106:ERISA 101: Key Issues in Health & Welfare Plans

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Eileen A. Groves is an associate general counsel of United Space Alliance, LLC (USA) in Houston. USA is the prime contractor for NASA for human spaceflight, responsible for the day-to-day operation and management of the U.S. space shuttle fleet, and is also involved in the operations of the International Space Station. Ms. Groves' responsibilities at USA include providing legal counsel to its benefits department regarding all USA's retirement, health, and welfare plans, as well as day-to-day counsel to human resources and managers regarding labor and employment issues.

Prior to joining USA, Ms. Groves had been a partner with Baker & Daniels in Indiana. Earlier, Ms. Groves had been associate corporate labor counsel for Borden, Inc. in Columbus, Ohio where she advised on all Borden's United States benefits plans as well as Borden's Canadian plans. She also represented Borden on labor and employment issues in both state and federal agencies.

She is currently a member of ACC's Labor and Employment Committee executive board, chairing the ERISA subcommittee, as well as a member of the board of directors of the ACC's Houston Chapter.

Ms. Groves received a BA from St. John's University in New York, MA in American history from Purdue University in Indiana, and her JD from the University of Notre Dame.

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106 – ERISA 101: Key Issues in Health & Welfare Plans

Barbara W. Doose, The Boeing Company
Eileen A. Groves, United Space Alliance, LLC
Steve Haugen, U.S. Dept. of Labor, EBSA
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ERISA BACKGROUND

ERISA - Background

- Employer sponsored Pension & Welfare Plans are a product of 20th. Century
- Most workers worked until they died
- Some employers shared profits with long term employees. But there was no control over these promises
- Pivotal event in the movement of federal regulation of private pension plans was the closing of the Studebaker Plant in Dec. 1963

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ERISA - Background

- The fallout fed the movement for government regulation.
- Welfare & Pension Plans Disclosure Act (WPPDA) – 1958 required full disclosure to participants & beneficiaries of plan's financial operations so they could police it themselves.
- In 1965 the WPPDA was amended to add fiduciary standards for plan trustees. This was forerunner of the fiduciary provisions of ERISA.
- In Sept. 1974, Pres. Ford signed the Employee Retirement Income Security Act (ERISA).

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ERISA - Background

- ERISA is divided into Titles and Parts:
  - Title I – Reporting & disclosure rules for both pension & welfare plans under supervision of DOL.
  - Title II – Administration & enforcement under IRS with coordination with DOL.
  - Title III – Miscellaneous
  - Title IV -Plan Termination Insurance -PBGC

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ERISA - Background

- Welfare Plans only fall within 5 parts of Title I
  - Part 1 – reporting & disclosure
  - Part 4 – fiduciary responsibility
  - Part 5 – administration & enforcement
  - Part 6 – added in 1986 –Continuation of coverage & additional standards for Group Health Plans – COBRA
  - Part 7 – added in 1996 – Portability of health coverage - HIPAA

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Government Regulation

- IRS
  - tax qualification issues
  - "prohibited transactions" (pension plans)
  - funding issues (pension plans)
- Plans do NOT have to be "tax qualified"
- No ***requirement*** to seek IRS Approval

Government Regulation

- DOL
  - fiduciary issues
  - "prohibited transactions"
  - reporting & disclosure issues
  - tax qualified or not
  - NO plan document approval process

IRS TAX OPTIONS

IRS – Pre-Tax Options

- Cafeteria or 125 Plans – salary reduction plan where employees elect certain benefits and they are paid on a pre-tax basis. In principle, employee is foregoing taxable cash compensation for these benefits.
- Types of Cafeteria benefits –
  - Group life insurance up to $50,000
  - Accident or health insurance
  - Medical expense reimbursement
  - Dependant care assistance
  - Adoption assistance
  - Participation in a cash or deferred arrangement under 401(k)(2)

IRS –Tax Options

- Medical Savings Accounts – tax-favored savings vehicle to defray medical expenses for individuals covered by a "high deductible" plan.
- For employers < 50
  - Established in HIPAA as pilot program
    - If contributed by individual – deductible
    - If contributed by employer – excludible
    - Earning on assets not currently taxable
    - Distributions non-taxable if used to pay qualified medical expenses

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IRS –Tax Options

- Health Savings Accounts – created in 2003 Medicare Act & modeled after MSAs
- Allows tax-free savings for health care expenses for participants < 65 in high deductible health plan – balances carry over year to year
- Contributions, earnings & distributions are all tax-free
- HSAs are for individuals covered by high deductible plan and no other health coverage.
- HSAs are *not* employee welfare benefit plans. *See* **http://dol.gov/ebsa/regs/fab_2004-1.html**

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IRS –Tax Options

- If individual has high deductible health plan and no drug coverage, individual's drug coverage needs to be high deductible too. (1/1/06).
- Individual entitled to Medicare not eligible for HSAs.
- IRS has issued several notices re. HSAs. *See* **http://www.ustreas.gov/press/releases/reports/hsanotice200450072304.pdf**
- Health Reimbursement Accounts – similar to HSAs without HDHP. *See* **http://www.irs.gov/pub/irs-drop/n-02-45.pdf**

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ERISA Requirements

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ERISA Requirements

- Does NOT require a plan
  - If there is a plan, must follow ERISA rules
- Does NOT mandate any benefits
  - Plan sponsor decides what benefits to provide
- Does NOT establish benefit levels
  - Plan sponsor decides

ERISA Requirements

- Plan must have –
  - governing document
  - named fiduciary
  - claims & appeals procedure
  - plan amendment procedure
- Plan assets must be held in trust or insurance contracts (with limited exceptions)
- Plan participants & beneficiaries
  - (Ps & Bs) have a right to sue
- DOL / EBSA has right to investigate & sue

ERISA Requirements

- Fiduciary must –
  - Act "solely in interest" of Ps & Bs
  - Discharge his / her duties prudently
  - Diversify plan assets
  - Follow terms of governing documents (to the extent consistent with ERISA)
  - Avoid self-dealing
  - Avoid "prohibited transactions"
- Fiduciary personally liable for violations

ERISA Requirements

- Fiduciary Responsibility to
  - select and monitor service providers
  - (insurance carrier, claims processor, administrator, attorney, accountant)
- Issues:
  - Necessary services
  - Quality of service
  - Cost of service
  - DOL Information Letter to Diana Orantes Ceresi, Associate General Counsel, SEIU, AFL-CIO, CLC, 2/19/98

ERISA Requirements

- Reporting Requirements
  - Form 5500 / Accountant's Opinion
- Disclosure Requirements
  - Summary Plan Descriptions (SPDs)
  - Summary of Material Modifications (SMMs)
  - Summary Annual Reports (SARs)

ERISA Requirements

- Disclosure Requirements (cont.)
  - Provide documents on request
  - Answer questions
  - No misrepresentations of plan changes under "serious consideration"
- Fidelity Bond Requirements
  - Protect against dishonesty

ERISA – Pension Plans Only

- Participation rules
  - Who is in the plan
- Vesting rules
  - How quickly benefits become non-forfeitable
- Benefit Accrual
  - Prevents "back loading" of benefits
- Funding rules
  - Setting aside $$$ to pay promised benefits

Sarbanes-Oxley Act of 2002

- New and enhanced criminal penalties
  - Willful violations of ERISA R&D provisions
    - Maximum $100,000 fine for individuals
    - Maximum $500,000 fine for non-individuals
    - Maximum 10 years imprisonment for individuals

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HEALTH & WELFARE PLANS

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ERISA - Background

- ERISA isn't just a pension reform law but it also covers welfare benefit plans such as health care, life, AD & D, disability, severance pay plans, etc.
- Sec. 3(1)[29 U.S.C. §1002(1)] defines "employee welfare plan" & "welfare plan" as any plan, fund or program which was established by an employer or by an employee organization or both . . . For the purpose of providing…(A) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training. . .,or day care centers, scholarship funds, or prepaid legal services or (B) any benefit described in §186(c).

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Health Plan Structures

- Single Employer Plans
  - Including "controlled groups"
- Employer Association Plans
  - *Bona fide* association
  - Serve as conduit for premium payments
- Multi-employer (Union) Plans
  - *Bona fide* unions
  - *Bona fide* collective bargaining agreement setting aside $$$ to pay promised benefits

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Health Plan Structures

- Multiple Employer Welfare Arrangements (MEWAs)
  - Involve at least two employers
  - Sometimes created to
    - look like ERISA health plan
    - avoid state regulation as insurance company
    - make $$$ for creator
    - disappear after claim backlog develops

Health Plan Structures - MEWAs

- Usually also subject to state regulation
- Recent Example = Employers Mutual
  - Involved 16 "associations"
  - Marketed through some insurance brokers
  - Covered more than 22,000 policyholders
  - Received $16.1 million in premiums
  - Paid $4.8 million in claims
  - Left $24 million in UNPAID claims

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Paying for Promised Health Benefits

No ***ERISA*** Funding Requirement

- Self-insured (self-funded) –
  - Claims paid from sponsor's general assets
- Trust Fund –
  - $$$ set aside & held by trustee to pay claims

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Paying for Promised Health Benefits

- Insured –
  - Purchase insurance product to pay claims
  - States regulate
    - Insurance products
      - Mandated benefits
      - Premium & reserve requirements
    - Insurance companies
    - Sale of insurance

Health Plan Amendments

- **COBRA (1986)**
- **HIPAA (1996)**
- **Mothers & Newborns (1996)**
- **Women's Health & Cancer Rights (1998)**
- **Mental Health Parity Act (1996)**

COBRA

- Consolidated Omnibus Budget
  - Reconciliation Act of 1986
- If ER has Health Plan & has 20+ Ees,
  - COBRA applies

<< NOTE: state & local government plans covered; CMMS handles >>

COBRA

- Qualified Beneficiaries" entitled to continuation coverage upon "Qualifying Event"
- "QB" must have been covered
  - 1 Day is enough
- "QE" must lead to loss of coverage
- "QB" can be
  - EE
  - EE spouse
  - EE dependent children
- "QE" depends on "QB" status

COBRA

- QEs For EE,
  - Termination, except "Gross Misconduct"
  - Reduction in hours of employment
- QEs For spouse,
  - EE Termination, except "Gross Misconduct"
  - Reduction in hours of EE's employment
  - EE entitled to Medicare
  - Divorce / legal separation from EE
  - Death of EE

COBRA

- QEs For dependent children,
  - EE Termination, except "Gross Misconduct"
  - Reduction in hours of EE's employment
  - EE entitled to Medicare
  - Death of EE
  - Loss of dependent status (per Plan rules)

COBRA – Length of Eligibility

- 18 months
  - termination / reduction in hours
- 29 months
  - Social Security disability
- 36 months
  - other QEs
  - spouse & dependent children only

COBRA – Cost

- QB can be required to pay
  - Full cost (ER & EE shares)
  - + 2% Administrative Charge
  - + 50% for months 19 – 29 on disability
  - other QEs
  - spouse & dependent children only

COBRA – Notices

New COBRA Notice requirements effective January 1, 2005!

- General Notice
  - COBRA description
  - Within 90 days of coverage starting
  - SPD = OK
  - *See* http://edocket.access.gpo.gov/2004/pdf/04-11796.pdf and Corrective Notice in 69 F.R. 34920 (6/23/04)

COBRA – Specific Notices (Single ER Plans)

- ER issues to Administrator within 30 days of QE
- Administrator issues to QB within 14 days
- QB must provide notice to Administrator within 60 days

See Model Notice of DOL – might need to customize for your plan.

COBRA - Elections

- 60 Day election period
- Starts with later of
  - Loss of coverage
  - Receipt of Notice
- Coverage must be retroactive
- QB has 45 Days to pay (from election)

HIPAA

- Health Insurance Portability & Accountability Act of 1996
- Added as Part 7 to ERISA
- If ER has Health Plan & has 2+ EEs, HIPAA applies

<< NOTE: state & local government plans covered; CMMS handles >>

HIPAA

- Limits exclusions for pre-existing conditions
- No Pre-Ex for pregnancy
- No Pre-Ex for newborns or adopted
  - if become covered within 30 days
- No Pre-Ex for genetic info only cases

HIPAA

- Must advise Ps & Bs that Plan uses Pre-Ex ***before*** it can be applied
- Establishes 6 month look back standard
- Establishes a 12 month maximum (18 months for Late Enrollees)
- Plan must allow "offset" for prior creditable coverage

HIPAA

- Certificates of Creditable Coverage
  - Certify length of health plan coverage
  - Must be issued --
    - Upon loss of coverage
    - Upon loss of COBRA coverage
    - Upon request (within 24 mos. of coverage loss)

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HIPAA

- Special Enrollment Opportunities – Changes in Family Status
  - Upon loss of "other" coverage (e.g., spouse's plan)
  - Upon becoming "New" Dependent
    - Marriage
    - Birth
    - Adoption / Placement for adoption

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HIPAA

- Cannot discriminate based on
  - Health status
  - Medical condition
  - Claims experience
  - Receipt of health care
  - Medical history
  - Genetic information
  - Evidence of insurability / disability

HIPAA

- New SPD / SMM Requirements
  - Notice re: material benefit reductions (or deductible / co-payment increases) within 60 days of adopting change
  - Disclose role of insurance company / HMO
  - Disclose EBSA Office for assistance
  - Disclose New Hospital Stay Rules (maternity)

HIPAA

- Privacy Regulation – Dept of Health & Human Services – 45 CFR Parts 160 & 164
  - Health Care Providers
  - Covered Entity
  - Business Associates
  - Protected Health Information (PHI)
- Plan sponsors must ask are we insured or self-insured? If self-insured = covered entity
- Large Plans – 4/14/2003 Small Plans – 4/14/2004

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HIPAA

- Privacy Notice
- Privacy Officer
- Privacy Policy & Enforcement
- Training
- Business Associate Agreements
- Authorizations to Disclose PHI

http://www.hhs.gov/ocr/hipaa/

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Mothers & Newborns

- Added Section 711 to ERISA
- Does ***NOT*** require Health Plans to include maternity benefits
- If ER has 2+ EEs & Health Plan has maternity benefits, M & N applies
- May not restrict hospital stays in connection w/ childbirth to less than –
  - 48 hours (vaginal delivery)
  - 96 hours (Caesarean delivery)

  (advance notice requirement OK for cost savings)

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Mothers & Newborns

- Mother & attending provider may decide to leave earlier (their decision).
- No contrary inducements to mother or provider permitted.
- *See* **http://www.cms.hhs.gov/hipaa/hipaa1/content/hi102798.asp**

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WHCRA

- Women's Health & Cancer Rights Act of 1998
- Added Sec. 713 to ERISA
- Does ***NOT*** require Health Plans to provide mastectomy benefits.
- If ER has 2+ EEs & Health Plan has mastectomy benefits, WHCRA applies.

WHCRA

- Must provide additional benefits for:
  - Reconstruction of affected breast
  - Surgery and reconstruction of other breast for symmetrical appearance
  - Prostheses & treatment for complications

WHCRA

- Must provide additional notices -
  - One-time notice of WHCRA benefits, including deductibles & co-insurance
  - Annual notice regarding mastectomy & reconstruction benefits
  - *See* **http://www.cms.hhs.gov/hipaa/hipaa1/content/hiwhfaq2.asp**

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MHPA

- Mental Health Parity Act of 1996
- Added Sec. 712 to ERISA
- Does ***NOT*** require Health Plans to provide mental health benefits
- If ER has 51+ EEs & Health Plan has mental health benefits, MHPA applies
- Cannot have lower annual or lifetime dollar limits on mental health benefits

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MHPA

- Must be on par with medical benefits
- ***Not applicable*** to substance abuse or chemical dependency benefits
- Exception available ***IF*** costs increase 1% or more (using claims data)
  - Notice to Ps & Bs and EBSA required
- Annual sunset provisions
- *See* **http://www.cms.hhs.gov/hipaa/hipaa1/content/mhpa.asp#interimrules**

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Claim Processing

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Claims Processing

- ERISA passed into law in 1974
- Original focus – Pension plans
- Industry has seen lots of changes
  - COBRA, HIPAA, *et al*
  - Health care advances
  - Rising costs
  - HMOs, PPOs, Managed Care
  - Computers everywhere

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Claims Processing

- **Every ERISA plan must**
  - Afford a reasonable opportunity for full and fair review of claim by the appropriate fiduciary
  - Provide adequate notice of claim denial (with specific reasons & citations)
  - Provide appeals process

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Claims Processing

- 29 CFR 2560.503-1
- Effective now (published Nov 21, 2000)
- Establishes
  - Timeframes for claims processing
    - ***NOT payment***
  - Contents of denial notices
  - Standards for appeal
- Timeframes depend on type of benefit

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Claims Processing

- Applies to ERISA Plans
- Must be followed
  - regardless of how funded
  - regardless of how claims are processed
- Fiduciary's responsibility to ensure compliance
  - Must monitor plan operations & service providers
  - Must make adjustments as necessary

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Failure to Comply

- Claimant deemed to have exhausted his / her administrative remedies
- No longer required to continue with the plan's claims / appeals process
- Entitled to file suit under ERISA

Effect on State Laws

- Insurance law preempted only to the extent it "prevents the application" of the regulation
- External review laws NOT affected

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Contributory Plans

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Contributory Plans

- Employees may contribute to cost (regardless of plan type)
  - Plan sponsor decision (Single ER Plans)
  - Often thru payroll deduction for EEs
  - For COBRA coverage, usually thru direct payments

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Contributory Plans

- EE Contributions = plan assets (regardless of where held)
  - As soon as they can be reasonably segregated from ER's general assets
  - Outside limit – 90 days from receipt or withholding

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Contributory Plans

- Misuse of plan assets
  = fiduciary breach & prohibited transaction

Contributory Plans

- Assume Life Insurance Plan
- Assume ER pays 100% of Basic Life
- Assume EE pays 100% of Optional Life
- Assume Experience Rated Contract
- Assume $1 million refund @ year end

Contributory Plans

Question:

Can ER keep entire refund??

Answer:

It depends

Contributory Plans

- What does contract say??
- What representations were made to Participants??
- Refund based on Basic or Optional??

Demutualization

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Demutualization

- When a mutual insurance company converts to a stock company, it may distribute cash and/or stock to its policy holders.
- If Plan owns policy, all plan assets
- If Plan paid premiums, all plan assets
- If pension plan involved, all plan assets
- If welfare plan involved,if participants paid a portion of premiums, then a portion of proceeds is plan assets

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Demutualization

- Not a "small" issue
- Prudential had $15 - $20 Billion in equity
- Tens of thousands of Plan contracts
- Guidance provided in:
  - AO 01-02A
  - AO 01-03A
  - "Groom Information Letter"

Bankruptcy / Orphan Plans

Bankruptcy

- Rapid ERISA Action Team (REACT)
- When the Plan Sponsor is in distress –
  - Plans often neglected
  - Claims often backlogged or go unpaid
  - Insurance premiums may not get paid
  - Employee contributions may be commingled

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Orphan Plans

- Plans may be abandoned upon –
  - Cessation of business operations
  - Death of Fiduciary
  - Incarceration of Fiduciary
  - Disappearance of Fiduciary
  - Refusal of Fiduciary to perform duties

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Orphan Plans

- Plans are neglected
- Claims get backlogged or go unpaid
- Insurance premiums are not paid
- Plan filings are not made
- Plan is not terminated properly
- Ps & Bs are be kept in the dark

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Compliance Assistance

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Compliance Assistance

- **www.dol.gov/ebsa**
- General Assistance
  (866) 444 –3272 (EBSA)
- Office of Regulations & Interpretations
  (202) 693-8523
- Chicago Regional Office
  200 W. Adams St., Suite 1600
  Chicago, IL 60606
  (312) 353-0900

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Voluntary Fiduciary Correction Program (VFCP)

- NOT available for all fiduciary violations
- 15 Eligible Transactions
  - Untimely handling of EE contributions
  - Prohibited transactions (loans, sales, leaseback)
  - Below market loans
  - Sale / Purchase NOT @ Fair Market Value
  - Excessive compensation
  - Benefits based on improper valuations (pension issue)

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VFCP

- Self-help program
- Applicant
  - identifies problem,
  - corrects problem,
  - files complete application with EBSA
- EBSA issues "No Action" Letter

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Delinquent Filer Voluntary Compliance (DFVC) Program

- EBSA objective – get all Form 5500 filings in system
- Penalties for not filing ($1000/day)
- Substantial penalty reductions available
- Per "filing" maximum = $2,000 (Large Plans)
- Per "plan" maximum = $4,000 (Large Plans)

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DFVC Program

- Administered by National Office
- DFVC Hotline: 202 / 693-8360 (NOT toll-free)

NO separate filing with IRS
NO separate IRS penalties

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DFVC Program

- Reminders
  - Forms 5500 filed under EFAST (Kansas)
  - Penalty payments go to different address (DFVC Program, P.O. Box 530292, Atlanta, GA 30353-0292)
  - Penalties cannot be paid with plan assets

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Compliance Assistance

- Reporting & Disclosure Guide
- New Health Laws Notice Guide
- Self-Compliance Tool (Part 7)
- Compliance Assistance Tips (Part 7)

(866) 444 –3272 (EBSA)

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Compliance Assistance

- Publications
- Model Notices
- Frequently Asked Questions

<< NOTE: Always being updated >>

MODEL NOTICES

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(For use by single-employer group health plans)

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [*add if Plan provides retiree health coverage:* commencement of a proceeding in bankruptcy with respect to the employer,] or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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

***appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]**

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former

employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE
(For use by single-employer group health plans)

[*Enter date of notice*]

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

This notice contains important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [*enter date*] due to [*check appropriate box*]:

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

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [*enter* 18 *or* 36*, as appropriate and check appropriate box or boxes; names may be added*]:

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

If elected, COBRA continuation coverage will begin on [*enter date*] and can last until [*enter date*].
[*Add, if appropriate:* You may elect any of the following options for COBRA continuation coverage: [*list available coverage options*].

COBRA continuation coverage will cost: [*enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.*] You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

[*Add if appropriate:* Coverage option elected: _____]

b. _____

[*Add if appropriate:* Coverage option elected: _____]

c. _____

[*Add if appropriate:* Coverage option elected: _____]

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____

_____ _____
Print Address Telephone number

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [*add if applicable:* open enrollment and] special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[*If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:*]

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.*] Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

[*If employees might be eligible for trade adjustment assistance, the following information may be added*: The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact

[*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

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

Grace periods for periodic payments

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

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

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

[*enter appropriate payment address*]

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Sample Language for the Newborns' Act Disclosure Requirement

"Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)."

Sample Language for WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator [insert telephone number] for more information.

Sample Language for WHCRA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, call your Plan Administrator [insert telephone number].

