualified Beneficiary during an Election Period. Instead, the plan can wait until a timely election and premium payment has been made before processing suspended claims

In the case of an HMO plan, the plan can require a Qualified Beneficiary who has not yet elected and paid for COBRA continuation coverage to either: (1) elect and pay for coverage, or (2) pay the reasonable and customary charge for the plan's services. For the latter, the plan must provide reimbursement to the Qualified Beneficiary within 30 days after election and payment of continuation coverage are made. Alternatively, the plan can provide continued access to services and treat the Qualified Beneficiary's use of the facility as a constructive election whereby the Qualified Beneficiary is obligated to pay any applicable charge for the coverage. However, the Qualified Beneficiary must be informed of this stipulation prior to use of the facility.

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

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- 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 (for Social Security purposes) 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 UnitedHealthcare 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 UnitedHealthcare 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

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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.

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Disability Extension

Time Frame	Participant	UnitedHealthcare	Carrier
Within 60 days of receiving the determination letter	The participant provides UnitedHealthcare with documentation declaring disability by the SSA.		
Within 2 business dates		Stamp the date received on the SSA letter of the award and scan the document and envelop in Issue View.	
Within 2 business dates		Issue View is assigned to operations team member for assessment and processing	
Within business 14 days of receipt of the request		Enter the extension in the system / send participant a notification of new eligibility end date / premium information.	
Monthly	Participant remits monthly premiums by due date / grace period		
As scheduled		UnitedHealthcare notifies carrier of extension thru eligibility reporting	
Upon receipt			Carrier updates enrollment with new pay through date
Not received within the required time or not the proper documentation			
If the letter is not received within 60 days of receiving the determination letter	The participant provides UnitedHealthcare with documentation requesting disability extension		
Within 2 business dates		Stamp the date received on the SSA letter of the award and scan the document and envelop in Issue View.	
Within 2 business dates		Issue View is assigned to operations team member for assessment and processing	
Within business 14 days of receipt of the request		Send a letter to the participant advising them of the timing and the denial of the extension	
Upon mail delivery	Participant is aware of the denial of the 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 UnitedHealthcare 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.

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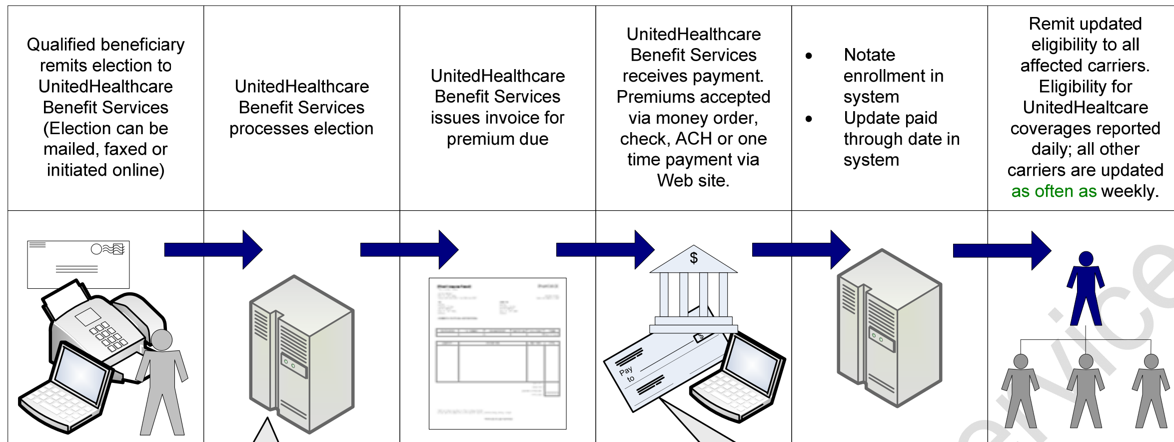

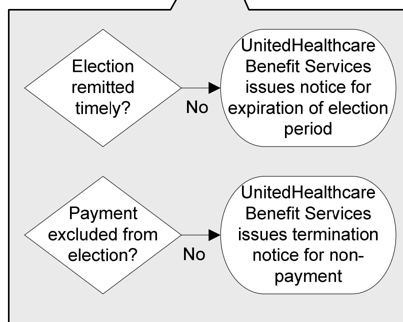

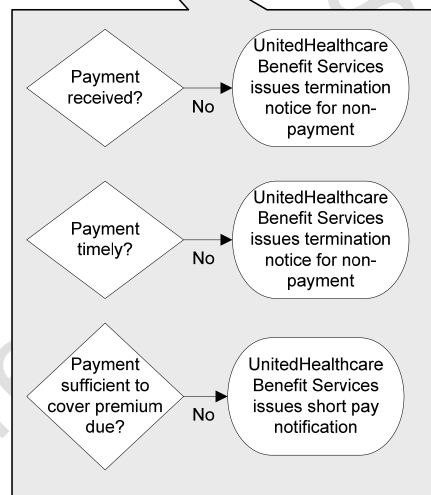

Premium Due Dates

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.

UnitedHealthcare Services

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

	Step	Timing	Responsible Party			
			EE	UnitedHealthcare	Client	Carrier
1.	Participant remits premium that is short by an "insignificant" amount.		√			
2.	UnitedHealthcare 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.	UnitedHealthcare 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, UnitedHealthcare 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

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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.

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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 does not 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 UnitedHealthcare. UnitedHealthcare 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.

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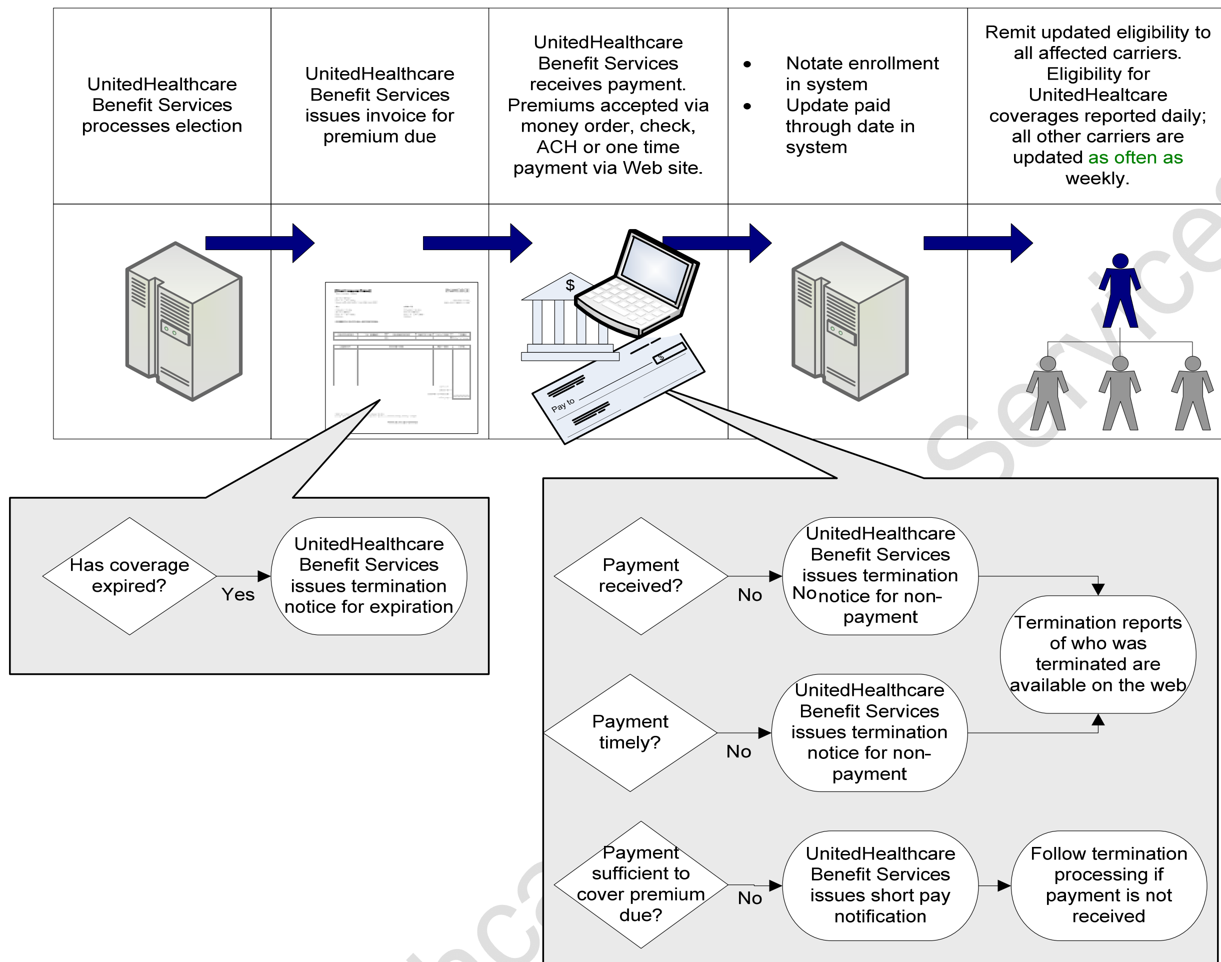

Termination of Retiree Continuation

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.

UnitedHealthcare Services

	Step	Timing	EE	UnitedHealthcare	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 Based on pre agreed upon schedule for all other carriers		√		√
6.	Termination notification sent to participant advising of retroactive termination	7th mail day	√	√		

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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	UnitedHealthcare	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	√	√		

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

Description: Termination of coverage due to request.

	Step	Timing	EE	UnitedHealthcare	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 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	UnitedHealthcare	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	√	√		

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	Step	Timing	EE	UnitedHealthcare	Client	Carrier
4.	Termination notification sent to participant advising of termination	Last day of coverage	√	√		
5.	Termination notification is sent to the carrier	Daily for UnitedHealthcare 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	UnitedHealthcare	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	√		√	

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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 UnitedHealthcare 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.

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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).

Business Reorganizations

The 2001 final IRS regulations set forth new rules that govern how COBRA applies where there is business reorganization. The new rules are as follows:

- Buyer is responsible for providing COBRA if seller cease to maintain a Group Health Plan: The regulations provide that the buyer is responsible for providing COBRA continuation coverage to existing Qualified Beneficiaries if the seller ceases to maintain a group health plan for any Employee. This secondary liability for the buyer applies in all stock sales and in all sales and transfers of substantial assets in which the buyer continues the business operations associated with the assets without interruption or substantial change.
- COBRA Obligation by Contract: The IRS regulations make clear that the parties to a business transaction are free to allocate the responsibility for providing COBRA continuation coverage by contract, even if the contract imposes responsibility on a different party than would the regulations. However, if the party allocated responsibility under the contract defaults on its obligation, and if, under ht regulations, the other party would have the obligation to provide COBRA continuation coverage in the absences of a contractual provision, and then the other party would retain that obligation.
- Asset Sale When Health Insurance is Maintained: This type of asset sale is one in which, after purchasing a business as a going concern, the buyer continues to employ the Employees of that business and continues to provide those Employees exactly the same health coverage that they had before the sale (either by providing coverage through the same insurance contract or by establishing a plan that mirrors the one that provided benefits before the sale). The application of the rules in the IRS regulations to this type of asset sale would require the seller to make COBRA continuation coverage available to the Employees continuing in employment with the buyer. Ordinarily, the continuing Employees would be very unlikely to elect COBRA continuation coverage from the seller when they can receive the same coverage (usually at much lower cost) as active Employees of the buyer.

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Please consult legal counsel to advise the company on issues pertaining to mergers, acquisitions, or business reorganizations. (See also Chapter 4, “Adding a New Division”.)

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.

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UnitedHealthcare 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, UnitedHealthcare 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.

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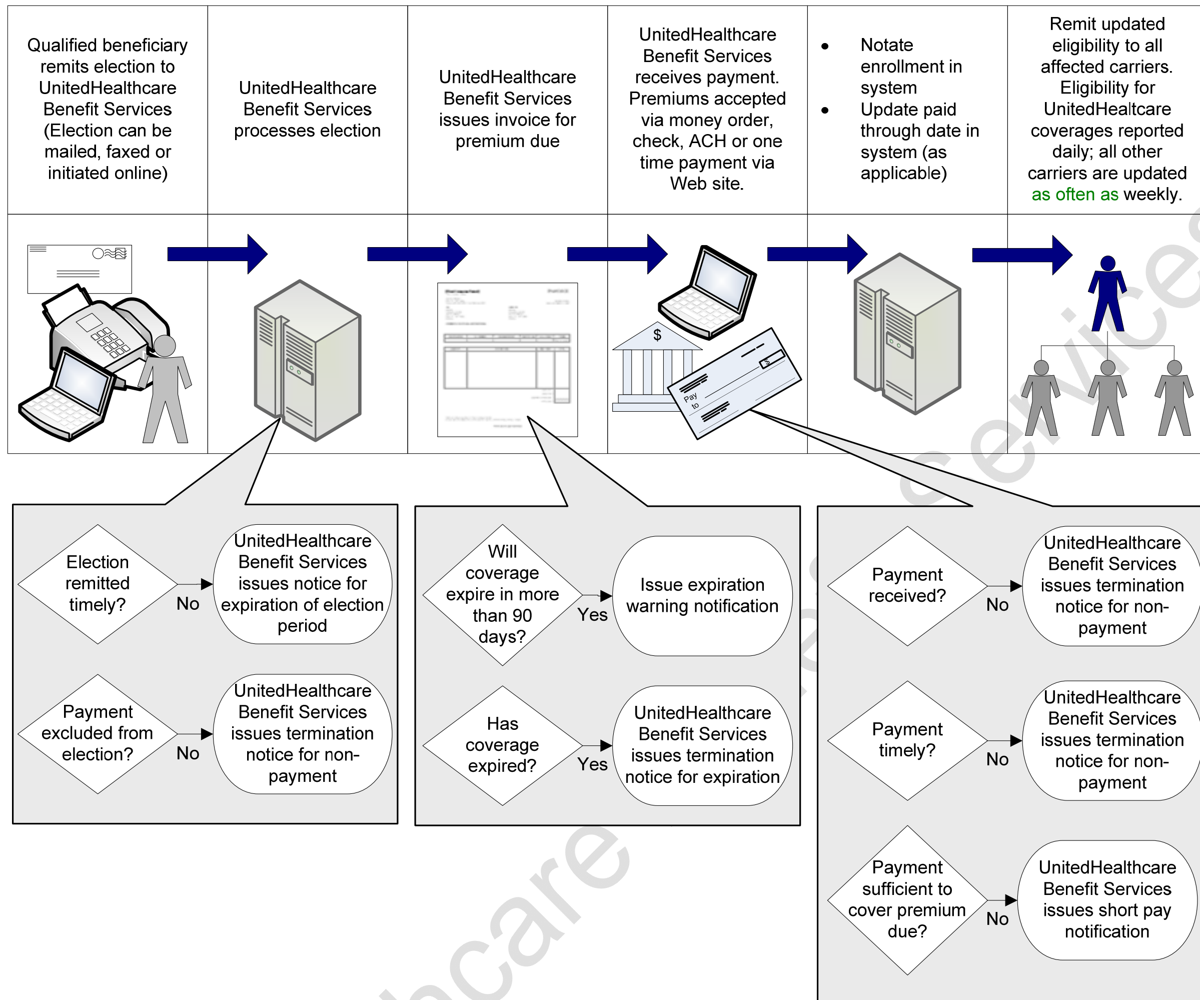

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Description: Process if a Participant requests reinstatement of coverage due to cancellation.

	Step	Timing	EE	UnitedHealthcare	Client	Carrier
1.	The Participant sends in a written request to appeal for reinstatement coverage.	Within 60 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 document processing 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	Within 10 business days	√	√		

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

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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.

President Bush Signs 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.

Background

Group health plans commonly provide coverage to dependent children, age 19 and older but under age 24, who are full-time students. However, plans often do not allow for coverage during a medical leave of absence from school. Michelle's Law requires plans to close this gap under certain circumstances, precluding termination of coverage for a certain period of time for a covered dependent child due to a medically necessary leave of absence. The law is based on a New Hampshire state insurance law that was named after a college student, who was required to maintain her full-time student status while fighting colon cancer, to avoid losing her health insurance coverage.

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.

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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

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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

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COBRA PROVISONS IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

Congress has passed the American Recovery and Reinvestment Act ("the Act"), and the Act has been signed by President Obama. This alert describes the provisions in the Act that affect COBRA continuation coverage and similar state continuation coverage.

Applicability and Effective Date

The COBRA changes affect both the federal COBRA provisions and the Public Health Service Act program that provides similar extension benefits for public programs. In addition, however, the subsidy provisions apply to state continuation coverage that is comparable to federal COBRA. That would include so-called "mini-COBRA" state laws that cover groups below the 20-employee threshold for COBRA. To be comparable, the state continuation law must allow the individual to continue substantially similar coverage as was provided under the group health plan at a monthly cost that is based on a specified percentage of the group health plan's cost of providing such coverage. Reference to "COBRA" throughout this memo will also refer to the state programs that meet those requirements.

The Act is effective February 17, 2009, the day that President Obama signed the bill. All of the COBRA provisions that have a period will date from that day. As for calendar monthly billed programs, the effective date is March 1, 2009.

<u>New Subsidy for COBRA Beneficiaries</u>

The Act provides for a new subsidy for certain COBRA beneficiaries. The subsidy is 65% of the COBRA continuation coverage premiums for eligible individuals for up to 9 months. The COBRA beneficiary will pay only 35% of the overall COBRA premium for that period. The period expires on the earlier of (i) nine months, (ii) the date the individual becomes eligible for major medical group coverage or Medicare or (iii) the end of the maximum required period of continuation under COBRA. Further, the beneficiary must notify the employer in writing if they become eligible for coverage under a major medical group health plan or Medicare and is subject to significant penalties (110% of the subsidy amount) for failing to do so.

An individual who does not receive a subsidy that he/she believes appropriate may appeal the plan's determination to the Department of Labor for private plans or to the Department of Health and Human Services for public plans covered under the Public Health Services Act. The relevant agency must rule on the appeal within 15 business days. Individuals whose appeal is denied may sue under ERISA.

<u>Eligibility for the Subsidy—Timing</u>

The subsidy is available to individuals (and their dependents) who were involuntarily terminated from their employment and became eligible for COBRA beginning September 1, 2008 through December 31, 2009. Persons who elected prior to the enactment of the Act (but on or after September 1, 2008) will be eligible to receive the subsidy prospectively from the date of enactment through the maximum nine-month period. Otherwise, eligible persons who did not elect COBRA between September 1, 2008 and the date of enactment will have the opportunity to elect COBRA on a prospective basis with the maximum duration of the coverage

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dating from the date that they could have first elected COBRA. Employers or plans will have to provide notice to these groups of individuals. In addition, a group health plan or insurer must refund the individuals any COBRA premiums that subsidy-eligible persons paid on or after the date of enactment in excess of 35% of the premium. This may be in the form of a reimbursement payment or credit against future premium payments due.

Eligibility for the Subsidy—Income Test

The subsidy is adjusted based on income. Joint filers with $250,000 or more of modified adjusted gross income and all other filers with $125,000 or more of modified adjusted gross income are not eligible for the full subsidy. The subsidy is phased out completely for persons with modified adjusted gross incomes of $290,000 joint or $145,000 for other filers. The subsidy is not considered income as long as the beneficiary meets the income tests. Excess amounts of subsidy over the amount the person is entitled to by income will be added to the person's tax on the person's federal tax return. The employer will not have to be concerned about the taxable effect on COBRA beneficiaries although a COBRA beneficiary may request that the employer not provide any subsidy.

Mechanics of the Premium Subsidy

The Act requires that the relevant entity that is collecting the 35% premium simply not collect the remaining 65% and, instead, obtain reimbursement from the federal government. In cases of a multiemployer plan, a group health plan subject to federal COBRA and/or a self-funded employer, the plan or the employer that is collecting the premium will recoup the subsidy amounts through commensurate reductions in payroll taxes. For insured plans not subject to federal COBRA, where the insurer is collecting the premium, the insurance company will be entitled to the reimbursement through a corresponding credit to its own payroll taxes. In cases where the payroll taxes are not sufficient to cover the subsidy, the additional amount will be provided as a credit to the taxpayer as if it was an overpayment of payroll taxes. There are filings that payers receiving the subsidy must make with the Secretary of the Treasury.

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Electing a Different COBRA Option

An employer may allow a COBRA-subsidy eligible individual to change his or her health insurance coverage option when making a COBRA election. The new plan option must be made within 90 days of receipt of the COBRA election notice, must have the same or lower premiums and must be available to non-COBRA active employees under the plan.

Notice Requirements and Election Period

Under the Act, employers must provide modified election notices or provide separate supplemental notices to all persons who became entitled to elect COBRA continuation coverage during the period beginning on September 1, 2008 and ending on December 31, 2009.

The new forms would notify the individual about the subsidy and, if applicable, the right to change to different benefits options. DOL, Treasury and HHS are supposed to work together to provide a model notice within 30 days of enactment.

Notices are required to be sent to subsidy-eligible persons who became qualified beneficiaries before the date of enactment within 60 days of enactment. (The Act does not affect the timing of notices sent to individuals who become qualified beneficiaries on or after the date of enactment.) The election period for those beneficiaries who became eligible before the date of enactment will begin on the date of enactment and end 60 days after the date the plan administrator provides the required notice.

Failure to provide the notices would be a COBRA violation and subject to the standard COBRA penalties of up to $110 a day under ERISA. Additionally, there could be adverse tax consequences under the Internal Revenue Code, which can impose excise taxes of $100 per day per notice on the plan administrator.

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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.

Initial Notifications

The most recent legislation regarding insurance portability now requires that a notice is distributed to all new full-time Employees who will be offered the opportunity to enroll in-group health plans informing them of special enrollment rights and Preexisting Condition provisions, as described in the following paragraphs.

Process: New Hire (HIPAA Initial Notice)

If you have selected the Initial HIPAA Rights Notification service from UnitedHealthcare, we should be notified immediately (via file or website entry) upon the first day of work of a new Employee.

Portability Provisions

HIPAA restricts the extent to which group health plans may impose Preexisting Condition limitations on Plan Participants. The law provides that the length of a plan's Preexisting Condition exclusion must be reduced by the period of an individual's prior continuous creditable coverage (including COBRA coverage). For example, suppose that Employee A was

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covered by a group health plan for four months prior to termination and elected COBRA coverage for an additional two months. Assume further that Employee A accepts a new job and enrolls in his new employer's group health plan that has a 6-month Preexisting Condition exclusion period.

In this example, the new plan's Preexisting Condition exclusion period would be eliminated by Employee A's six months of prior creditable coverage (four months of coverage as an active Employee plus two months of COBRA continuation coverage). Therefore, the former employer may invoke COBRA's "other group health plan coverage" rule in which continuation coverage may be terminated if a Qualified Beneficiary becomes covered under another group health plan that does not have any applicable Preexisting Condition exclusion or limitation.

Preexisting Condition Rules

HIPAA established certain rules that regulate how a group health plan can impose Preexisting Condition exclusions. These rules pertain to the duration, applicability and criteria for identifying which medical conditions can be excluded. First, to the extent that a medical condition is recognized as "pre-existing," exclusions or limitations may only apply to conditions in which medical care or advice was recommended or received within the six-month period preceding the Plan Participant's Enrollment Date. Second, the preexisting exclusion or limitation period cannot exceed 12 months (except if the Plan Participant is a Late Enrollee, in which case the maximum period is 18 months). Third, the maximum exclusion period can be reduced or eliminated by any period of prior continuous creditable coverage (see "Creditable Coverage" below).

Creditable Coverage

HIPAA includes a significant mandate to provide portability of covered benefits under its guidelines for creditable coverage. Creditable coverage is defined as coverage under a group or individual health plan, Social Security, public health plans or similar programs. Creditable coverage does not include such plans as accident or disability income insurance, limited scope dental or vision benefits, long-term care plans, specified illness benefits or automobile medical insurance.

Only an individual's period of prior continuous creditable coverage may be applied to reduce or eliminate a new plan's Preexisting Condition exclusion period. The law stipulates that coverage is deemed prior continuous creditable coverage if there has been no break in coverage greater than 63 days. A Waiting Period under the new plan may not be taken into account when calculating whether a break in coverage exceeds 63 days. If a break in coverage greater than 63 days has occurred, the entire period of prior coverage may be disregarded and a new plan's Preexisting Condition exclusion would apply.

Because of HIPAA's 63-day break in coverage rule, the result has been an increase in COBRA

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participation since continuation coverage serves as a convenient method to preserve creditable coverage under a former employer's plan. In other words, if an Employee does not anticipate finding a new job within 63 days of employment termination, he may be compelled to elect COBRA in order to protect himself from a subsequent plan's Preexisting Condition exclusions.

HIPAA provides two methods of determining how to apply creditable coverage. The standard method is to apply creditable coverage without regard to the specific benefits covered during the period. The alternative method allows the employer to compare creditable coverage with respect to a specific class or category of benefits. If the alternative method is chosen, the plan must prominently disclose the use of such method to each Plan Participant and within plan documents, SPDs and other documents, which describe the plan.

Employers are cautioned to await more specific regulations on this matter before applying rigid restrictions on plan benefit exclusions under the alternative method.

All documents queued are batched and printed the same day. These documents are mailed on the same day unless an error has occurred or the Quality Review process causes a necessary delay.

Special Enrollment Periods

Under the special enrollment period provisions of HIPAA, employers must permit an Employee or any Dependent that was eligible, but previously declined to enroll for group health coverage, to enroll for coverage at a later time. All of the following conditions must be met for special enrollment privileges:

- The Employee or Dependent had COBRA coverage that was exhausted or other coverage that terminated due to a loss of eligibility. -The Employee or Dependent must have had other coverage at the time coverage was previously offered.
- The Employee stated in writing that coverage was being declined due to coverage under another plan (if the employer notified the Employee of such written request at the time coverage was being offered). -The Employee requested enrollment under the plan not later than 30 days after the date of the loss of other coverage. -In addition, a Plan Participant must be allowed to add a new family member (acquired through marriage, birth, or adoption) to the plan within 30 days of the event.

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Guaranteed Insurability for Individuals

In an effort to expand access to health care, HIPAA includes guaranteed insurability provisions, which prohibit health plans from declining insurance coverage to certain individuals who have had prior group health coverage. To be eligible for guaranteed insurability, an individual must meet all of the following criteria:

- The individual must have had group health coverage for at least 18 months,
- The individual did not have their group health coverage terminated because of fraud or nonpayment of premiums,
- The individual is ineligible for COBRA or has exhausted their COBRA benefits,
- The individual is not eligible for coverage under another group health plan.

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.

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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.

Other Evidence of Credible Coverage

In the event that an individual cannot or does not receive a Certificate of Creditable Coverage (presumably after reasonable attempts to obtain one have been made), other evidence of prior coverage can be reviewed by a new plan to determine creditable coverage. For example, an individual can produce pay stubs, EOBs, or doctor verification that proves prior coverage existed.

Obtaining Employee's Dependent Information

Reasonable efforts to collect and report detailed Dependent information must be included on the Certificate of Creditable Coverage (i.e., Dependent name, plan coverage type, duration of coverage). Therefore, you should consider collecting this information at the next Annual/Open enrollment period to track required Dependent data. This tracking system should also have archival capabilities for quick retrieval of aged data.

HIPAA Certificates for Employees Who Terminate During the Waiting Period

A Certificate is not required by HIPAA for individuals who were never covered under a group health plan— e.g., an individual who terminates during the Waiting Period—because the individual never lost coverage under the plan. Nevertheless, some employers may wish to distribute HIPAA Certificates that reflect the duration of employment subject to the Waiting Period to individuals. This should help address questions relating to the Waiting Period and whether a break in coverage occurred.

Family and Medical Leave Act (FMLA)

The following is a summary of the Family and Medical Leave Act of 1993 (FMLA). For more specific details about the law, please contact the Department of Labor to obtain a copy of the statute.

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The Family and Medical Leave Act of 1993 (FMLA) allows eligible Employees to take up to 12 weeks of unpaid leave during a 12-month period for any of the following four reasons: 1) to care for a child within 12 months of his or her birth, 2) to care for a child within 12 months of his or her foster care placement or adoption, 3) to care for the Employee's spouse, child or parent if the person has a serious health condition, or 4) because of a serious medical condition which makes the Employee unable to perform his or her job.

During the period of FMLA leave, the employer is required to maintain health coverage for the leave-taking Employee at the same level as before the leave. The employer must fund the same portion of the Employee's premium contribution that was paid prior to the FMLA leave. Additionally, an Employee who previously contributed to his or her premium must continue to do so during the FMLA leave.

Employers of 50 or more Employees in one location must comply with the provisions of FMLA. The law also applies to employers with fewer than 50 Employees at one location, but at least 50 Employees within a 75mile radius (distributed among different worksites or locations).

The law states that 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 UnitedHealthcare that a COBRA Qualifying Event has occurred.

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Chapter 4: The Client Delivery Team

Introduction

UnitedHealthcare offers multiple methods of customer service support for our customers' benefits administration teams, their brokers and consultants, as well as COBRA participants. Customer service access is available through toll-free lines or via the Web at **https://www.uhcservices.com**.

UnitedHealthcare COBRA customers will be assigned an experienced, designated COBRA service consultant (CSC). The CSC handles initial data gathering and installation activities and remains active on the account until all implementation responsibilities are addressed and finalized. The CSC provides a direct employer contact for items requiring more personal support. If the designated contact is not available, new COBRA customers can leave a voicemail for their designated CSC or press "0" to be immediately transferred to another team member for assistance.

Toll-free numbers for employers, brokers and COBRA participants provide easy access to our national call center team of experienced customer service representatives for live support and resolution on questions regarding COBRA and direct billing administration. With both inbound and outbound calling capabilities, participants will be contacted by our service center when an inquiry is not able to be resolved during the initial call.

Through direct access to the AT&T Language Line call center, support is available to individuals of almost any foreign dialect.

An internal inquiry tracking system is utilized to track each item-requiring follow-up. Each follow-up entry is assigned a unique case ID; this includes every e-mail received by the customer service mailbox. The case ID is provided to the participant allowing for easy follow-up when first-call resolution is not achieved. The service representative taking the initial call routinely tracks the inquiry to completion even if assistance is required from other parties within our organization.

Additional customer service support is provided through our Web site, which allows access to participant data 24/7. Participants now have a fast and easy way to enroll in their COBRA benefits by logging into **https://www.uhcservices.com**. In addition, they can ask questions, make payments online, change their address or drop coverage. The participant will then receive an e-mail confirmation regarding their response when completed or an answer to their question.

Chapter 5: COBRA Administrative Service

Introduction

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

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Plan Sponsor Role as the COBRA Plan Administrator

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

UnitedHealthcare strictly adheres to the timeframes and eligibility rules for continuation coverage. This protects you, the Plan Sponsor, and assures that all Qualified Beneficiaries receive equal, fair and consistent treatment. As you receive information from UnitedHealthcare pertaining to terminations, elections or payments received, you may be inclined to extend leniency toward certain COBRA Participants who are or become ineligible for continuation coverage. For example, you may wish to authorize an exception for UnitedHealthcare to accept a late payment or election. It is strongly recommended that you avoid any actions or decisions that could be deemed inconsistent with standard policy and would set an undesirable precedent for future Qualified Beneficiaries.

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. UnitedHealthcare refers to this notice as the "Initial Rights COBRA Notification," although it is also known as an "initial notice" or simply 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, an Initial COBRA Rights Notification 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.

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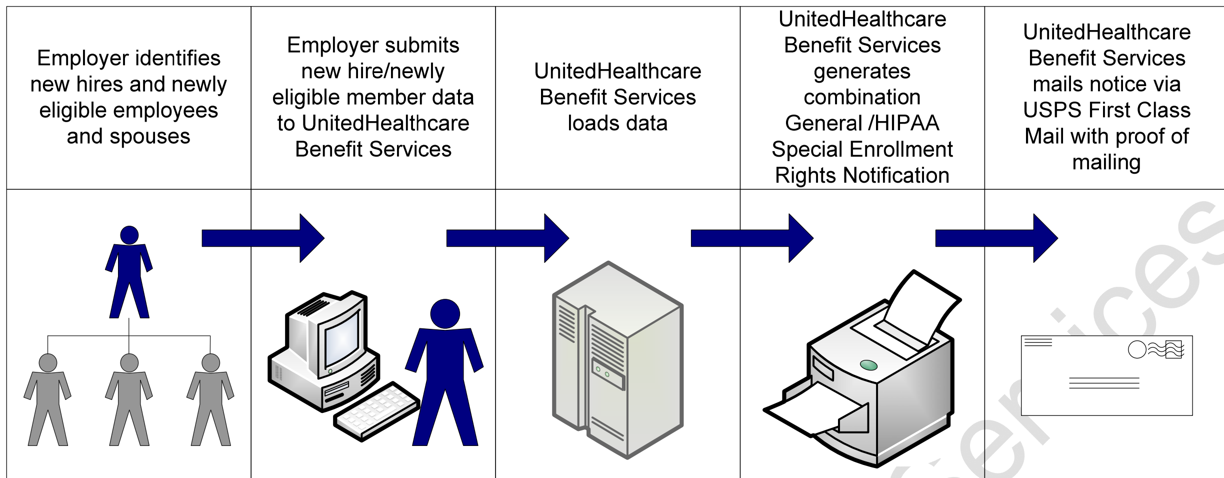

new hires and newly eligible are the same thing when it comes to the General Notice. Unless the participant enrolls (newly eligible) there is not a general notice requirement.

The Initial COBRA Rights Notification 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.

If you have selected the Initial COBRA Rights Notification service, the following process is valid.

Process: Newly Covered On COBRA Eligible Plan (COBRA Initial Rights Notice)

Plan Sponsor Responsibility

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

With the dynamic nature of COBRA legislation, even subtle changes to continuation coverage law can necessitate a number of revisions to be made to the Initial COBRA Rights Notification. If it has been some time since the company performed its original distribution of Initial COBRA Rights Notifications or you are uncertain of the accuracy of the notification, you may consider re-distributing this important notice.

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UnitedHealthcare provides an optional service to perform the Initial COBRA Rights Notification requirement on the company's behalf (see "UnitedHealthcare Optional Administration Service" below). Unless UnitedHealthcare is otherwise advised, the company is responsible for distributing the Initial COBRA Rights Notification to the active insured Employees and their covered spouses.

A sample Initial COBRA Rights Notification entitled, "Important Notice of Continuation Coverage Benefits" is shown in this guide. However, please be advised that UnitedHealthcare is not responsible for developing, maintaining or updating the contents of the company's Initial COBRA Rights Notification when you choose to self-administer this important COBRA requirement. Our recommendations for distribution and mailing are outlined below.

Guidelines for Distributing Initial COBRA Rights Notifications:

The law requires companies subject to COBRA to distribute an Initial COBRA Rights Notification to each Employee and spouse covered under the group health plan. Thus, employers are discouraged from distributing Initial COBRA Rights Notifications 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 Initial COBRA Rights Notification 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.

A Plan Administrator may satisfy the requirement to provide the Initial Cobra Rights Notification by including in their SPD the information described in paragraphs (c)(1)-(5) of 29 CFR 2590.606-1. UnitedHealthcare cautions against an employer utilizing verbal notice as a means to satisfying the Initial COBRA Rights Notification.

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.

UnitedHealthcare COBRA Optional Administration Service:

As an optional service, UnitedHealthcare will perform the distribution of Initial COBRA Rights Notifications on the behalf of the Plan Sponsor. Note that separate Initial COBRA Rights Notifications must be sent to family members who reside at a different mailing address from the Employee. This optional Initial COBRA Rights Notification service includes:

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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 an Initial COBRA Rights Notification 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.

UnitedHealthcare 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, UnitedHealthcare 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 the UnitedHealthcare website (www.UnitedHealthcare.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 UnitedHealthcare 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.

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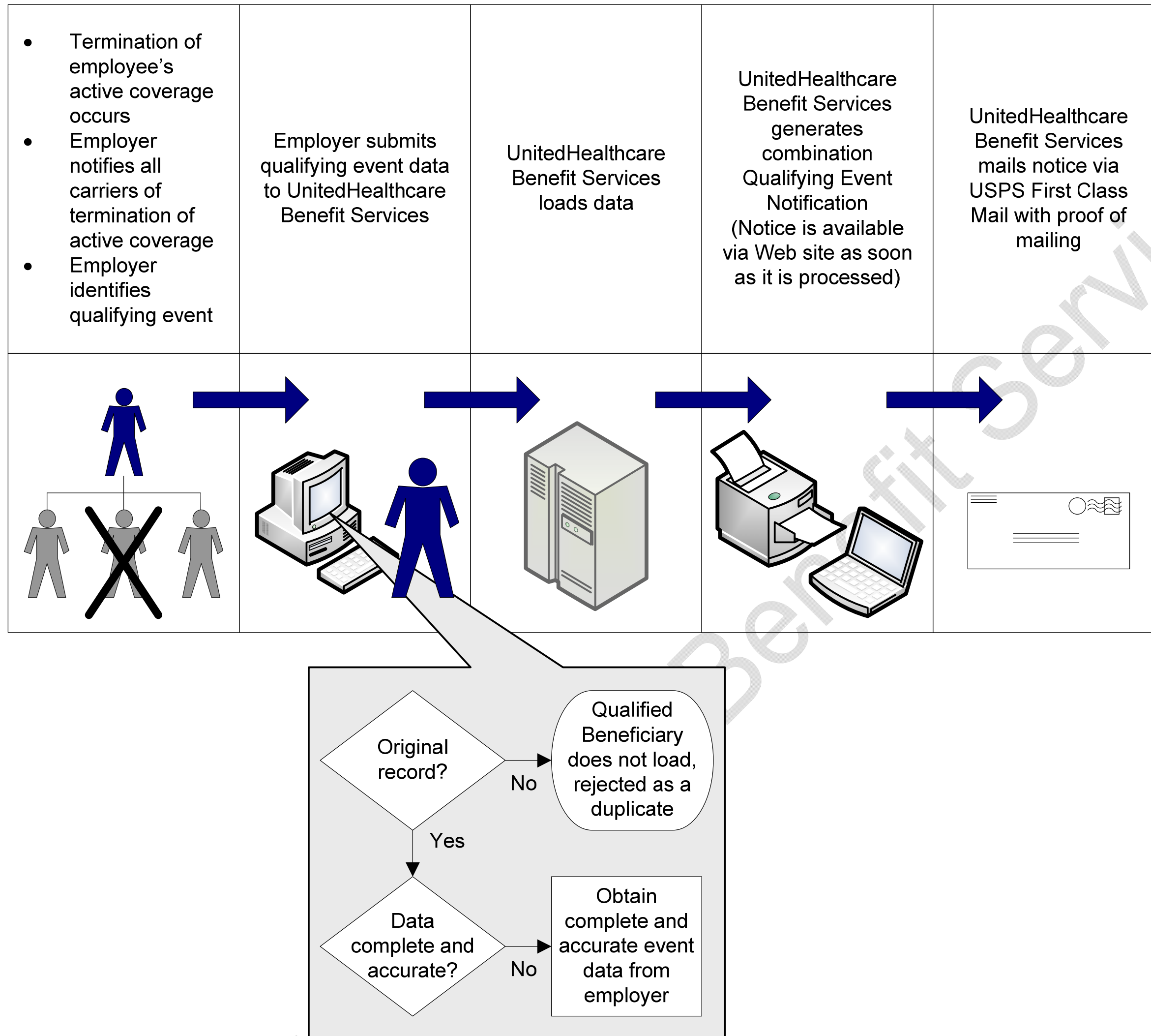
Qualifying Event Process in the UnitedHealthcare Benefit Services System



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.

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UnitedHealthcare 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 UnitedHealthcare legal communication notifications are sent to Plan Participants via certificate of mailing through the USPS.

UnitedHealthcare uses a batch processing which logs process for queuing and tracking notices required by COBRA and HIPAA law.

UnitedHealthcare 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 UnitedHealthcare personnel.

Standard Participant Notification Services

Optional Participant Notification Services

UnitedHealthcare 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.

UnitedHealthcare 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

UnitedHealthcare Benefit Services

mailed. The ASN document is retained by UnitedHealthcare in batch number order for future retrieval.

When a Qualified Beneficiary Elects and pays for COBRA Continuation

When COBRA continuation coverage is elected, UnitedHealthcare will send the Qualified Beneficiary 6-month invoice coupons. 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	UnitedHealthcare
1.	Eligibility codes are programmed in the UnitedHealthcare system for a specific Carrier which include plan names, plan numbers, plan types, etc.				√
2.	The Data Exchange parameters are set up in the UnitedHealthcare 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 UnitedHealthcare system as Weekly, or Daily scheduled eligibility reports.				√
4.	The UnitedHealthcare 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 UnitedHealthcare sends reports based on the time each report is received into the queue.				√

UnitedHealthcare Benefit Services

Process: Urgent Eligibility Updates

	Step	**Timing**	**Responsible Party**		
			EE	**Carrier**	**UnitedHealthcare**

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 view 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		√		√

UnitedHealthcare Benefit Services

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, UnitedHealthcare 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 UnitedHealthcare 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, UnitedHealthcare 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. UnitedHealthcare 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 UnitedHealthcare 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

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.

UnitedHealthcare Administration Services

For each Qualified Beneficiary on COBRA continuation coverage, UnitedHealthcare 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

UnitedHealthcare 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

UnitedHealthcare Benefit Services

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. The policy of most insurance companies is to allow a credit if requested within a limited amount of time.

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

	Step	Timing	EE	UnitedHealthcare	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		√		

UnitedHealthcare Benefit Services

5.	Termination notification is sent to the carrier	Daily for UnitedHealthcare 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	UnitedHealthcare	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 Based on pre agreed upon schedule for all other carriers		√		√

Description: Termination of coverage due to request.

	Step	Timing	EE	UnitedHealthcare	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	√			

UnitedHealthcare Benefit Services

	Step	Timing	EE	UnitedHealthcare	Client	Carrier
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 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	UnitedHealthcare	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 Based on pre agreed upon schedule for all other carriers		√		√

UnitedHealthcare Benefit Services

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 UnitedHealthcare, 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, UnitedHealthcare has introduced an online enrollment tool through **https://www.uhcservices.com** to simplify the enrollment process for participants.

Upon receipt of their enrollment materials, participants can log on to **https://www.uhcservices.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).

UnitedHealthcare Benefit Services

Recent court cases reinforce the importance of incorporating a thorough and meticulous discussion of COBRA in a company SPD. Even though an employer may use comprehensive Initial COBRA Notifications and election notices, court decisions have hinged on COBRA omissions and inaccuracies within company SPDs to substantiate enormous judgments against employers. For this reason, 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.

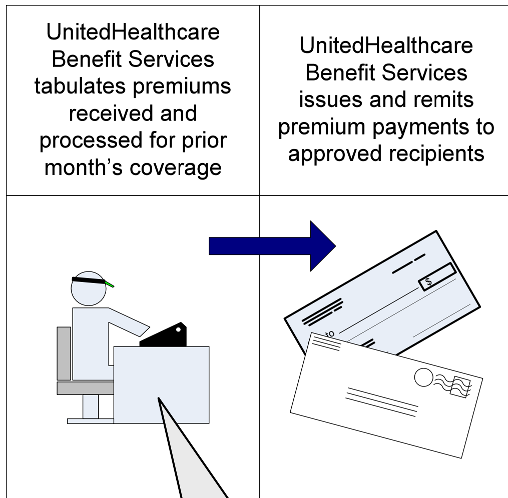
Reporting

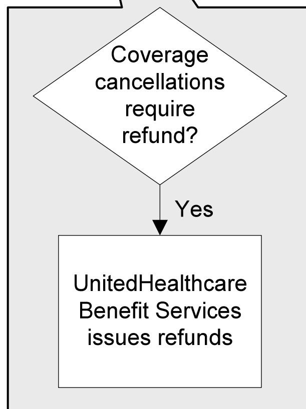
Available on the web 24 x 7 at
https://www.uhcservices.com

- 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.

UnitedHealthcare Benefit Services

Disbursement processing





UnitedHealthcare Benefit Services

Disbursement Processing

Time Frame	Participant	UnitedHealthcare	Client	Carrier
Monthly	Participant remits monthly premiums by due date / grace period			
On the 6th business day of each month		UnitedHealthcare runs disbursements through the 1st of the current month		
On the 9th business day of each month		UnitedHealthcare completes the review and sends to fulfillment for mailing		
On the 11th business day of each month		UnitedHealthcare – The fulfillment center mails all disbursement checks and reports		
Upon mail delivery			Receives all payments based on premiums collected and disbursement set up	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	UnitedHealthcare	Client	Carrier
Monthly	Participant remits monthly premiums by due date / grace period			
On the 6th business day of each month		UnitedHealthcare runs disbursements through the 1st of the current month		
On the 9th business day of each month		UnitedHealthcare CSC has available databases to create electronic reaporting		
On the 11th business day of each month		UnitedHealthcare – Base on request, CSC delivers the electronic version of disbursement reporting		

UnitedHealthcare Benefit Services

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 301A Cobra w/ RX	01	PARTICIPANT ONLY	1/1/2009	2/8/2009	Last Name, First Name	$395.03		$395.03
			00890089:01	CH + PS1 H S A 301A 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 301A 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 301A 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 301A 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 301A 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 301A 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 301A 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 301A 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 301A 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. 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). 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.
Qualifying Event Notification and 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. Same as delivery rules for general notice.

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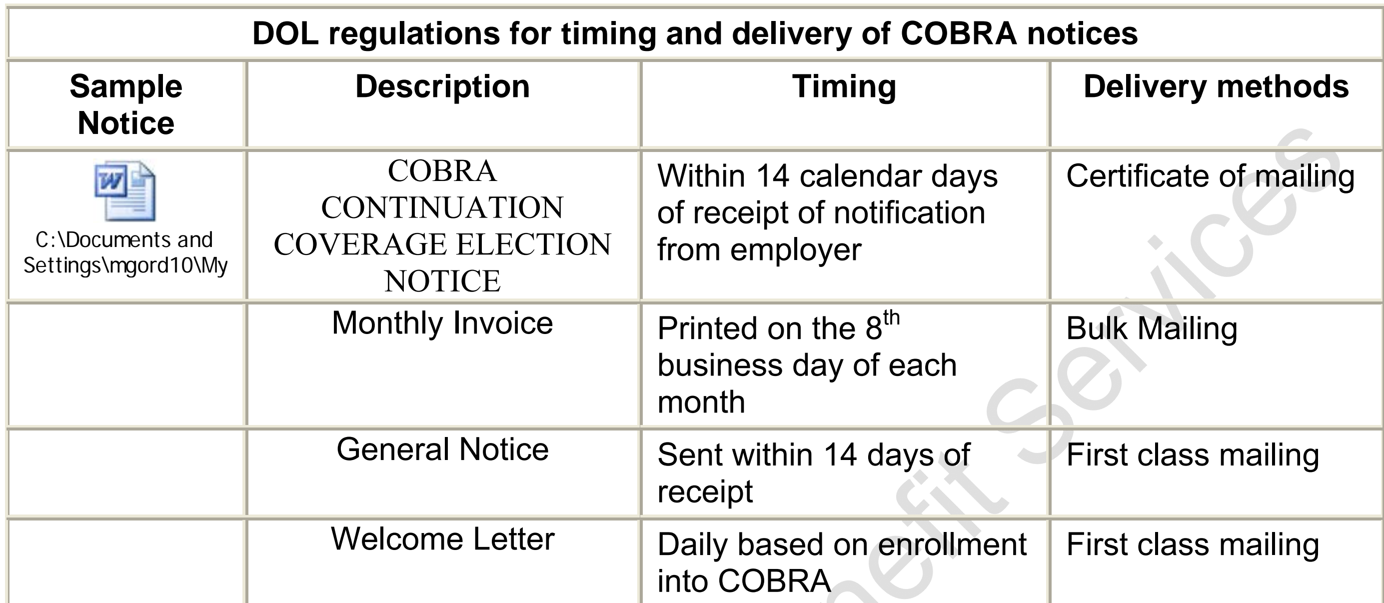
Sample COBRA NOTICES TIMING/DELIVERY CHART



DOL regulations for timing and delivery of COBRA notices			
Sample Notice	**Description**	**Timing**	**Delivery methods**
C:\Documents and Settings\mgord10\My	COBRA CONTINUATION 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

Sample Reports Timing/Delivery Chart

UnitedHealthcare reports / timing			
Sample Report	**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
	ARRA Payroll (941) supporting documentation	Available on the web the 5th of each month	Web pick up
	ARRA Payroll (941) supporting documentation – special request	Emailed on the 10th 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://www.uhcservices.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://www.uhcservices.com	Web pick up
	Employees – This report will allow The client to select the employees to include in the	Available on the web 24 x 7 at https://www.uhcservices.com	Web pick up

UnitedHealthcare Benefit Services

UnitedHealthcare reports / timing			
Sample Report	**Description**	**Timing**	**Delivery methods**
	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.	Available on the web 24 x 7 at https://www.uhcservices.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://www.uhcservices.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://www.uhcservices.com	Web pick up
	Covered Participants by Plan – This report provides a listing of participants by plan.	Available on the web 24 x 7 at https://www.uhcservices.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://www.uhcservices.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://www.uhcservices.com	Web pick up

UnitedHealthcare Benefit Services

UnitedHealthcare Benefit Services

July 23, 2010

UNITEDHEALTHCARE - COBRA Administration

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

Dear «First_Name»

UnitedHealthcare 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. UnitedHealthcare 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) 747-0048 if you have any questions or concerns.

Sincerely,
UnitedHealthcare
Telephone: (866) 747-0048

UnitedHealthcare Benefit Services

Important contact information for UnitedHealthcare Benefits Services		
	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. 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://www.uhcservices.com	**UnitedHealthcare Benefit Services PO BOX 713082, 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://www.uhcservices.com
Customer Service Phone Number	Our customer service number is:	**(866) 747-0048**
Email Address	Customer service email address:	COBRA_KYOperations@uhc.com
Mailing Address For Routine Correspondence	New mailing address for all correspondence, **other than premium payments**	**UnitedHealthcare Attn: Benefit Services PO Box 740221 Atlanta, GA 30374-0221**
Fax Number	Our Fax number is:	**(866) 525-1740**

Want a fast and easy way to enroll?

Log into https://www.uhcservices.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://www.uhcservices.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.

UnitedHealthcare is committed to meeting your service needs. Please contact our Customer Service Center at **(866) 747-0048** if you have any questions. We look forward to serving you.

Sincerely,

UnitedHealthcare Benefit Services

UnitedHealthcare

UnitedHealthcare Benefit Services

UnitedHealthcare
A UnitedHealth Group Company

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 UHC Benefit Services. 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 UHC Benefit Services in the amount of the outstanding premium payments along with this form.

☐ **I hereby authorize** UHC Benefit Services 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, UHC Benefit Services 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: ______________________________

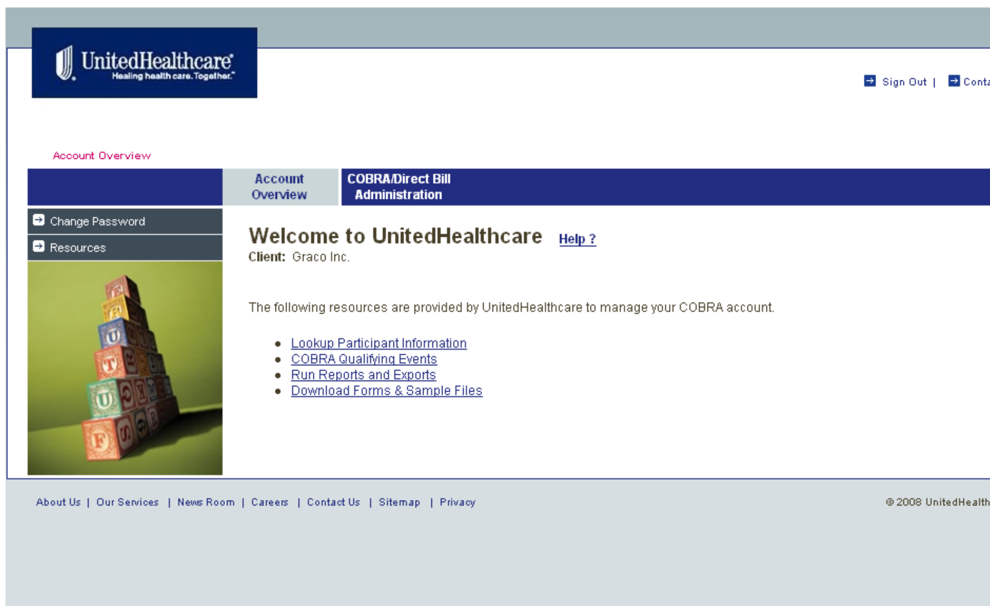
Date: ______________________________

UnitedHealthcare Benefit Services

Chapter 6 – https://www.UHCServices.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?

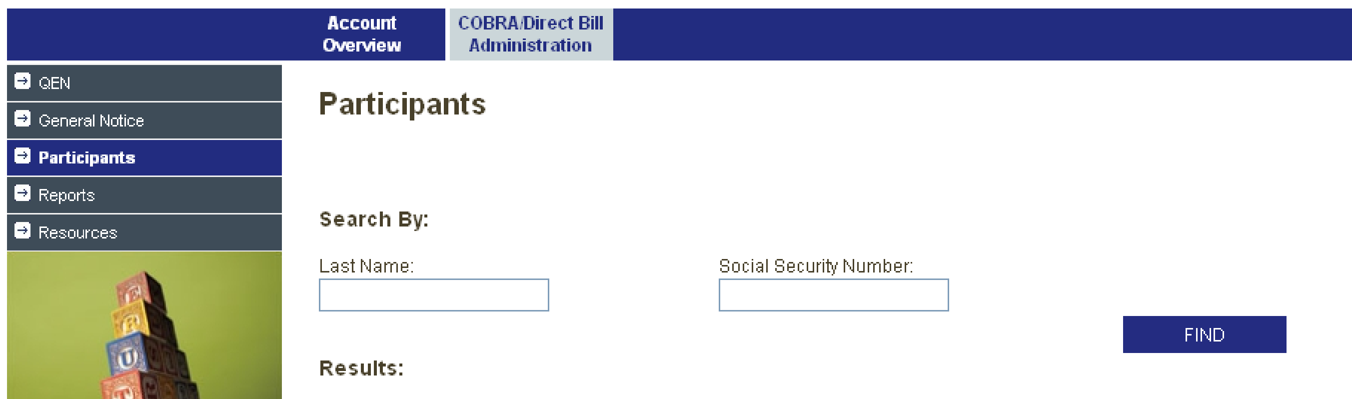
- Entry of a new Qualified Beneficiary
- Participants and Dependents which are enrolled
- Payments received by participant
- Amount due by participant
- Who has terminated
- Who is in notified status

UnitedHealthcare Services

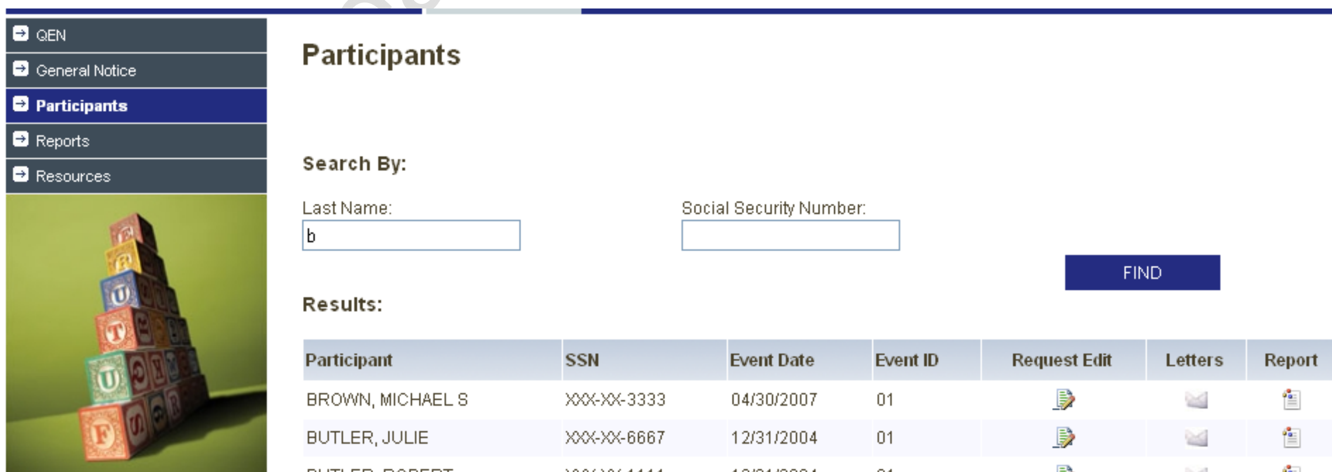
- New features scheduled for release this quarter
- Participant demographic information
- Dependent demographic information
- Invoice / Payment history
- All forms previously sent to a participant, viewable and printable
- Notes on participant's account
- Printable status sheet per participant
- Expanded 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.



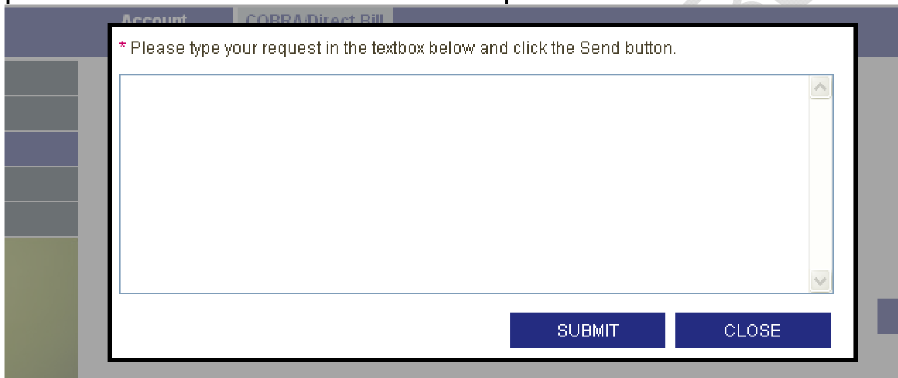
The results of the search will be displayed along with the options available for the participant.



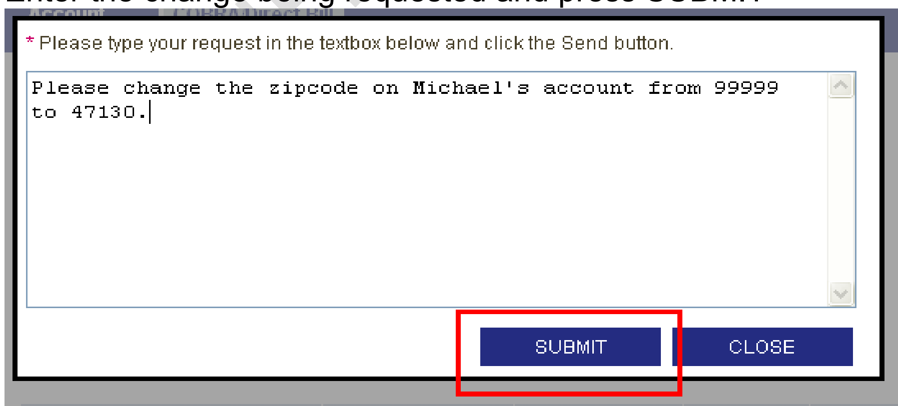
- Participant – Last Name, First Name of the participant
- SSN – Social Security Number of the participant. The information is masked for security reasons
- Event Date – For COBRA this will be the date of event, i.e. termination, divorce, date the child left college or reached maximum age of coverage. 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 01/01/2008 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 UnitedHealthcare work flow.



Enter the change being requested and press SUBMIT



Benefit Services

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

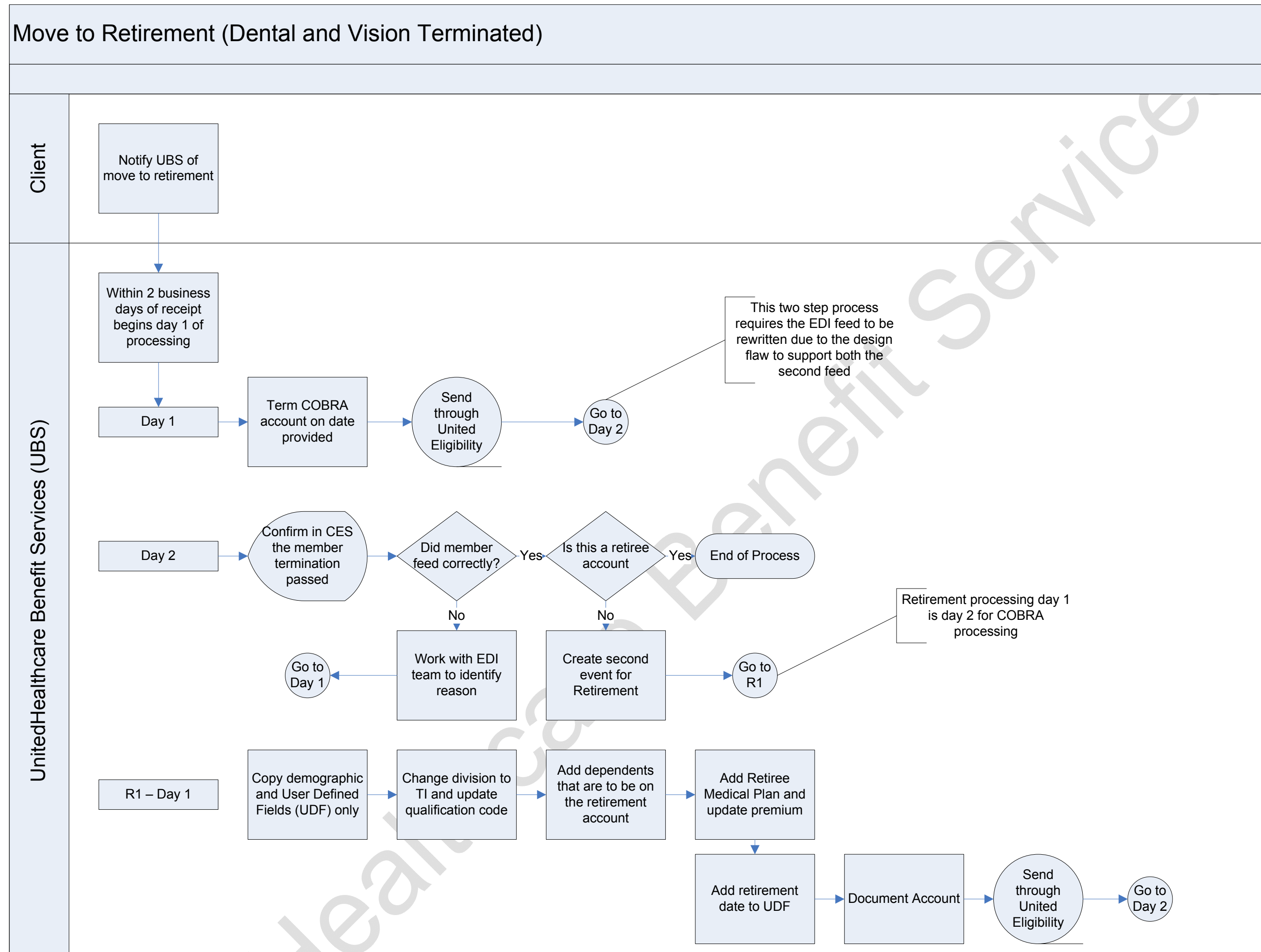
Your request has been submitted for BROWN, MICHAEL S. Please keep the Request Number for future reference. Request Number: PWIR0119726

CLOSE

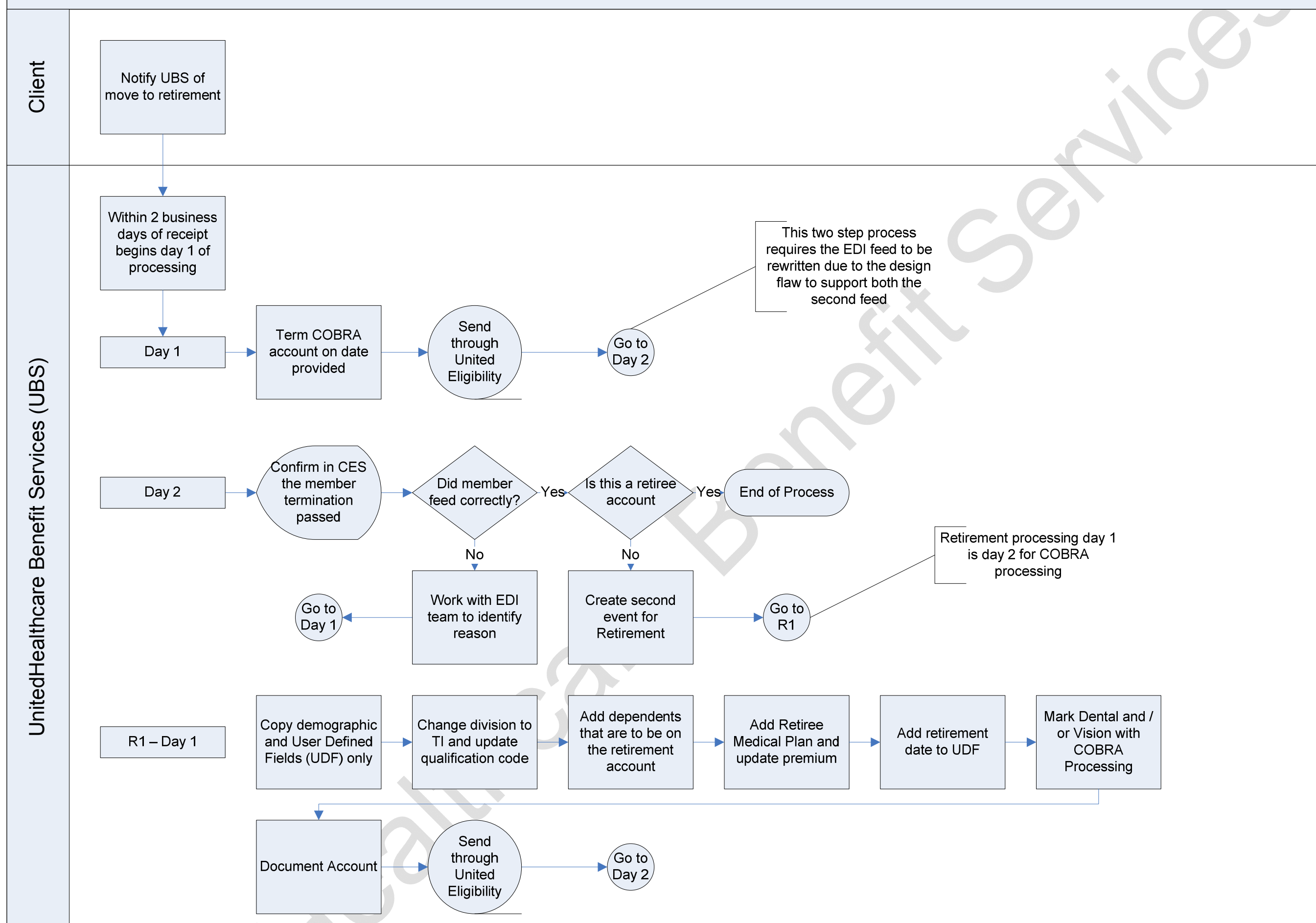
UnitedHealthcare Benefit Services

Chapter 7 – Direct Bill Continuation

Direct bill continuation is offered as a service by UnitedHealthcare Benefit Services.



UnitedHealthcare Benefit Service



UnitedHealthcare Benefit Services

Chapter 8 - State Continuation Laws

UnitedHealthcare Benefit Services 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. This section describes two state laws, which UnitedHealthcare Benefit Services has incorporated into its administration system as a special service to its California and Texas COBRA administration clients.

At the outset, it should be clearly understood that state continuation laws apply to insured group health plans only. These laws do not apply to self-funded (i.e., self-insured) plans because ERISA preempts state laws that relate to group health plans. ERISA, however, does not preempt state laws that relate to insurance. 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 like Texas and California also provide for continuation coverage beyond the typical 18 or 29 months of COBRA for all insured plans. These are often referred to as COBRA extension laws.

California Law

California Continuation Benefits Replacement Act (Cal-COBRA)

Effective January 1, 1998, every health care service plan and health insurer that provides coverage to small employer groups in California must offer continuation coverage to individuals upon certain Qualifying Events. A small employer, as defined by the Cal-COBRA, is an employer with 2-19 Employees on at least 50 percent of its working days during the preceding calendar year.

Cal-COBRA Qualifying Events include: (1) employment termination or reduction in hours of employment for reasons other than gross misconduct, (2) divorce or legal separation, (3) Employee Medicare entitlement, (4) death of the Employee, or (5) a child losing Dependent status under a health plan. During the period of Cal-COBRA continuation, plans may charge up to 110% of the applicable group rate charged to similarly situated individuals. The duration of Cal-COBRA coverage for small employers is 36 months.

While Cal-COBRA is similar to COBRA in many respects, it is important to note that this is not an employer mandate. Rather, the law is primarily directed to health care service plans and health insurers who must carry out the bulk of the law's administrative requirements. Therefore, employer obligations under Cal-COBRA are generally limited to: (1) notifying the health care service plan or health insurer of employment terminations and reduction in hours of employment, and (2) notification to Cal-COBRA Participants of impending Carrier changes.

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With the existence of two distinct continuation coverage programs, Cal-COBRA and COBRA, employers will need to carefully monitor their Employee count on an annual basis to determine which continuation coverage requirement applies for a particular calendar year.

AB 1401 (Extends Cal-COBRA 36-month Coverage to COBRA Qualified Beneficiaries)

Effective January 1, 2003, Assembly Bill 1401 amended the California Health and Safety Code and Insurance Code to allow that any individual who experiences any Qualifying Event is entitled to 36 months of continuation coverage. The law requires health care service plans and health insurers to offer enrollees of employer-sponsored healthcare plans, who have exhausted continuation coverage at the end of 18 months under federal COBRA guidelines, the opportunity to continue coverage for up to 36 months from the date of the original COBRA Qualifying Event. The additional 18 months of coverage falls under Cal-COBRA guidelines, and thus this charges the health care service plan or health insurer with the responsibility of administration.

All other Cal-COBRA regulations apply to this additional Continuation Period in the same manner that they apply to employer groups and individuals that are subject to Cal-COBRA. Please note that any Qualifying Event which requires 36 months of continuation under Federal guidelines will be exempt from the Cal-COBRA extension of coverage. The law requires that notification of eligibility of this extended coverage must be included in the notice of pending termination of the primary 18-month or 29-month Continuation Period under COBRA. UnitedHealthcare Benefit Services issues these notices three months prior to the termination date and the notices already include an explanation of this entitlement to all eligible Continuees that are approaching the end of the COBRA 18-month or 29-month Continuation Period.

Cal-COBRA Plan Sponsor Responsibility

Employers are mandated to notify Cal-COBRA Participants of any impending Carrier changes. Additional responsibilities on employers may be found in the Carrier benefits agreement. Check with the Carrier if you have any questions regarding the specific plan requirements related to Cal-COBRA.

UnitedHealthcare Benefit Services Administration Services Related to Cal-COBRA

UnitedHealthcare Benefit Services is responsible for Cal-COBRA administration as part of the services it provides on behalf of UnitedHealth Group plans. To the extent that employers have non-UnitedHealth Group plans, they need to work with those Carriers to ensure compliance with Cal-COBRA administrative requirements.

UnitedHealthcare Benefit Services mails out a conversion letter which notifies Qualified Beneficiaries three months in advance that their eligibility under COBRA (18 or 29 months) is coming to an end. This notice communicates to them their options for obtaining coverage at

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the end of their eligibility period, including information about AB 1401 and what it means for them.

Cal-Senior

Under California law, certain individuals are allowed to extend their health coverage beyond the date coverage under COBRA would normally end. The extension of continuation coverage is available to a former Employee who worked for the employer for at least five years prior to the date of termination of employment and who is 60 years of age or older on the date employment ends. This law is commonly referred to as Cal-Senior. Coverage cost may not exceed 213% of the applicable premium. Effective January 1, 2005, Cal-Senior was repealed (in Assembly 254) for anyone who terminates employment on that date or thereafter. Existing Cal-Senior Qualified Beneficiaries may continue Cal-Senior coverage until the earlier of:

- A written request for termination made by the Qualified Beneficiary,
- The date the individual reaches 65 years of age,
- The date the individual is covered under any group health plan not maintained by the employer or any other health plan, regardless of whether that coverage is less valuable,
- The date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act,
- Five years from the date on which continuation coverage under COBRA was scheduled to end for the spouse or former spouse,
- The date on which the employer or former employer terminates its group subscriber agreement with the health care service plan and ceases to provide coverage for any active Employees through that plan, in which case the health care service plan shall notify the former spouse of the right to a conversion plan, if any, or
- The date on which correct and timely payment is not made.

NOTE that Cal-Senior is a state law that is closely related to, but not directly a part of COBRA federal law. UnitedHealthcare Benefit Services does not normally give guidance on state continuation coverage laws. However, as a special service to our California COBRA administration clients, UnitedHealthcare Benefit Services has incorporated the requirements of this law with our COBRA procedures for the overall continuation coverage compliance.

In general, the law requires fully insured health insurers and health care service plans (insurers and HMOs, not employers) to bill, collect and monitor premium payments during the period of extended coverage. The health care service plan may charge 102% or up to 213% of the premium depending upon whether the rate is adjusted for the age of the specific Employee, or eligible Dependent, on other than a composite basis. In general, the health care service plan makes this determination and adjusts premiums accordingly during the period of extension.

UnitedHealthcare Benefit Services Administration Services Related to Cal-Senior

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To the extent that an employer has existing Cal-Senior Qualified Beneficiaries, UnitedHealthcare Benefit Services may provide Cal-Senior administrative services to the extent contracted.

California Health Insurance Premium Payment Program (Cal-HIPP)

Effective January 1, 1993, the state of California added Section 2807 to the Labor Code. This amendment requires all employers, whether public or private, to provide a standardized written description of the Health Insurance Premium Payment (HIPP) Program to all insured individuals who terminate employment. The State Continuation Laws HIPP Program offers to pay insurance premiums for Medi-Cal recipients and/or disabled persons with HIV/AIDS who meet eligibility requirements established by the California Department of Health Services. According to Section 2807, this notification is to be provided along with the COBRA notification required by federal law.

As the COBRA administrator, UnitedHealthcare Benefit Services is contractually obligated to fulfill only federal requirements pertaining to COBRA, not state requirements such as the one mandated by Section 2807. You may find a copy of the required HIPP notice on the California Department of Health Services website: www.dhs.ca.gov/publications/forms/pdf/cobraeng.pdf

Texas Law

Texas requires insurance policies to offer an either six months or 36 months of continuation coverage, depending on the qualifying event. The primary provisions for continuation can be found in the Texas Insurance Code, article 3.51-6.

Six Months of Continuation Coverage

An additional six months of continuation coverage is available to all individuals who had at least three months of coverage prior to termination and who were terminated for any reason except involuntary termination for cause. Texas law excludes termination for a health-related cause from the definition of "involuntary termination for cause". The six months of continuation coverage start either when employment terminates (for employers with 2-19 employees) or when COBRA coverage is exhausted (for employers with 20 or more employees). If COBRA coverage is terminated early for any reason, there is no state continuation obligation. In the case of six months of continuation coverage, the applicable premium that the individual must pay is 102% of the total cost of coverage to the employer policyholder for similarly situated individuals.

The individual's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within the later of:

- 31 days of the date coverage would otherwise terminate, or

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- the date the employee is given notice of the right of continuation by either the employer or the group policyholder.

Coverage may terminate on the earlier of:

- the expiration of six months of coverage,
- the date on which failure to make timely payments would terminate coverage,
- the date on which group coverage terminates in its entirety,
- the date on which the individual is or could be covered under Medicare,
- the date on which the individual is covered for similar benefits by another policy, plan or program,
- the date the individual is eligible for similar benefits, whether or not covered, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or
- similar benefits are provided or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

At least 30 days prior to the end of the six-month period, the insurer is required to notify the covered individual of the availability of coverage under the Texas Health Insurance Risk Pool along with the appropriate contact address.

36 Months of Continuation Coverage

The continuation coverage period is extended to 36 months if the individual had coverage for at least one year before the loss of coverage and the reason was due to:

- divorce or legal separation (i.e., the law describes it as severance of the family relationship), or
- retirement of the employee, or
- death of the employee.

In this case, the applicable premium that the individual must pay is the total cost of coverage to the employer policyholder for similarly situated individuals, plus an administrative fee of up to $5 per month.

Within 60 days of the qualifying event, the individual must give written notice to the group policyholder of the desire to exercise the option.

Coverage may terminate on the earlier of:

- the expiration of 36 months of coverage,
- the individual becomes eligible for substantially similar coverage under another policy, plan or program, or
- the date the individual fails to make a premium payment in the time required to make that payment.

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UnitedHealthcare Benefit Services Administration Services Related to Texas Continuation

Pursuant to Texas state law, an election form will be sent to the qualified beneficiaries at the time that their COBRA conversion letter is sent. UHCDirectBill performs this notice requirement prior to the last 45 days of COBRA continuation coverage.

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Chapter 9 – 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.

ARRA:

ASO:

Assistance Eligible Individual:

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.

Certificate of Coverage:
The certificate issued upon loss of coverage confirming the period in which the participants were covered under the Plan Sponsor's health plan.

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:

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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.

Coverage Waiting State Date (Date of Hire):
The first day of the waiting period.

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.

Elected Participant:
An Eligible Participant that has elected to continued health insurance coverage through their COBRA eligibility.

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.

Eligible Participant:
A Plan Participant who has experienced a Qualifying Event.

Elimination Period:
A period that must elapse before benefits become payable under a disability or health plan for the onset of a covered illness.

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:

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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.

Initial HIPAA Rights Notification:

This notice explains that Employees and their Dependents may be eligible to receive Preexisting Condition credit if they previously had health insurance benefits. It also explains that they are currently able to enroll in the insurance program. However, if they do not enroll at their initial enrollment opportunity, they may be limiting their eligibility for the coverage.

Initial COBRA Rights Notification:

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.

Late Enrollee:

Individuals who previously declined coverage. Their enrollment opportunities may be limited to specified time periods as quoted in the Employer’s contract or plan document.

Look-Forward Period:

The 12 or 18 month period during which pre-existing condition exclusions may be exercised and begins with the enrollment date.

Mandated Benefit:

A specific coverage that an insurer or plan sponsor is required to offer by law. Mandated benefits in insurance contracts vary from state to state according to each state’s insurance laws.

Medicaid:

A medical benefits program for low-income people paid for jointly by the federal government

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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.

NAIC:
National Association of Insurance Commissioners: An organization that assist state insurance departments. A major function is the drafting of model laws.

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

Participant or Plan Participant:
An Employee or a Dependent both eligible and covered under Plan Sponsor's health plan. Participant wording in this agreement is both singular and plural.

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. UnitedHealthcare Benefit Services 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 UnitedHealthcare Benefit Services.

Plan Sponsor:
The employer or employee organization in the case of a plan established or maintained by an employee organization. UnitedHealthcare Benefit Services is not the Plan Administrator, 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 UnitedHealthcare Benefit Services.

Preexisting Condition:
A medical condition that existed, or for which a Participant was being treated, before coverage under a current health or disability plan commenced and for which benefits under the plan are not available or are limited.

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.

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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.

Waiting Period:
The period of time between an Employee's hire and his or her enrollment in a program (eligibility to receive benefits).

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Chapter 10 – ARRA Frequently Asked Questions

FREQUENTLY-ASKED QUESTIONS ON THE ARRA COBRA PROVISIONS

We are pleased to share information on the American Recovery and Reinvestment Act (ARRA) changes to COBRA to support our employers' compliance with the recent changes.

As you are aware, ARRA, which was signed February 17, 2009 was effective the first billing period on or after that effective date. ARRA provides 65% subsidy for COBRA continuation premiums for up to 9 months for workers and their eligible family members who are affected by involuntary termination from September 1, 2008 through December 31, 2009.

In general, group health plans maintained by employers with 20 or more employees are required by federal law to provide covered employees and covered dependents with the right to continue their health coverage after the occurrence of certain "qualifying events". These qualifying events include, but are not limited to, termination of employment, divorce, or death of the covered employee. For employees who are involuntarily terminated from their jobs, ARRA provides premium subsidies to help pay for the cost of continuing their health coverage.

We have attached answers to many of your questions that have come up since ARRA went into effect. Please understand that we will continue to provide additional information, guidance and support as more details are forthcoming from the Department of Labor (DOL) and the Internal Revenue Service.

EFFECTIVE DATE

What is the effective date of the new law?

ARRA is effective February 17, 2009, the day that President Obama signed the bill. All of the COBRA provisions that have a time frame will date from that day. For example, notices are required to be sent to subsidy-eligible persons who became qualified beneficiaries before the date of enactment (2/17) within 60 days of enactment. As for calendar monthly billed programs, the effective date is March 1, 2009.

What happens if an employer has not been able to establish the subsidy program by March 1?

Due to the close effective date, many employers have not been able to transition to the subsidy process by March 1 and subsidy-eligible persons have continued paying the full COBRA premium. The Act contemplates that subsidy amounts that are applicable may not be implemented in the first two months of the program. In that case, the subsequent premiums for the subsidy-eligible persons may be provided with a refund of the overpayment or receive a credit on one or more subsequent premium statements equal to the accumulated overpayment. The method of refund is at the discretion of the entity to whom such payment is

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payable as long as the credit can be paid out over less than a 180 day period. The Act does not contemplate that employers will go more than two months in not applying the subsidy.

PLANS TO WHICH THE ARRA SUBSIDY PROVISIONS APPLY

What plans does ARRA apply to?

ARRA covers all plans, both insured and self-funded, that are subject to COBRA and state and municipal plans that are subject to the Public Health Service Act which provides provisions parallel to that of COBRA. In addition, the subsidy applies to non-COBRA plans that are subject to state continuation laws that are comparable to COBRA.

The subsidy applies to COBRA premiums for medical coverage, including dental, vision and prescription. The subsidy does not apply to Flexible Spending Accounts.

Does this Apply to Employers with Fewer than 20 Employees?

Federal COBRA law does not apply to employers with fewer than 20 employees. Some states require employers with fewer than 20 employees to provide "COBRA-like" continuation of coverage plans. If these plans meet certain structural requirements for comparable continuation coverage, employees who are involuntarily terminated and are covered by these "COBRA-like" plans will also be eligible for Recovery Act premium subsidies.

Does ARRA affect State Continuation?

ARRA impacts continuation coverage offered under state continuation to the extent such requirements are "comparable" to the federal COBRA standards.

How will we determine which state continuation laws are "comparable" to COBRA?

The Conference Committee report states that state continuation laws will be comparable to COBRA and eligible for the subsidy if the law requires continuation of substantially similar coverage as was provided under the group health plan and at a monthly cost that is based on a specified percentage of the group health plan's cost of providing such coverage.

WHO IS ELIGIBLE

Who is an eligible individual?

An eligible individual is someone who is involuntarily terminated from employment during the period of September 1, 2008 through December 31, 2009 and is eligible to elect COBRA during that time.

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Employees with modified adjusted gross income (MAGI) that exceeds $250,000 (for joint returns) or $125,000 (for all other filers) will not be eligible for the full premium subsidy. The premium subsidy will be fully phased out for those individuals with MAGI of $145,000/$290,000.

Individuals who exceed these income limits must repay any subsidy he/she realized. These repayments are reported on the individual's income tax return.

Individuals may make a permanent election to waive the subsidy.

What does "involuntarily terminated" mean?

Persons who are involuntarily terminated from employment are eligible for the subsidy. This is not a term that is defined either in ARRA or in COBRA generally. We may assume that the COBRA ban on persons who were terminated for "gross negligence" would continue to operate and those persons would not have COBRA at all. However, anyone who is laid off, fired or otherwise dismissed from a job involuntarily during the applicable periods would likely be eligible. A reduction in hours, even if resulting in loss of coverage, would not trigger eligibility for the subsidy since it does not involve termination of employment.

Will UnitedHealthcare make any determinations about "involuntary termination"?

No. This is a determination that only the employer can make. If UnitedHealthcare is acting as COBRA administrator, it will not engage the subsidy for any COBRA participant unless the employer has certified, in a form acceptable to UnitedHealthcare, that the individual has been involuntarily terminated and therefore eligible for the subsidy.

Who isn't eligible for the subsidy?

- Employees who were terminated for gross negligence are not eligible
- Employees who terminated voluntarily are not eligible
- Employees who were eligible for COBRA prior to 9/01/08 are not eligible

What about domestic partners?

Domestic partners are generally not recognized under COBRA. However, in some circumstances where the employer allows domestic partners to continue with the eligible employee, the presence of the domestic partner may have an impact on the cost of the coverage and the subsequent subsidy amount. For example, if the domestic couple has family coverage, it is clear that the intent of ARRA is to provide subsidy only for the employee, not the domestic partner. It is not clear how the premiums are to be bifurcated. This is an area where we hope to have further clarification from DOL or IRS.

What about dependents?

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Dependents will be eligible for a subsidy of their own if they experience a second qualifying event during the subsidy period. For example, if a subsidy-eligible former employee divorces his or her spouse during the subsidy period, the divorced spouse will be independently eligible for the subsidy. The subsidy period in this case will date from the earliest subsidy trigger event, i.e., the employee's involuntary termination.

How about dependent children who are no longer eligible based on their not being in school? Are they eligible for the subsidy?

No. Existing COBRA rules would apply. If the dependent ages out or is no longer eligible based upon school participation, he or she would not be eligible for the subsidy.

What does it mean to those individuals who are already on COBRA?

Individuals who elected COBRA due to an involuntary termination on or after September 1, 2008 but prior to the date of enactment (2/17/09) are eligible to receive the 65% subsidy on a prospective basis; it is not retroactive to when they first elected COBRA.

What does it mean to those individuals who might have elected COBRA, but didn't?

Individuals who were eligible to elect COBRA during the period beginning September 1, 2008 and ending December 31, 2009 due to an involuntary termination but did not elect COBRA will be given the opportunity to elect COBRA on a prospective basis. The maximum coverage period will still be measured from the earliest date that COBRA coverage could have been elected, but coverage will not be retroactive. The coverage would generally date from March 1, 2009.

What does it mean to those individuals who elected COBRA on or after September 1, 2008, but dropped it prior to enactment?

These individuals are entitled to elect COBRA during the period beginning on the date of enactment (2/17/09) and ending sixty (60) days after the date on which they are notified of the additional election period.

What is the true definition of involuntary? What about individuals on sick leave who ran out of sick leave and the employer let them go because their FMLA is over? Will the government reimburse the employer?

The Department of Labor will be providing additional guidance. Ultimately the employer will need to make the decision. The key is that the employment relationship must end in order for the person to meet the standard set forth in ARRA. Therefore any situation where an employment relationship continues to exist will not qualify for the subsidy.

What rights are available to individuals who do not receive a subsidy, but believe they should have?

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An individual who does not receive a subsidy that he/she believes appropriate may appeal the plan's determination to the Department of Labor for private plans or to the Department of Health and Human Services for public plans covered under the Public Health Services Act. The relevant agency must rule on the appeal within 15 business days. Individuals whose appeal is denied may sue under ERISA

How will UnitedHealthcare know who is eligible for the subsidy?

Eligibility is in virtually all cases determined by the plan sponsor. We will require the plan sponsor or employer to let us know which of its terminated members is subsidy-eligible. This will mainly be through designating that person as "involuntarily terminated." We will not attempt to determine this status on our own. If a person is not designated as such by the employer, we will not apply the subsidy when we are doing the COBRA billing.

How will the employer know if the beneficiary becomes eligible for other coverage?

The beneficiary must notify the employer in writing if they become eligible for coverage under a major medical group health plan or Medicare and is subject to significant penalties (110% of the subsidy amount) for failing to do so. The employer is not responsible for this notification.

Does an Employer have to determine the income of the subsidy recipient?

The subsidy is only available to otherwise eligible persons who meet certain income thresholds. However, that is not a concern of either the employer or the COBRA administrator; the eligible person is responsible for determining the taxable effect of the subsidy. If a person's modified adjusted gross income (MAGI) makes him ineligible for the subsidy, the subsidy must be added to his tax liability. This would occur in the next year after the subsidy has been received. For example a person may be close the income threshold in 2009 but, being laid off, will not know exactly how much he will make in 2009. If, when doing his taxes in 2010, he finds out that his MAGI excludes him from eligibility, he will add the subsidy amount to his tax due. A person who knows that his MAGI will be too high to qualify for the subsidy may inform the subsidy payer of that fact and the payer will not include that person as subsidy eligible.

THE SUBSIDY

What is the ARRA COBRA subsidy?

It allows eligible individuals to receive a premium subsidy from the federal government in the amount of 65% of a COBRA qualified plan. Eligible individuals will only have to pay 35% of the COBRA premium to continue coverage.

How does the ARRA COBRA subsidy work?

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The entity that pays the 65% subsidy (the multi employer group health plan, employer or insurance carrier) is permitted to take the amount of any subsidy payments as an offset against their payroll tax payments to the federal government. The subsidy may be offset from employee income tax withholding, employee FICA tax withholding or employer FICA tax obligations.

The Internal Revenue Service (IRS) has released a revised Form 941 and Instructions for reporting the amount of the premium subsidy that is taken as a payroll tax credit.

What amount is the subsidy based on? What is the beneficiary charged?

The subsidy is based on the actual amount that the employer is charging the eligible person for COBRA. This could be the full 102% of the plan cost allowed under COBRA in which case the subsidy would be 65% of that amount. For employers who subsidize COBRA coverage, the amount subject to the subsidy is the actual amount charged to the eligible person. For example, if the gross plan cost is $1000 per month but the employer is only charging the eligible person $500 per month, the subsidy is based on the $500 (that is, the eligible person pays $175 and the subsidy amount is $325).

When does the subsidy end?

The subsidy is effective for 9 months for COBRA beneficiaries who become eligible March 1, 2009 or through December 31, 2009 (including late-enrollers from September 1, 2008 on who will initially become eligible on March 1, 2009). Therefore the maximum extent of the subsidy for a person becoming eligible on December 1, 2009 would be through August 31, 2010.
The subsidy will otherwise end if the assistance-eligible person becomes eligible for coverage under a group health plan or becomes eligible for benefits under Medicare.
If the COBRA coverage ends for any reason listed under the COBRA statutory provisions (e.g., continuation period ends by duration, coverage ends due to failure on the part of the assistance-eligible person to pay her share of the premium) the subsidy will also end.

FUNDING THE SUBSIDY

Does the subsidy apply to multi employer group health plans or to the insurer providing coverage under an insured plan?

The responsibility to pay the 65% subsidy depends on the type of continuation coverage:
In the case of a multi employer group health plan • the subsidy is paid by the plan.
In the case of a group health plan subject to the • federal COBRA requirements, the subsidy is paid by the employer.

In the case of continuation coverage offered • pursuant to state requirements (where the coverage is comparable to COBRA), the subsidy is paid by the insurance carrier.

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For those employers for whom UnitedHealthcare will file for the subsidy credit, what will UnitedHealthcare need from employers in order to file for the credit?

UnitedHealthcare will be responsible for filing for the subsidy credit for non-COBRA small employers under certain state continuation laws. The IRS has published questions and answers that detail what supporting documentation UnitedHealthcare will need to obtain from a non-COBRA employer in order to confirm that a particular individual was eligible for the credit. Regardless of who is administering the continuation plan (the employer, a third party or a UnitedHealthcare entity) we will need the following information:

- Information on the receipt, including dates and amounts, of each assistance eligible individual's 35% share of the premium;
- In the case of an insured plan, a copy of the invoice or other supporting statement from the continuation administrator (if not UnitedHealthcare) or the employer.
- In the case of a self-funded plan proof of the continuation premium amount and proof of the coverage provided to assistance eligible individuals;
- Attestation of the involuntary termination of the employee, including the date of the termination;
- Proof of each assistance eligible individual's eligibility for continuation coverage during the relevant time period and election of continuation coverage;
- Social security numbers of the covered employees, the amount of subsidy reimbursed with respect to each covered employee and, with respect to each covered employee, a designation as to whether the subsidy reimbursement is for coverage of one person or two or more people.
- Other documents necessary to verify the correct amount of reimbursement.

What information will UnitedHealthcare provide to insured and self-funded employers when UnitedHealthcare is providing COBRA administration?

The IRS has published questions and answers that detail what supporting documentation that UnitedHealthcare will need to provide to a COBRA employer in order to confirm that a particular individual was eligible for the credit. Regardless of who is administering the continuation plan (the employer, a third party or a UnitedHealthcare entity) the following information is required:

UnitedHealthcare will provide:

- Information on the receipt, including dates and amounts, of each assistance eligible individual's 35% share of the premium;
- In the case of an insured plan, a copy of the invoice or other supporting statement.
- In the case of a self-funded plan proof of the continuation premium amount and proof of the coverage provided to assistance eligible individuals;

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- Social security numbers of the covered employees, the amount of subsidy reimbursed with respect to each covered employee and, with respect to each covered employee, a designation as to whether the subsidy reimbursement is for coverage of one person or two or more people.
- Other documents necessary to verify the correct amount of reimbursement.

Employer will provide:

- Attestation of the involuntary termination of the employee, including the date of the termination;
- Proof of each assistance eligible individual's eligibility for continuation coverage during the relevant time period and election of continuation coverage.

How does a multi-employer plan recover the subsidy?

Under ARRA the plan itself has the responsibility for the subsidy in COBRA-covered multi-employer plan. This could be a Taft-Hartley plan or any other plan that involves multiple employer participants but which represents a single ERISA plan. The plan would provide the subsidy and then file for the rebate of the subsidy on its own payroll tax liability.

What if the plan does not have any employees and therefore no payroll tax liability?

The IRS has not provided guidance on this point. IRS has revised the Form 941, the quarterly payroll tax return, to add the COBRA subsidy information on lines 12a and 12b. Absent further guidance, the plan would fill out the Form 941 and include the subsidy payment on line 12a. This would presumably show an overpayment if the plan had no other employment taxes, and this would be recorded on line 16. The plan representative would then check the "Send a Refund" box on line 16. The IRS would then provide a refund to the plan in the amount of the subsidy for that quarter.

Is a plan entity that has no employees and no assets required to front the subsidy?

Yes, the subsidy must be paid by the multi employer plan when the eligible participants make their 35% payment. The reimbursement from the federal government is retroactive, so the plan must come up with the funds somehow.

NOTICE REQUIREMENTS

How will eligible individuals be notified of their right to the subsidy?

Under ARRA employers or their COBRA Administrator must provide modified election notices or provide separate supplemental notices to all persons who became entitled to elect COBRA continuation coverage during the period beginning on September 1, 2008 and ending on December 31, 2009.

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When must the notices be provided?

Notices are required to be sent to persons who became qualified beneficiaries before the date of enactment (but on or after September 1, 2008) within 60 days of enactment (April 18, 2009). The election period for those beneficiaries who became eligible before the date of enactment will begin on the date of enactment and end 60 days after the date the plan administrator provides the required notice.

ARRA does not affect the timing of notices sent to individuals who become qualified beneficiaries on or after the date of enactment.

The information that I have is the COBRA subsidy would apply to those who involuntarily terminated but as far as the notice requirement, I've read some information that seems to indicate that we would be required to send notices to anyone who left?

ARRA requires communication to all individuals who had a qualifying event between 9/1/08 and 12/31/09 - whether assistance eligible or not. For those clients for whom UnitedHealthcare administrates COBRA, we will issue these notices for both assistance eligible and for those not assistance eligible who had a qualifying event per the requirements of the Act.

Does UnitedHealthcare have a form that we send out to our employees that says "for the subsidy"? Are employers required to let former employees know that these options are available again?

For those for whom we administer COBRA, we will handle the notifications of the Act on behalf of the employers - including those prior qualifying events and including current and future individuals with qualifying events.

The specifics of the communication are pending DOL guidance, which is due out on March 18. This guidance will explain the act and the eligibility for subsidy assistance.

Are the options available for terminated and laid off individuals?

Yes. ARRA applies to those individuals who were involuntarily terminated from employment. However, persons who still have an employment relationship, such as those on furlough, are not eligible.

Under what circumstances will UnitedHealthcare send out the new required COBRA notices?

This is primarily an employer responsibility under ARRA. However, if UnitedHealthcare is the COBRA administrator for the plan, UnitedHealthcare will send out the notice once we receive the model notice from the federal agencies charged with developing that notice by mid-March.

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Will UnitedHealthcare make any changes in our COCs or SPDs to reflect the subsidy arrangement?

Since the subsidy is presumably a limited-time event, we are not recommending any changes to COCs or SPDs. Instead, we will encourage plan sponsors to do a one-time mailing of the new prescribed notice to all of their employees as required by ARRA. That notice will cover the particulars of the subsidy program. If the subsidy program is re-authorized for years after 2009, we will consider the appropriateness of specific changes to our plan documents. For special enrollment option plans, the notice will need to cover the options available to the eligible COBRA participants.

Will UnitedHealthcare provide an interim notice to persons who become eligible for COBRA between March 1 and the date that the model notice is published?

UnitedHealthcare will be providing additional information in conjunction with current qualifying event notices as an interim step between the time of the Act becoming law and the execution of the model notice from the DOL. Upon execution of the model notice, assistance eligible individuals who had a prior qualifying event will be re-notified with the updated information to make their plan selection.

STATE CONTINUATION

Do the ARRA provisions require plans subject to state continuation to offer enrollment/the subsidy to those individuals who were eligible for state continuation prior to the 2/17/09 enactment date (but on or after September 1, 2008)?

Although certain state continuation plans are eligible for the subsidy, the COBRA changes that allow assistance eligible individuals who did not previously elect (from September 1, 2008 through February 17, 2009) to elect coverage prospectively do not apply to comparable state continuation plans. ARRA does not require state plans to offer such an election. Some states have already proposed legislation that would allow their continuation laws to mimic the federal COBRA enrollment options. Further, some state insurance departments have provided guidance that they expect carriers to offer the special election regardless of what ARRA says. However, absent any state by state guidance, the subsidy will be available only to persons who are either covered as of March 1, 2009 by the state plan or who become eligible March 1, 2009 and after.

Do the ARRA provisions that allow employers to offer the special enrollment option impact plans that are subject to state continuation laws?

No. The COBRA changes that allow assistance eligible individuals access to the optional special enrollment provision (where a member may elect a lower-cost plan) do not apply to comparable state continuation plans.

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For small groups with fewer than 20 individuals, which are not subject to COBRA (only state continuation rules apply) Have you determined how it is going to be handled (the subsidy for the groups with less than 20) that are not subject to COBRA that would only be subject to in state continuation rules.

We are reviewing all state continuation laws to determine which are comparable to COBRA. Further, there is a lot of activity at the state level to bring non-comparable state plans into line with COBRA so that the subsidy is available for that state's non-COBRA beneficiaries. For those that are determined to be included within ARRA, UnitedHealthcare will handle the support for the subsidy including the collection of the 65% subsidy via reduction of the UnitedHealthcare payroll taxes as outlined in the act.

IMPACT OF PRE-EXISTING CONDITION PROVISIONS

Will late-electing persons be subject to pre-existing condition exclusions?

ARRA protects late-electing persons (those who were previously eligible for COBRA under the terms of ARRA on or after September 1, 2008 but did not elect COBRA) by not counting any period of non-coverage between September 1, 2008 and February 29, 2009 as a lapse in coverage for determining the HIPAA 63-day gap in coverage rule (which would allow the imposition of a pre-existing condition exclusion).

Will UnitedHealthcare amend the HIPAA-required Certificate of Creditable Coverage to reflect ARRA's changes to the "gap in coverage" rule?

No. The HIPPA –required Certificate of Creditable coverage will remain in place to reflect the actual coverage. For those individuals who elect coverage as an assistance eligible individual under the Act, an updated Certificate of Creditable Coverage would be issued where appropriate based upon the updated coverage term.

SPECIAL OPTIONAL BENEFIT ENROLLMENT OPTION

What is the special enrollment option?

ARRA allows (but does not require) an employer to make available to subsidy-eligible individuals a lower cost plan option within 90 days of the date of the notice of the plan enrollment option. In order to qualify, the other plan must have a premium that does not exceed the premium in the plan in which the individual is enrolled at the time the qualifying event occurred and that plan must be offered to active employees of the employer at the time at which the election is made. The eligible individual would pay 35% of the premium charge for the newly elected plan.

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Do the ARRA provisions that allow employers to offer the special enrollment option impact plans that are subject to state continuation laws?

No. The COBRA changes that allow assistance eligible individuals access to the optional special enrollment provision (where a member may elect a lower-cost plan) do not apply to comparable state continuation plans.

How will UnitedHealthcare administer the special enrollment option?

Since the special enrollment option is selected by the employer, UnitedHealthcare will not administer a special enrollment provision unless the employer specifically requests in writing that it desires a special enrollment option and spells out the details of the option (plans covered, cost of plans for COBRA purposes, etc). The details of the special enrollment option should be included in the required ARRA notice to eligible persons.

MISCELLANEOUS

How will UnitedHealthcare handle fully insured programs where it is not the COBRA administrator?

UnitedHealthcare will look to the COBRA administrator to perform the functions required by ARRA, including providing the required information to the employer concerning the subsidy amounts and recipients. On insured cases UnitedHealthcare will continue to bill 100% of the contract premium regardless of the subsidy. The employer will be responsible for pursuing the subsidy through the payroll tax mechanism set out in ARRA.

Does UnitedHealthcare contemplate making rate adjustments based on the fact that both retroactive enrollments and future COBRA enrollments may increase significantly under the subsidy provisions?

UnitedHealthcare is presently reviewing this question. There are many types of programs that ARRA affects, and if the contract under which the program operates allows a rate increase based on these circumstances, that would be an underwriting decision to be determined on a case-by-case basis.

What if an employer is struggling and is not able to make the whole premium payment including the subsidy?

For an insured case, the failure of the employer to make the full premium payment due to UnitedHealthcare would cause a shortfall in premium under the policy that could lead to lapse. If the employer refuses to engage the subsidy and instead continues to collect 100% of the premium from the subsidy-eligible COBRA participant, the employer is violating the terms of the Act and the new provisions of COBRA and would be potentially subject to enforcement actions from the Internal Revenue Service or the Department of Labor. Further, the assistance

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eligible individuals who are denied eligibility for the premium reduction (whether by their plan, employer or insurer) may request an expedited review of the denial by the U.S. Department of Labor. The Department must make a determination within 15 business days of receipt of a completed request for review. The Department is currently developing a process and an official application form that will be required to be completed for appeals.

For non-COBRA small employers who are covered by a "comparable" continuation law will UnitedHealthcare accept the reduced premium that includes the subsidy amount?

If UnitedHealthcare bills the eligible individual directly, we will include in the bill the reduced premium based on the subsidy. If UnitedHealthcare does not bill the eligible individual directly, we will accept a reduced premium assuming we have accurate information on the subsidy amount and other information required by the Internal Revenue Service.

What effect does this have on stop loss coverage?

We are presently exploring the potential impact of the retroactive eligibility provisions for non-electors on our stop loss coverage. Whether this can be considered a "change in plan" that would allow us to adjust the premium is presently under review.

EMPLOYER OBLIGATION

What do employers need to do?

1. Seek Legal Counsel − COBRA is a law that is addressed to employers, and employers have the primary responsibility for compliance. The ARRA changes are similar in that employers need to understand them and comply with them on their own. Employers should seek the advice of their own legal counsel as to how the ARRA changes will affect their own plans. While UnitedHealthcare and other administrators may provide helpful structural and operational support for the new changes, the burden of compliance remains with the employer.
2. Identify and notify individuals − In general, an employer will need to identify individuals eligible for COBRA on or after September 1, 2008 and provide notification to these individuals of their potential new election period and of the availability of the premium subsidy, and any other COBRA coverage options, if any.
3. File for subsidy through payroll taxes − Employers will need to understand the mechanics of the subsidy and how they can file for the subsidy refund through their payroll taxes. This may involve the employer's tax and other consultants in addition to their legal counsel.

EMPLOYEE/MEMBER QUESTIONS

How do I know if I am eligible for the subsidy?

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You may be eligible if you were involuntarily terminated on or after Sept. 1, 2008 and are not eligible for other health care coverage including Medicare. UnitedHealthcare will be sending a listing to each of our COBRA customers the week of March 20th to identify all eligible individuals. You will receive a notification from UnitedHealthcare no later than April 18th.

What's my new rate going to be? When will I start paying the lower amount?

Your new rate will be determined by your current COBRA premium. Until we have identified you as an Assistance Eligible Individual you must continue to pay 100% of the premium. You will be notified of your new rate prior to your May premium.

Will the lower rate be retroactive and will I receive a refund?:

The new rate is retroactive to March 1, 2009, the effective date of the legislation. Any amounts paid above the 35% will be credited to future payments. If you discontinue your COBRA coverage and have a credit remaining you will receive a refund.

Will I be receiving something telling me what my new rate is? If so, when?

Yes, You will be receiving a notification prior to April 18th indicating your eligibility. Upon confirmation of your eligibility for the subsidy you will be notified of your new rates.

Does ARRA make any other changes to COBRA or health benefit provisions?

Yes. ARRA extends COBRA continuation eligibility for certain persons covered under the Trade Adjustment Act (TAA). ARRA adds new special length of COBRA continuation rules for certain individuals who are either TAA eligible or who have a nonforfeitable right to a benefit from the Pension Benefit Guaranty Corporation (but the rules do not apply after December 31, 2010).

- For TAA-eligible persons, the COBRA time period will extend beyond the normal COBRA termination dates until earlier of the date the person ceases to be TAA-eligible or the end of 2010. Thus, for example, if a TAA-eligible person was at the 18 month limit, the Act would provide additional coverage through the end of 2010 or the person's ceasing to be TAA-eligible, whichever first occurs.

- For the PBGC-eligible persons, the date is extended to the date of death of the individual or, if earlier, December 31, 2010. In the event of death of the covered individual, coverage is extended 24 months from the date of death for the individual's dependent children and/or surviving spouse—but in no event beyond December 31, 2010.

Does ARRA make subsidy changes under the Trade Adjustment Act?

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Yes. ARRA raises the TAA health care credit under Code Section 35 for persons who meet the requirements of the TAA (someone whose job has been eliminated by virtue of some documented aspect of foreign competition) from 65% to 80% for coverage months beginning before January 1, 2011. In addition, TAA-eligible persons will continue to receive the credit even if they are not enrolled in a re-training program during the same period (this was a requirement of the prior law). The health coverage involved may be COBRA or a variety of other state and federal programs.

ARRA also allows beneficiaries of deceased TAA-eligible persons and divorced spouses of such persons to have extended coverage for eligible coverage months beginning before January 1, 2011. For divorce, the spouse is eligible to up to 24 months of continued coverage; in the case of the death of the TAA-eligible person, the coverage is continued for dependents (who were dependents on the date of death) for up to 24 months from the date of death.

Finally, ARRA adds a new class of group health plan under the TAA for persons who have an employment-related terminating event prior to January 1. 2011. Those persons are ones covered under a VEBA established pursuant to an order of a bankruptcy court. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates.

FAQs FOR ARRA COBRA AMENDMENTS IN DOD BILL

What is the effective date of the amendments in the Bill?

The President signed the Bill December 19, 2009, and that is the effective date and the date from which time frames in the bill start.

What is the extension of the ARRA eligibility period in the Bill?

The Bill extends eligibility for the ARRA subsidy through February 28, 2010. Eligibility for the subsidy ended on December 31, 2009 under the earlier ARRA provisions.

What is the extension of the subsidy period under the Bill?

The Bill extends the nine-month subsidy period to fifteen months.

What are the transitional provisions in the Bill for persons who previously had the COBRA subsidy?

- Group health plans are required to allow assistance eligible individuals who exhausted the 9 month COBRA subsidy period and dropped COBRA coverage to retroactively

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elect COBRA coverage for up to an additional 6 months, and receive the subsidy for that time (i.e., pay 35% of the COBRA premium for the retroactive coverage).

- Group health plans are required to allow assistance eligible individuals who exhausted the 9 month COBRA subsidy period and continued to maintain COBRA coverage (and paid 102% of the premium) to receive a reimbursement payment or credit for 65% of the COBRA premium payments that were paid for up to 6 months following the 9 month COBRA subsidy period.

What changes did the bill make to the timing of eligibility for COBRA?

The Bill clarifies that an individual's status as "assistance eligible" is based on the date that the individual experiences a qualifying event. This change is intended to correct an issue that arose under ARRA, in which an individual who was involuntarily terminated but did not lose coverage until the last day of the month was not eligible for the COBRA subsidy in the month that it expired (e.g., Under ARRA, December 31, 2009).

What new communications does the Bill require group health plans to make?

Group health plans are required to provide notice of the extension of premium assistance to the following individuals:

- Anyone who is an assistance-eligible individual at any time on or after October 31, 2009, or who experiences a qualifying event consisting of termination of employment on or after that date (notice must be provided on or before February 17, 2010, 60 days after enactment); and

- Anyone who is eligible for a retroactive COBRA election or rebate, as described above (notice must be provided within 60 days after the date individual exhausts the 9 month COBRA subsidy period).

What will happen with State Continuation plans that are “comparable” to COBRA and for which the subsidy applied?

Since ARRA applies to state continuation laws that are comparable to ARRA, the extension of the subsidy and the rules with regard to the transition period will apply to those plans that are subject to state continuation. In any event the extension of the availability of the subsidy to February 28, 2010 will apply. As for the extension of the duration of the subsidy to 15 months, that may or may not be picked up by the state plans depending on the stated duration of coverage. For example, if a comparable state statute has only nine months continuation duration, the ARRA extension will not automatically extend that state’s coverage to 15 months. The state legislature would have to act to extend that period of time to correspond to the 15 month COBRA subsidy duration.

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