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**COBRA**

**Continuation of Coverage**

Quick Reference Guide  
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Revised November, 2000

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## TABLE OF CONTENTS

### GENERAL PROVISIONS

Purpose of this Guide.  
Background.  
Description.  
Effective Dates.

### PROVISIONS IN THE LAW

What Group Health Plans are Subject to COBRA?  
Who is a Qualified Beneficiary (QB)?  
Can Dependents be Added During Annual Enrollment Period?  
What is a Qualifying Event (QE)?  
What Does it Mean to Lose Coverage?  
What Coverages Should be Offered?  
Exceptions – QB Relocating  
What Deductibles and Other Plan Limits Apply if COBRA Continuation is Elected?  
May a Qualified Beneficiary Change Plans Other Than During an Annual Enrollment Period?  
What are the Maximum Periods of Continuation Coverage?  
Disability  
What Other Events Will Terminate COBRA Coverage?

### ELECTION PERIOD

How Long is the Election Period?  
Waiving (Declining) Continuation Coverage.  
Must Coverage be Provided During the Election Period?  
Providing Qualified Beneficiary's Status to Health Care Providers.  
Can an Employer Withhold Money or Other Benefits Owed to a Qualified Beneficiary until the Qualified Beneficiary either Waives Continuation Coverage, Elects and Pays for the Coverage, or Allows the Election Period to Expire?

### PREMIUMS

Payment of Premium.  
How is the Applicable Premium Determined?  
Timely Payment (Grace Period).  
Providing Qualified Beneficiary's Status to Health Care Providers During the Grace Period.

### NOTIFICATION REQUIREMENTS

Initial Notice.  
Notice When an Event Occurs.  
Notice By Employee or Spouse.

### ALTERNATIVE COVERAGE

Other Continuation Options.

### EXTENSION OF BENEFITS

Is the Extension of Benefits Provision applicable to COBRA Continuation Coverage?

### MEDICAL CONVERSION

Conversion Rights.  
Exceptions.  
Conversion Notice.  
“SPECIAL NOTICE.”

February 1999 PROPOSED REGS RE:

- FLEXIBLE SPENDING ACCOUNTS FOR HEALTH CARE.
- COBRA and the FMLA.
- BUSINESS RE-ORGANIZATIONS: MERGERS and ACQUISITIONS.

### PENALTIES

Penalty for Non-Compliance.

### ADMINISTRATION

Requesting COBRA Administrative Services from the Melville/COBRA unit for New Business.

### CONTINUATION/CONVERSION CHART

### SAMPLE BOOKLET TEXT

## GENERAL PROVISIONS

### Purpose of this Guide

This Quick Reference Guide is intended to provide a summary of the law, information from the final regulations, and information from the new proposed regulations regarding (1) mergers and acquisitions, (2) the interaction between COBRA continuation coverage and the Family and Medical Leave Act (FMLA), and (3) the application of COBRA to HC FSAs.

### Background

COBRA is an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985. Congress had been concerned for some time about the access to and affordability of group health coverage in cases of job loss, divorce, death or other circumstances that resulted in the loss of health coverage.

The original COBRA law has been amended many times since it was originally enacted. In addition, the Internal Revenue Service (IRS) issued several detailed proposed regulations to implement the COBRA provisions; the Department of Labor (DOL) issued a model notice for Employers to use in describing COBRA rights to plan participants; and there have been many court cases that have clarified (or perhaps added confusion to) certain aspects of the COBRA law and its regulations.

On February 2, 1999, the IRS published “final” regulations which, according to the IRS, are intended to provide clear, administrable rules on COBRA, and they offer guidance on many questions that have been raised under COBRA.

### Description

The COBRA law requires employers that maintain group health plans to allow certain individuals called *Qualified Beneficiaries* the right to elect *continuation coverage* up to a *maximum period* of time upon the occurrence of a *Qualifying Event*. This means that each person who is a Qualified Beneficiary has the right to continue the group health coverage.

For example, assume an employee has group coverage for himself/herself and also covers his/her spouse and two dependent children. If the employee terminates employment, then each, all or any of these four people can elect to continue the medical coverage under the federal COBRA law.

The final regs:

1. prevent group health plans from terminating COBRA continuation coverage on the basis of Medicare or other coverage that a Qualified Beneficiary had before electing COBRA coverage;
2. give employees and employee organizations significant flexibility in determining, for COBRA purposes, the number of group health plans they maintain;
3. eliminate the requirement that group health plans offer qualified beneficiaries the option to elect only health coverage under a group health plan that otherwise provides both health and vision and/or dental coverage; (i.e., the “core” “non-core” coverage distinction was eliminated.
4. give employers, in determining whether the small employer plan exception applies, the option of counting by pay period rather than by every business day, and allow for the consistent treatment of part-time employees through the use of full-time equivalents by providing formulas for equating part-time employees to full-time employees. For example, two 20-hour employees would equal 1 full-time 40-hour employee.

The Proposed regs:

5. provide baseline rules for determining the COBRA liabilities of buyers and sellers to reallocate and carry out those liabilities by agreement;
6. limit the application of COBRA for most health flexible spending arrangements (FSAs).

### Effective Dates

The final regs apply to Qualifying Events occurring in plan years beginning on and after January 1, 2000. For Qualifying Events that occur before this date, employers and plans may follow these final regulations, or at least comply in good faith with a reasonable interpretation of the law - IRC Section 4980B.

## PROVISIONS IN THE LAW

### What Group Health Plans are Subject to COBRA?

Practically all U.S. employers that have group health plans covering their employees are subject to COBRA. The only group health plans that are NOT subject to COBRA continuation are:

1. Small employers - that is, employers with fewer than 20 employees on at least 50% of its typical business days during the preceding calendar year. All full-time and part-time common law employees, whether or not they are covered under the plan, are taken into account in determining whether an employer had fewer than 20 employees; however, part-time employees may be counted in full-time equivalents. Common law employees do not include self-employed individuals, independent contractors, or directors when determining the size of the employer.
2. Church plans as defined in IRC Section 414(e).

Although state and local governmental plans are not subject to the rules in IRC Section 4980B, these plans are generally subject to parallel continuation requirements that were added to the Public Health Services Act.

Generally similar, but not parallel, provisions cover Federal employees and their dependents covered under the Federal Employees Health Benefit Program.

### Who is a Qualified Beneficiary?

Each employee, the spouse of the employee and/or the dependent children of the employee may be considered a Qualified Beneficiary, if they would *lose coverage* as a result of a Qualifying Event. A covered employee is any person who is or was covered under the group health Plan on the day before the Qualifying Event by virtue of the individual's employment or previous employment with the employer. This includes a retiree or former employee, self-employed individuals, independent contractors, and company directors who are or were actually covered under the Plan.

In addition, a Qualified Beneficiary is any child who is born to or placed for adoption with the covered employee during a period of COBRA continuation.

Domestic Partners are not considered Qualified Beneficiaries because they are not the spouse of the employee or a dependent child of the employee.

### Can Dependents Be Added During Annual Enrollment Period?

An annual enrollment period means a designated period during which an employee may enroll for coverage under a group health Plan, may choose to be covered under another group health Plan maintained by the employer, or may choose to add or drop coverage of family members. If this provision is part of the active Plan and is available to similarly situated Non-COBRA active employees, then each Qualified Beneficiary or continuant must be given the same rights during an annual enrollment period. This means that each Qualified Beneficiary may choose to be covered under another Plan such as changing from HMO to indemnity coverage, or may choose to add family members under the same terms and conditions that apply to active employees. If the employer's group health Plan does not include an annual enrollment period and/or allow Non-COBRA active employees to enroll family members before the annual enrollment period, those same provisions must be applied to qualified beneficiaries.

Except for a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation, new family members are not and cannot become qualified beneficiaries. They are dependents of the Qualified Beneficiary and they remain covered only as long as the Qualified Beneficiary remains covered under the Plan.

### What is a Qualifying Event?

A Qualifying Event is what triggers the offering of COBRA continuation coverage to qualified beneficiaries. A Qualifying Event is any of the following events that would *cause a loss of health coverage*:

For covered employees:

- a) Termination of employment, whether voluntary or involuntary (other than for gross misconduct), or reduction in hours worked.

For covered spouse and/or dependent children:

- a) Termination of the covered employee's employment, whether voluntary or involuntary (other than for gross misconduct), or reduction in hours worked by the covered employee;
- b) The covered employee's death;
- c) The divorce or legal separation of the covered employee from the employee's spouse; (A legal separation will be as determined by the court in the State or jurisdiction in which the spouse filing for the legal separation resides.)
- d) The covered employee becomes entitled to Medicare; however, other than as a second Qualifying Event, this could only occur if the employee chooses to terminate his/her group coverage in favor of Medicare; or
- e) A dependent child is no longer eligible for coverage under the Plan.

An Addition Event For Retired Employees and Their Covered Dependents:

- f) If the employer provides health coverage for retired employees and their eligible dependents, a bankruptcy proceeding under U.S.C. Title 11. (Special rules apply. If the individual has any questions in this regard, he/she should contact his/her former employer.)

**What Does it Mean to Lose Coverage?**

To lose coverage means to cease to be covered under the same terms and conditions as in effect on the day before the Qualifying Event. A loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the *maximum period of coverage*. If the individual does not lose coverage before the end of what would have been the maximum period of coverage, then the event is not a "qualifying" event.

If coverage is reduced or eliminated "in anticipation" of an event (such as, an employee dropping coverage of the spouse in anticipation of a divorce or legal separation, or an employer terminating a Plan in anticipation of selling a plant), the reduction or elimination of coverage is

disregarded in determining whether the event causes a loss of coverage.

**What Coverages Should be Offered?**

Qualified Beneficiaries generally must be given the right to continue health coverage that is identical to the health coverage provided to the Qualified Beneficiary on the day before the Qualifying Event. Although the final regulations eliminated the rules regarding "core" v. "non-core" benefits, CIGNA will allow a Qualified Beneficiary to elect medical without dental, or dental without medical, if the premium rates are not bundled. If, after the election, the health coverage provided to Non-COBRA beneficiaries is modified in any way, then the coverage made available to Qualified Beneficiaries must be changed in the same way.

Exception:

If a Qualified Beneficiary is covered under a closed panel plan, such as an HMO, and moves out of that plan's service area, the employer must offer that Qualified Beneficiary the right to continue coverage under any other health plan that is maintained by the employer that would cover the Qualified Beneficiary in the relocated area. *See the chart at the end of this booklet.*

With respect to a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the child is generally entitled to have the same coverage that dependent children of active employees receive under the health plan under which the covered employee has coverage at the time of the birth or placement. The child may elect coverage different from that elected by the covered employee during the next annual enrollment period, if any, under the plan.

**What deductibles and other plan limits apply if COBRA continuation coverage is elected?**

Qualified Beneficiaries are subject to the same rules regarding deductibles as similarly situated non-COBRA beneficiaries. When COBRA begins before the end of the deductible accumulation period, the Qualified Beneficiary must retain credit for expenses incurred by him/her toward those deductibles as though the Qualifying Event had not occurred.

If a deductible is computed on a family basis, the remaining deductible for the family depends on the members of the family electing COBRA continuation coverage. In computing the family deductible for COBRA continuants that remains on the date COBRA begins, only the expenses of the family members continuing COBRA coverage need be taken into account. If the Qualifying Event results in two family units (e.g., following a divorce), the family deductible may be computed separately for each unit based on the members in each unit. For example, assume:

- A group health plan applies a separate \$200 annual deductible to each covered person and a \$500 annual family deductible. A covered employee with 4 dependent children (2 are stepchildren) divorces his spouse. The former spouse has custody of the two older children (employee's stepchildren), and elects COBRA continuation coverage for himself and both children. Prior to the divorce the family of 6 had accumulated \$420 toward the family deductible, as follows: \$70 was incurred by each spouse; \$200 by the oldest child who is now with the former spouse; \$80 by the youngest child who is with the employee, and none by the other two children. The family unit on COBRA, consisting of the former spouse and the two older children, had incurred a total of \$270 of covered expenses.
- Since the oldest child with the former spouse had satisfied his individual \$200 deductible prior to the Qualifying Event, he has no further deductible for the remainder of this plan year.
- The former spouse and other child who elected COBRA would have to satisfy a total of \$230 to meet the \$500 family deductible for this plan year.

Other plan limits, such as out-of-pocket limits, and maximums are treated in the same way as the deductible amount.

### **May a Qualified Beneficiary Change Plans Other Than During an Annual Enrollment Period?**

In general, a Qualified Beneficiary need only be given the right to continue the coverage that he/she was receiving immediately before the

Qualifying Event, *even if that coverage ceases to be of value* to the Qualified Beneficiary; for example, when a Qualified Beneficiary is covered under a region-specific HMO and leaves the HMO's service area.

However, if a Qualified Beneficiary participates in a region-specific HMO that does not service the area to which the person is moving (regardless of the reason for relocating), the Qualified Beneficiary must be allowed to elect alternative non-region specific coverage that the employer makes available to active employees. If the employer makes group health coverage available to similarly situated Non-COBRA beneficiaries that can be extended in the area to which the Qualified Beneficiary is moving, then that coverage is the alternative coverage that must be made available to the relocating Qualified Beneficiary. (For example, if the employer makes another HMO available in that area or the employer offers a separate indemnity Plan.)

If the employer does not make group health coverage available to similarly situated Non-COBRA beneficiaries that can be extended in the area to which the person is moving but does have health coverage available to other employees that can be extended in that area, then the relocating Qualified Beneficiary must be allowed to continue under that other coverage. (For example, an optional PPO Plan with an out-of-network benefit.)

If the only health coverage the employer makes available to active employees is not available in the area to which the Qualified Beneficiary relocates, then the employer is not required to make any other coverage available to that person. (That is, the employer is not required to establish a new health Plan in that area.)

### **What are the Maximum Periods of Continuation Coverage?**

If elected, the maximum periods of coverage are as follows:

- For termination of employment or reduction of hours worked (Qualifying Event # a on page 4), except as shown below, the

maximum period is 18 months from the date of the event.

- If a second Qualifying Event occurs during this 18 month period (or during the additional 11 months explained below), the spouse and/or dependent child(ren) who would otherwise lose their continuation coverage as a result of that second event, may continue their health coverage for up to 36 months from the date the employee terminated employment or had a reduction in hours worked.

Disability:

- If a Qualified Beneficiary is totally disabled under the Social Security Act within 60 days of the Qualifying Event, the 18 months may be extended for up to 11 more months. For this additional 11 months to be available, the individual must provide the employer with a copy of the Social Security Administration's letter of disability determination within 60 days of the date of that letter. The copy of the letter must also be provided to the employer before the end of the initial 18 months. If one member of the family qualifies for the additional 11 months, all members of the family may extend their coverage for up to 11 months.
- If a covered employee becomes entitled to Medicare before he/she terminates employment or has a reduction of hours worked, then any other Qualified Beneficiary (the covered spouse and/or dependent child(ren)) may continue their health coverage until the later of: (1) 36 months from the date the employee first became entitled to Medicare, or (2) 18 months from the date of the employee's termination of employment or reduction of hours worked. The covered employee may continue his/her own coverage for 18 months from the date of termination of employment or reduction of hours worked. For example:
  - Assume a covered employee attains age 65 and becomes entitled to Medicare on May 1, 2001, and terminates employment on December 1, 2001. This employee's

spouse and dependent child(ren) may continue their coverage under COBRA from December 1, 2001 until May 1, 2004, which is 36 months from the date the employee became entitled to Medicare. The employee may continue his/her own coverage until June 1, 2003, which is 18 months from the date of termination of employment.

- For a Qualifying Event involving retired employees and their eligible dependents of employers under U.S.C. Title 11 Bankruptcy (Qualifying Event # f on page 4), coverage may be continued until (1) the date of the Qualified Beneficiary's death, or (2) for a surviving spouse or eligible dependent, 36 months after the retired employee's death.

For all other Qualifying Events (b,c,d, and e on page 4), the maximum period is 36 months from the date of the event.

*The maximum period of coverage* for a child born to or placed for adoption with a covered employee during a period of COBRA continuation is from the date of birth or placement until the date that is 18 months from the date of the employee's termination of employment or reduction of hours worked. If there is a second Qualifying Event, such as the employee's death within the initial 18 months, the child's coverage may be continued for up to 36 months from the date the covered employee terminated employment or had a reduction of hours worked.

- For example, assume a covered employee terminates employment on March 1, 1999 and elects COBRA continuation coverage. A child is born to this employee on June 1, 1999. The child's coverage may be continued until August 31, 2000, even if the covered employee's COBRA coverage ends on an earlier date. If the covered employee dies while covered under COBRA, the child's coverage may be continued until March 1, 2002.

## What Other Events Will Terminate COBRA Coverage?

Except for an interruption of coverage in connection with a *waiver*, as explained below, COBRA continuation coverage must extend from the date of the Qualifying Event and end on the earliest of the following dates:

- The first day for which *timely payment* of any required premium is not made by the Qualified Beneficiary.
- The date the employer ceases to provide any group health Plan coverage to any employee.
- The first day, after the date of election, on which the Qualified Beneficiary first becomes covered under any other group health Plan that does not contain any exclusion or limitations with respect to any pre-existing condition applicable to such person.
- The first day, after the date of election, on which the Qualified Beneficiary first becomes entitled to Medicare benefits.
- For a disabled Qualified Beneficiary whose coverage is being extended for up to the additional 11 months, COBRA continuation coverage will cease on the first day of the month that is more than 30 days after the date final determination is made that he/she is no longer disabled for Social Security purposes. This earlier termination date will also apply to any other family members who are continuing their coverage under COBRA. However, the early termination date will not apply before the end of the initial 18 months.

## ELECTION PERIOD

### How Long is the Election Period?

If a Qualified Beneficiary chooses to continue the health coverage, he/she must make that decision within the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, and may not end before the date that is 60 days after the later of: (1) the date the Qualified Beneficiary would otherwise lose coverage, or (2) the date COBRA *notice* is provided to the Qualified Beneficiary. (See page 9.)

For example:

1. Assume a single employee terminates employment on June 1, 2000, and the coverage terminates on June 1, 2000. In this case, the election period must begin not later than June 1, 2000, and must not end before July 31, 2000. If the employer provides the notice on June 15, 2000, the Qualified Beneficiary has until August 14, 2000, to elect COBRA continuation coverage.
2. If the Plan provides that the employer-paid coverage does not end until 6 months after the termination of employment, the above employee does not lose coverage until December 1, 2000. The election period can therefore begin as late as December 1, 2000, and the Qualified Beneficiary has until January 30, 2001, to elect COBRA continuation coverage **FOR THE BALANCE OF THE 18 MONTHS.**
3. Assume a single employee terminates employment on June 5, 2000, and the coverage terminates at the end of the month in which the termination occurred, i.e., June 30, 2000. This election period must begin not later than June 30, 2000 and may not end before August 29, 2000. If this employer does not provide the notice until July 10, 2000, the election period may not end before September 8, 2000.

### Waiving (Declining) Continuation Coverage.

During the election period, a Qualified Beneficiary may *waive* (i.e., decline) COBRA continuation coverage, and the waiver (declination) can be revoked at any time before the end of the election period. If a waiver (declination) is revoked within the election period, the coverage need not be provided retroactively (that is, from the date of the loss of coverage until the date the waiver is revoked). Revocation of a waiver is an election of COBRA continuation coverage. In this case, coverage would be provided from the date of election. Waiving (declining) COBRA and then revoking that waiver does not extend the Maximum period of continuation coverage. Waivers, revocations and elections are considered made on the date they are sent to the employer, employee organization, or Plan administrator, whichever is applicable.

### **Must Coverage be Provided During the Election Period?**

Except as explained regarding the revocation of a waiver, before any election is made coverage can be provided as described in (a) or (b) below:

- a. For indemnity or reimbursement plans:
  - the Plan can provide for coverage during the election period OR;
  - the coverage can be terminated when the Qualifying Event occurs and retroactively reinstated when the election is made (**This is CIGNA's standard position**); OR
  - a Plan could also provide coverage during the election period and then cancel it retroactively if COBRA continuation is not elected.

Claims incurred by a Qualified Beneficiary during the election period do not have to be paid before the election and premium payment is made.

- b. For plans that provide health services, such as a HMO or a clinic:
  - A Plan can require a Qualified Beneficiary who has not elected and paid for COBRA continuation coverage to choose between –
    - electing and paying for the coverage; OR
    - paying the reasonable and customary charge for the Plan's services, but only if a Qualified Beneficiary who chooses to pay for the services will be reimbursed for that payment within 30 days after electing and paying the COBRA premium.
  - or**
  - A Plan can provide continued coverage and treat the Qualified Beneficiary's use of the facility as a "constructive election." In this case, the Qualified Beneficiary is obligated to pay any applicable charge for the coverage, but only if he/she is informed before using the facility that use of the facility will be constructive election of COBRA continuation coverage.

### **Providing Qualified Beneficiary's Status to Health Care Providers During the Election Period.**

If a health provider contacts the Plan to confirm coverage for a Qualified Beneficiary during the election period, the Plan must give a complete and accurate response to the provider about the Qualified Beneficiary's COBRA coverage status during the election period. For example, if a Plan provides coverage during the election period but cancels coverage retroactively if COBRA is not elected, the Plan must explain this to the inquiring provider. Likewise, if the Plan cancels coverage when the Qualifying Event occurs but reinstates coverage when COBRA is elected, then the Plan must explain that the person does not currently have coverage but will be covered retroactively, if COBRA is elected within the election period.

### **Can an Employer Withhold Money or Other Benefits Owed to a Qualified Beneficiary until the Qualified Beneficiary either Waives Continuation Coverage, Elects and Pays for the Coverage, or Allows the Election Period to Expire?**

NO. An employer or employee organization may not withhold anything to which the Qualified Beneficiary is otherwise entitled (by operation of law or other agreement) in order to compel payment for COBRA coverage or to coerce the individual to give up his/her rights to COBRA continuation coverage (including the right to take the full election period to make a decision). However, this does not change the rule that states: Claims incurred by a Qualified Beneficiary during the election period do not have to be paid before the election and premium payment is made.

## **PREMIUMS**

### **Payment of Premium.**

A group health Plan may require the payment of an amount that does not exceed 102% of the *applicable premium*. A group health Plan may require payment of up to 150% of the applicable premium for any extended period of COBRA continuation covering a disabled Qualified Beneficiary (whether single or family coverage). The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

### **How is the Applicable Premium Determined?**

The applicable premium is determined as follows:

- If the Employee alone elects COBRA, the Employee will be charged the active Employee rate.
- If a Spouse alone elects COBRA, the Spouse will be charged the active Employee rate.
- If a child or children elect COBRA without a parent also electing the continuation, each child will be charged the active Employee rate.
- If the entire family elects COBRA, they will be charged the active Family rate.
- If the Schedule of Premium Rates (SOPR) is set up on a step-rate basis -- such as Employee Only, Employee and Spouse; Employee and Children; Employee, Spouse and Child(ren) – then the active rate basis that fits the individuals who elect to continue their coverage is the rate that will be charged. (If only children elect COBRA, each child would be charged the Employee Only rate.)

### **Timely Payment (Grace Period)**

- A group health Plan may not require payment for ANY period of COBRA continuation coverage earlier than 45 days after the date of election.
- After the initial period, the premium for each period of COBRA coverage must be paid within the applicable grace period. That is generally 30 or 31 days. A Qualified Beneficiary must be allowed to pay the premiums on a monthly basis.
- If the employer's or policyholder's grace period within which to pay the group health premium is longer than 30 days, the qualified beneficiaries must be allowed that longer period of time to pay their COBRA premiums.
- If payment is made within the grace period in an amount that is not significantly less than the amount the Plan requires to be paid, then the amount paid is deemed to satisfy the Plan's requirement. However, a Plan must notify the Qualified Beneficiary of the

deficiency and allow at least 30 days after notice is provided for payment to be made.

### **Providing Qualified Beneficiary's Status to Health Care Providers During the Grace Period.**

If, after COBRA has been elected, a health care provider contacts the Plan to confirm coverage for a Qualified Beneficiary for a period for which premium has not yet been received, the Plan must give a complete and accurate response to the provider regarding the status of the Qualified Beneficiary. For example, if the Plan provides coverage during the 30/45-day grace periods, then the Plan must inform the provider that the individual is covered but that coverage is subject to retroactive termination if payment of the premium is not received on time. Also, if the Plan terminates coverage during the grace period but reinstates it retroactively upon receipt of the premium, then that must be explained to the health provider.

### **NOTIFICATION REQUIREMENTS**

#### **Initial Notice.**

A general notice concerning COBRA continuation must be given by the employer: (1) to all covered employees and their covered spouses when a Plan first becomes subject to COBRA, (2) to each new employee when he/she is hired, and (3) to a spouse when that spouse is added to the Plan. This initial notice must be provided in a way that accurately informs the employees and dependents of their rights. A general notice posted on a bulletin board is not sufficient for this purpose. Mailing this notice first class to employees and their spouses would constitute good faith compliance.

The COBRA explanation included in the group benefit booklet, certificate, or general service agreement may be used for this purpose.

#### **Notice When an Event Occurs.**

When a Qualifying Event (a,b,d, or f on page 4) has occurred, the employer must notify the Qualified Beneficiary(ies) of their election right. If an independent COBRA administrator is involved, the employer has 30 days to notify the

COBRA administrator who then has 14 days to notify the Qualified Beneficiary(ies). If no independent COBRA administrator is involved, some courts say that the employer has only 14 days to notify the Qualified Beneficiary(ies).

#### **Notice By Employee or Spouse.**

When the Qualifying Event is either (c, or, e on page 4) a divorce or legal separation or a child losing eligibility for coverage under the Plan, the employee or spouse must notify the employer of this event within 60 days of its occurrence. If the employee or spouse does not notify the employer within the 60 days, then COBRA does not have to be offered. In order to enforce this rule, the employee and spouse must have knowledge of their obligation prior to the date of the Qualifying Event. Upon receipt of the notice from the employee or spouse, the employer and/or COBRA administrator must follow the same Notice rules as specified above.

#### **ALTERNATIVE COVERAGE**

##### **Other Continuation Options.**

Other continuation options may be provided or available under the Plan (for example, as a result of State or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994, a collective bargaining agreement, a severance agreement, or the employer's Plan procedure).

This "alternative coverage" will not extend the maximum period of coverage required under COBRA. If the alternative coverage does not meet all the requirements for COBRA continuation coverage, the Plan must offer the Qualified Beneficiary the opportunity to elect COBRA continuation coverage.

If the individual rejects COBRA continuation coverage in favor of the alternative coverage, then, at the expiration of the alternative coverage period, the individual need not be offered a COBRA election. However, if a covered spouse or dependent child(ren) would lose the alternative coverage as a result of a Qualifying Event (such as the death or divorce of the covered employee) then the spouse and/or dependent child(ren) must

be allowed to continue the alternative coverage, with a maximum period of coverage of 36 months measured from the date of that Qualifying Event.

#### **EXTENSION OF BENEFITS**

##### **Is the Extension of Benefits Provision Applicable to COBRA Continuation Coverage?**

Yes. If the Plan includes an extension of benefits provision, and if the qualified beneficiary is totally disabled on the date the COBRA coverage ends, then the specific terms of the extension will apply at that time.

#### **MEDICAL CONVERSION**

##### **Conversion Rights**

If the Plan includes a medical conversion privilege for non-COBRA covered persons, then the employer or COBRA administrator must allow the qualified beneficiaries to convert to individual medical coverage provided the COBRA coverage is continued for the full 18 or 36 months.

##### **Exceptions:**

Although the law requires that conversion be offered only as stated above, if the Plan includes a medical conversion privilege, CIGNA allows conversion to individual medical coverage if the Qualified Beneficiary loses coverage due to:

- the employer filing bankruptcy and has terminated the Plan;
- the employer closing a location and does not have another Plan to offer the Qualified Beneficiary; or
- the Qualified Beneficiary moving out of the employer's service area and the employer does not have another Plan to offer the individual at his/her new location. However, this exception only applies to indemnity business; for HMO plans the exception is available only if the person relocates within that HMO's service area. *See the chart at the end of this booklet.*

##### **Conversion Notice:**

The employer or COBRA administrator must notify the Qualified Beneficiary of his/her conversion rights within 180 days before 18 or 36 month COBRA period expires.

Whenever a medical conversion packet is sent to a person, the packet should include the following "Special Notice."

plan year of COBRA continuation coverage equals or exceeds the maximum benefit available under the FSA.

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### SPECIAL NOTICE

In lieu of conversion coverage, you may be eligible for other Individual coverage options. The Federal Health Insurance Portability and Accountability Act ("HIPAA") and similar state laws guarantee the availability of individual medical coverage - with no pre-existing condition exclusions - to individuals who qualify for eligibility and enroll on time. Please note: if you elect conversion coverage now, you may lose your eligibility for HIPAA Individual coverage.

HIPAA coverage may be provided through a state program, or by insurers that sell individual policies in your state. Eligibility and enrollment requirements for HIPAA coverage may vary. Your regional U.S. Health Care Financing Administration office can help direct you to the state programs and/or insurers who offer HIPAA coverage in your state.

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### February 1999 PROPOSED REGS RE:

#### 1. HEALTH CARE

##### FLEXIBLE SPENDING ACCOUNTS .

Regarding an employee who has a Health Care Flexible Spending Account (FSA) on the date of termination of employment or reduction in hours worked:

- Continuation of the FSA does NOT need to be made available to a Qualified Beneficiary for any plan year AFTER the year in which the Qualifying Event occurs if :
  - the FSA is not subject to HIPAA (most health care FSAs are not subject to HIPAA); and
  - in the plan year in which the Qualifying Event occurs, the maximum amount the FSA could require to be paid for a full

In addition, continuation of the FSA does NOT need to be made available AT ALL, if as of the date of the Qualifying Event, the amount available for the remainder of the year is not more than the total amount the plan could require to maintain the coverage. Of course, the total amount allowed cannot be more than 102% of the monthly contribution multiplied by the number of months remaining in the year.

For example:

1. Assume an employee elected a \$1,200 health care FSA; his salary is reduced by \$100 per month; and this is a calendar year plan. When the employee terminates employment on March 29, he had contributed \$300 to the FSA. He did not incur any medical expenses prior to his termination. Since he would have \$1,200 available and be required to pay \$918 for the balance of the plan year, he should be offered the option to continue his FSA under COBRA.
2. Assume an employee elected a \$1,200 health care FSA; his salary is reduced by \$100 per month; and this is a calendar year plan. When this employee terminates employment on March 29, he had contributed \$300 to the FSA. However, he had incurred \$700 in covered medical expenses in February. This employee would have \$500 available during the balance of the plan year and would be required to pay \$918 for the balance of the plan year. Therefore, the plan does not need to offer the employee the right to continue the FSA under COBRA.

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#### 2. COBRA and the FMLA.

The Family and Medical Leave Act of 1993 imposed certain requirements on employers regarding coverage under group health plans for employees taking FMLA leave.

The taking of a leave under the FMLA does not constitute a Qualifying Event under COBRA.

However, a Qualifying Event does occur if:

- An employee (or the spouse or child of the employee) is covered under the employer's group health plan on the day before the first day of the FMLA leave (or becomes covered during the FMLA leave);
- The employee does not return to work with the employer at the end of the FMLA leave; and
- The employee (or the spouse or child of the employee) would, in the absence of COBRA, lose coverage under the group health plan before the end of the COBRA maximum coverage period.

If these three criteria are met, a Qualifying Event would occur on the last day of the FMLA leave. The maximum coverage period would be measured from the last day of the FMLA leave. One exception to this rule is if the loss of coverage does not occur until a later date. In this case, the maximum coverage period would be measured from the date the coverage is actually lost.

However, if the employer terminates the group health plan on or before the last day of the FMLA leave for the class of employees to which the employee would have belonged if he/she had not taken the FMLA leave, there is no Qualifying Event.

If an employee fails to pay his/her share of the premium for group health coverage during the FMLA leave or declines such coverage during the leave, that does not affect the determination of whether or when a Qualifying Event occurred as explained above.

If any state or local law requires coverage during a leave of absence for a longer period of time than that required under FMLA leave, the COBRA Qualifying Event will still be considered to take place at the end of the federal FMLA. In addition, if there is a lapse in coverage during the FMLA leave, the date of the Qualifying Event will still be the last day of the FMLA leave. In either event, the maximum period of coverage under COBRA is measured from the end of the federal FMLA leave.

COBRA continuation of coverage cannot be conditioned upon reimbursement of the premiums paid by the employer for group health coverage during the FMLA leave. The Department of Labor has published rules describing the circumstances in which an employer may recover premiums it pays to maintain coverage, including family coverage, from an employee who fails to return from leave. Even if recovery of premiums is permitted under those rules, the right to COBRA continuation of coverage cannot be conditioned upon the employee's reimbursement of those premiums.

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### **3. BUSINESS RE-ORGANIZATIONS: MERGERS and ACQUISITIONS.**

The proposed regulations provide guidance on applying COBRA continuation coverage requirements in business reorganizations. In essence, the parties to a transaction may allocate continuing coverage responsibility by contract. However, if the responsible party under the agreement defaults on its obligation and the other party would have been obligated to provide coverage in the absence of the agreement, then the other party retains the obligation.

In the absence of a contract between the buyer and the seller, for *stock sales and substantial asset sales*, the proposed regulations provide that the seller retains the COBRA continuing coverage obligation for existing qualified beneficiaries. If the seller, in connection with the sale, ceases to provide a group health plan to any employee, then the buyer is responsible for providing COBRA coverage to the existing qualified beneficiaries. This secondary liability for the buyer applies in all stock sales and sales of substantial assets in which the buyer continues the business operations associated with the assets without interruption or substantial change.

#### **Questions and Answers from the Proposed Regulations**

##### **1. What are a business reorganization, a stock sale and an asset sale?**

- A business reorganization is a stock sale or an asset sale.
- A stock sale is a transfer of stock in a corporation that causes the corporation to

become a different employer or a member of different employer.

- An asset sale is a sale of substantial assets, such as a plant or division or substantially all the assets of a trade or business.
- 2. In a stock sale, what are the selling group, the acquired organization, and the buying group?**
- The selling group is the controlled group of corporations, or the group of trades or businesses under common control, of which a corporation ceases to be a member;
  - The acquired organization is the corporation that ceases to be a member of the selling group; and
  - The buying group is the controlled group of corporations, or the group of trades or businesses under common control, of which the acquired organization becomes a member. If the acquired organization does not become a member of such a group, the buying group is the acquired organization.
- 3. In an asset sale, what are the selling group and the buying group?**
- The selling group is the controlled group of corporations, or the group of trades or businesses under common control that includes the corporation or other trade or business that is selling the assets; and
  - The buying group is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is buying the assets.
- 4. Who is an M&A Qualified Beneficiary? (Merger and Acquisition)**
- In an asset sale, this is a Qualified Beneficiary whose Qualifying Event occurred prior to or in connection with the sale and who is a covered employee whose last employment prior to the Qualifying Event was associated with the assets being sold.
  - In a stock sale, this is a Qualified Beneficiary whose Qualifying Event occurred prior to or in connection with the sale and who is a covered employee whose last employment

prior to the Qualifying Event was with the acquired organization.

**5. Is the sale a Qualifying Event for a covered person who is employed by the acquired organization before the sale and who continues to be employed by that organization after the sale?**

- In a stock sale, NO, it is not a Qualifying Event. This employee does not experience a termination of employment as a result of the sale. This applies regardless of whether group health coverage is provided after the sale.
- In an asset sale, YES, it is a Qualifying Event, unless: (1) the buying group is a successor employer, and the covered employee is employed by the buying group immediately after the sale; or (2) the covered person does not lose coverage under a group health plan of the selling group after the sale.

If conditions (1) or (2) are not satisfied, the covered employee experiences a termination of employment with the selling group as a result of the asset sale. This is so regardless of whether the buying group employs the covered employee or whether the covered employee's employment is associated with the purchased assets after the sale. Therefore, the covered persons who lose coverage under the plan of the selling group are M&A qualified beneficiaries in connection with the sale.

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## **PENALTIES**

### **Penalty for Non-Compliance:**

If a group health Plan fails to comply with the COBRA continuation law, the Internal Revenue Service imposes substantial excise taxes under certain circumstances. In addition, non-tax remedies may be available if the Plan fails to comply with the parallel rules in ERISA. The excise tax is imposed on the employer, except that in the case of a multi-employer Plan, the excise tax is imposed on the Plan. This penalty is currently **\$110** per person per day from the date of the failure to comply.



**CONTINUATION/CONVERSION CHOICES**  
**Differences by CIGNA Product**

	* <b>Indemnity</b> * <b>PPO</b> * <b>Flex DPP &amp; EPP</b>	* <b>CHMO Lock-In</b> (assumes residency in service area is required)	* <b>CHA</b> (assumes residency in service area is required)
<b>1. COBRA continuation</b>	Must offer	Must offer if the member continues to reside in the service area. *  Members who move out of the service area * have no further coverage options with CIGNA.	Must offer if the member continues to reside in the service area. *  Members who move out of the service area may convert to a CGLIC conversion product (# 2 below).
<p>* If the employer offers other plans through CIGNA or through another company, either indemnity or HMO, to active employees in the location where the member has moved, the <b>employer</b> must arrange for COBRA through one of the other plans in that area.</p>			
<b>2. Conversion</b>	Must offer during last 6 months of COBRA.  (ASO must offer if it has a conversion privilege in its plan document/booklet)  <u>Product:</u> CGLIC conversion product available in the State where the individual resides at the time of issue.	Must offer during last 6 months of COBRA if the member continues to reside in the service area.  <u>Product:</u> CHMO conversion product  Members who move out of the service area have no further coverage options through CIGNA.	Must offer during last 6 months of COBRA if the member continues to reside in the service area.  <u>Product:</u> CHMO conversion product  Members who move out of the service area should be offered the CGLIC conversion product for their state of residence.
<b>3. Coverage under State Pools</b>	Federally Eligible Individuals (as defined in HIPAA): At the end of COBRA, federally eligible individuals may be entitled to coverage under the State Pools on a guarantee issue basis. Individuals may wish to investigate their State's programs before purchasing a conversion product.		
<b>4. Coverage with any insurer in the individual market</b>	Federally Eligible Individuals (as defined in HIPAA): May PURCHASE coverage with any insurer in the individual market, on a guarantee issue basis and no PCL.  Not Federally Eligible: May APPLY for coverage with any insurer in the individual market, subject to medical underwriting.		

## Sample Booklet Text

### **COBRA CONTINUATION OF COVERAGE REQUIREMENTS.**

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, an employer must give its covered employees and dependents the right to continue their group health care benefits. A **Qualified Beneficiary** is a person who would otherwise lose coverage as a result of a Qualifying Event. A Qualified Beneficiary is generally entitled to continue the same benefits that were in effect on the day before the date of the Qualifying Event, subject to future Plan changes. Coverage may be continued under COBRA only if the required premiums are paid when due and is subject to federal law, regulations and interpretations.

A **Qualifying Event** is any of the following:

- termination of the employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the employee ineligible for coverage;
- death of the employee;
- divorce or legal separation of the employee from his or her spouse;
- loss of coverage due to the employee becoming entitled to Medicare;
- a dependent child ceasing to qualify as an eligible dependent under the Plan; or
- if the Plan provides coverage for retired employees and eligible dependents, a Qualifying Event will also mean a substantial loss of that coverage due to the employer filing for Chapter 11 Bankruptcy. (The substantial loss can occur within one year before or after the filing for Chapter 11 Bankruptcy.)

When there is a divorce or legal separation or a child ceases to qualify as an eligible dependent, the Qualified Beneficiary must notify the employer within 60 days after the later of (a) the date of such Qualifying Event or (b) the date the person would lose coverage on account of the event. If the employer is not so notified, the person will not be allowed to continue coverage.

The employer must, within 14 days of notification of a Qualifying Event, advise the Qualified Beneficiary of the right to continue group health care benefits. After notification of his or her COBRA rights, the Qualified Beneficiary has a limited amount of time to elect continuation. Continued health care coverage is not automatic.

Continuation of COBRA benefits must be elected within 60 days of the later of:

- a) the date the Qualified Beneficiary loses coverage as a result of the Qualifying Event; or
- b) the date the Qualified Beneficiary is notified by the employer of the right to continued coverage.

Notice of the right to continue coverage to your spouse will be deemed notice to any dependent child residing with your spouse. Except as otherwise specified in writing, any election by a spouse, or by an employee whose employment has been terminated, shall be deemed to include an election of COBRA continuation coverage on behalf of any other dependents who would lose coverage under the Plan by reason of the Qualifying Event. No person may decline COBRA continuation coverage on behalf of any other person, other than a parent or legal guardian who declines coverage on behalf of a minor child.

The Qualified Beneficiary will be required to pay a premium to continue coverage. If the Qualified Beneficiary elects to continue coverage, the Qualified Beneficiary will have 45 days from the date of election to pay the initial premium due. All subsequent premiums will be due on a monthly basis. There is a 30-day grace period to pay premiums. If the premium is not paid before the expiration of the grace period, COBRA continuation benefits will end.

If elected, the **maximum period** of continued coverage for a Qualifying Event:

- involving a termination of employment or reduced working hours is 18 months from the date of such termination or reduction of hours. However, if a second Qualifying Event occurs (such as a divorce or death of the employee) within this 18 month period, the

period of coverage for any affected dependent may be extended for up to 36 months from the date of the first Qualifying Event.

- If a Qualified Beneficiary is totally disabled under the Social Security Act on the date of the Qualifying Event, or at any time during the first 60 days of continued coverage, the 18 month period may be extended to up to 29 months. If there are non-disabled family members of this Qualified Beneficiary who have elected COBRA continuation coverage, they are also entitled to this additional 11 months of coverage. In order for this additional 11 months of coverage to be effective, the Qualified Beneficiary must provide the employer with a copy of the Social Security Administration's determination of total disability within 60 days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of COBRA continuation coverage.
- If a covered employee has a Qualifying Event (termination of employment or reduction in hours worked) and he/she had become entitled to Medicare before the date of this Qualifying Event, then
  - a) the employee may continue the group health coverage for up to 18 months from the date of termination of employment or reduction in hours worked; and
  - b) any other Qualified Beneficiary (the spouse and/or children) will be entitled to the greater of: (i) 36 months from the date the employee first became entitled to Medicare; or (ii) 18 months from the covered employee's termination of employment or reduction in hours.
- The maximum period of continued benefits for a Qualifying Event involving retired employees of employers under Chapter 11 Bankruptcy and their dependents will be:
  - a) the date of death of the retired employee;
  - b) for a surviving spouse or eligible dependent, 36 months after the date of death of the retired employee.

- For all other Qualifying Events, the maximum period of continuation coverage is 36 months, except as provided below:
  - a) If there are any other continuation options available in the Plan, the Qualified Beneficiary may elect one of them in lieu of COBRA, but may not have both.
  - b) If the Plan provides for continuation of existing coverage for a certain period of time after any Qualifying Event, the employee may receive a COBRA election form when the existing coverage actually ends. The Qualified Beneficiary may elect COBRA continuation coverage for the *balance* of the 18, 29 or 36 month period.
  - c) If the employer provides another coverage option in lieu of COBRA, the Qualified Beneficiary may elect that option. However, if the former employee dies or divorces his or her spouse, or a dependent child no longer qualifies for the coverage under the terms of the employer's continuation option, then the spouse or dependent child will be entitled to continue that coverage for up to 36 months from the date of death or divorce, or from the date the dependent child no longer qualifies. The election of another continuation option is a waiver of COBRA.

**Other events** will cause COBRA benefits to end sooner and this will occur on the earliest of any of the following:

- a) the date the employer ceases to provide any group health plan to any employee;
- b) the date the Qualified Beneficiary fails to timely pay any required premium payment;
- c) the first day after the date of election on which the Qualified Beneficiary first becomes covered under any other group health plan. If the new health plan contains any exclusions or limitations with respect to any pre-existing condition for such person, the COBRA coverage may be continued until the date such exclusion or limitation no longer applies to the Qualified Beneficiary;
- d) the first day after the date of election on which the Qualified Beneficiary first becomes entitled to (that is actually covered

by) Medicare (except for a Chapter 11 Bankruptcy Qualifying Event); or

- e) with respect to a Qualified Beneficiary whose coverage is being extended for the additional 11 months as described above, coverage will terminate on the first day of the month that is more than 30 days after the date on which the disabled individual is no longer disabled for Social Security purposes. In no event will this be earlier than the maximum period of 18 months.

If the Plan provides for a conversion privilege, the Plan must offer each Qualified Beneficiary this option within 180 days before the end of the maximum period. However, no conversion will be provided if the Qualified Beneficiary does not actually maintain COBRA coverage to the end of the maximum period. Application and payment of the required premium for the conversion plan must be made within 31 days after the COBRA coverage ends.

**Newly Acquired Dependents.** If, while coverage is being continued under COBRA, a Qualified Beneficiary acquires a new Dependent, such Dependent will be eligible for this continuation provided the Dependent is enrolled and the required premium is paid in accordance with the terms of the Plan. Except as explained below for a newborn or adopted child, the coverage and provisions applicable to the new Dependent will be the same as that of the Qualified Beneficiary, including the termination of the Dependent's coverage.

If a newborn or adopted child is enrolled by a Qualified Beneficiary who was formerly a covered employee, the child's coverage will terminate on the earlier of:

- 18 months from the date of the former employee's termination of employment or reduction of hours worked;
- 36 months from the date of the former employee's termination of employment or reduction of hours worked, if a second Qualifying Event occurred; or
- the date any **other event** shown above would terminate the COBRA coverage.

**IMPORTANT NOTICE**

**COBRA benefits will only be administered according to the terms of the plan contract. CONNECTICUT GENERAL LIFE INSURANCE COMPANY will not be obligated to administer, or furnish, any COBRA benefits after the plan contract has terminated.**

Generally CGLIC is the administrator of COBRA. If a CHC plan is administering the continuation, then the name will be changed as appropriate.