



HealthEquity® | WageWorks

COBRA & Direct Bill Services

Client Administration Guide

TABLE OF CONTENTS

Table of Contents	1
Section 1 – Introduction	4
Background and Summary of COBRA Law	4
Summary of Requirements	4
Employers Subject to COBRA	5
Small Employer Exception	6
Penalties for Non-Compliance	6
COBRA Lawsuits	7
Section 2 – COBRA Continuation Coverage Guidelines	8
Introduction	8
Qualified Beneficiaries	8
Qualifying Events	9
Life Status Changes	10
Gross Misconduct	11
Plans and Benefits Subject to COBRA	11
Election Period	12
Extension of Continuation Coverage Periods	13
Employer-paid Alternative Coverage	19
Business Reorganizations	21
Voluntary Termination of Health Coverage	21
COBRA and Health Maintenance Organizations (HMOs)	25
Section 3 – HIPAA and FMLA	26
Introduction	26
HIPAA	26
Family and Medical Leave Act	31
Section 4 – The Client Experience Team	32
Introduction	32
Communicating with HealthEquity/WageWorks	33
Section 5 – COBRA Administration Services	34
Introduction	34
Plan Sponsor Role as the COBRA Plan Administrator	34
COBRA General Rights Notice to Active Employees	34
When a Qualifying Event Occurs	36
Alternative Coverage	37
Process of Qualifying Event in the System	39
Document Control	40

Premium Collection.....	42
Termination of COBRA Continuation.....	43
Benefit and Coverage Changes or Annual/Open Enrollment.....	45
Adding a New Division.....	48
COBRA and the Summary Plan Description.....	48
Section 6 – The HealthEquity/WageWorks Website.....	50
Hardware Specification.....	50
Firewall.....	50
Software Specification.....	50
Login.....	50
Home.....	50
Client Setup.....	50
Reports.....	51
Cases.....	53
Members.....	54
Data Entry.....	54
New Employee.....	55
Direct Bill.....	56
Member Website.....	57
Section 7 – Direct Bill Administration Services.....	59
Direct Bill Services.....	59
Direct Bill Administrative Process Overview.....	59
Section 8 – State Continuation Laws.....	61
Introduction.....	61
California Continuation Benefits Replacement Act (Cal-COBRA).....	61
California Assembly Bill 1401.....	62
California Health Insurance Premium Payment Program.....	63
Texas State Continuation.....	63
Section 9 – COBRA Terminology and Notice Definitions.....	66
Terminology.....	66
COBRA Notice Definitions.....	70

SECTION 1 – INTRODUCTION

Background and Summary of COBRA Law

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was signed into law on April 7, 1986. Federal law requires employers with 20 or more employees to offer employees who have experienced a qualifying event, as defined in this administrative guide, the right to continue group health coverage for a specified period at applicable group rates when this coverage would otherwise end.

COBRA legislation amended the Internal Revenue Code (IRC), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHSA) to include provisions requiring continuation of health coverage. After the original enactment of COBRA, the following technical corrections and revisions amended and clarified the law:

- Omnibus Budget Reconciliation Act of 1986 (OBRA '86)
- Tax Reform Act of 1986 (TRA)
- Technical and Miscellaneous Revenue Act of 1988 (TAMRA)
- Omnibus Budget Reconciliation Act of 1989 (OBRA '89)
- Omnibus Budget Reconciliation Act of 1990 (OBRA '90)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA '96)
- Small Business Job Protection Act of 1996 (SBJPA)
- IRS Proposed Regulations of 1998
- IRS Proposed Regulations of 1999
- IRS Final Regulations of 1999
- IRS Final Regulations of 2001
- IRS Final Regulations of 2002
- Trade Act of 2002
- IRS Final Regulations of 2004
- American Recovery and Reinvestment Act of 2009 as amended by the Department of Defense Appropriations Act of 2010, the Temporary Assistance Act of 2010 (TEA), and the Continuing Extension Act of 2010 (CEA)
- The Omnibus Trade Act of 2010
- The Trade Adjustment Assistance Act of 2011

Summary of Requirements

COBRA law requires employers to offer continuation of group health plans to individuals who lose coverage because of certain qualifying events including:

- Termination of employment
- Reduction in work hours
- Divorce or legal separation
- Death of the covered employee
- Employee Medicare Entitlement
- Employer bankruptcy
- A dependent child ceasing to be a dependent under the plan

The law defines a group health plan as any plan maintained by an employer or employee organization that provides health care to individuals who have an employment-related connection to the employer, employee organization, or employee's family.

COBRA includes any employer-maintained medical, dental, vision, or prescription drug program. It also includes certain health care flexible spending accounts (FSAs), mental health plans, drug or alcohol treatment programs, health-related employee assistance plans (EAPs), chiropractic programs, and self-insured plans that provide similar benefits. One or more individual insurance policies are considered a group health plan if it provides health care to two or more employees.

Individuals eligible for COBRA continuation coverage are “qualified beneficiaries.” An employee, federally recognized spouse, or dependent child can become a qualified beneficiary by participating in the group health plan on the day before a qualifying event. In addition, any child who is born to, adopted by, or placed for adoption with a covered employee during a period of COBRA continuation is also a qualified beneficiary when added within the time frame allowed by the plan. Also, a child of the covered employee receiving benefits pursuant to a qualified medical child support order (QMCSO), to the extent that the child is enrolled in accordance with the terms of the plan, is entitled to the same rights to elect COBRA coverage as an eligible dependent child of the covered employee.

Employers must offer qualified beneficiaries independent election rights and the opportunity to pay for the same coverage they had prior to the qualifying event. Qualified beneficiaries must receive the same rights as active employees regarding annual/open enrollment (OE) periods, plan or benefit changes, and adding or deleting dependents.

Employers Subject to COBRA

Group health plans for employers with 20 or more employees on more than 50 percent of their typical business days during the previous calendar year are subject to COBRA. Both full- and part-time common-law employees are counted to determine whether a plan is subject to COBRA. Church, government, and small employer plans (see Small Employer Exception section) are exempt from COBRA.

Under the small employer exception, self-employed individuals, agents, independent contractors, and corporate directors are not considered employees (unless these individuals are also common-law employees of the employer). Employers must still include employees from all divisions, subsidiaries, and other entities that make up a controlled group of corporations. A controlled group of corporations may consist of a parent-subsidiary controlled group, brother-sister controlled group, or a combined group as defined under Internal Revenue Code Section 414(b).

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

Small Employer Exception

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

If a plan that was subject to COBRA becomes a small employer, the plan must honor its continuation coverage obligations for qualifying events that occurred during the period when the plan was subject to COBRA. The employer is required to continue its COBRA obligation for these qualified beneficiaries generally until the end of the maximum coverage period (18, 29, or 36 months), including any applicable extensions (second qualifying events, Social Security disability, etc.).

Due to variables involved with calculating group size and employees under common ownership, HealthEquity/WageWorks is not responsible for monitoring a company's annual need for COBRA compliance. If you have any questions regarding COBRA guidelines, please contact our client services department.

IMPORTANT: If the company is subject to the laws of California or Texas, please read the state continuation section of this guide.

Penalties for Non-Compliance

Federal agencies responsible for enforcing COBRA provisions are the Internal Revenue Service (IRS), the Department of Labor (DOL), and the Department of Health and Human Services (HHS). Penalties for COBRA non-compliance are summarized below:

1. The penalty for failure to comply with COBRA is a \$100 excise tax per day of non-compliance per individual (or \$200 per day per family, maximum). The period of non-compliance begins on the date the failure first occurred and ends on the earliest date that the non-compliance is corrected. The following is a list of possible correction dates:
 - a) The date the failure is corrected
 - b) The date six months after the employer's responsibility to provide continuation of coverage ended without regard to the payment of premiums
2. The penalty is waived if the violation is proven to be unintentional and corrected within 30 days.
3. Violations discovered by the Internal Revenue Service (IRS) that are not corrected before the employer receives notice of an IRS audit, are subject to the lesser of the following:
 - a) A \$2,500 penalty per affected beneficiary
 - b) The excise tax (described above) that would be due based on the length of the violation
4. For violations discovered by the IRS considered more than "de minimus" (i.e., more than trivial), employers are subject to a \$15,000 fine instead of \$2,500.
5. The maximum annual penalty for single-employer plans is the lesser of the following:
 - a) \$500,000, or
 - b) Ten percent of the employer's prior-year health care costs
6. These overall limitations do not apply to failures attributable to willful neglect.

7. In addition to the IRS penalties above, ERISA penalties also apply. Because employees, qualified beneficiaries, or the Secretary of Labor may sue to enforce under ERISA, plan administrators may be subject to a \$110 per day penalty for refusal to comply with a request for information regarding coverage requirements (i.e., failure to provide notice of COBRA rights).

COBRA Lawsuits

The number of COBRA lawsuits increases every year. Court cases often bring insight and clarity to ambiguous COBRA issues, but not without great costs to the company being sued. Judgments in favor of qualified beneficiaries have left employers responsible for huge sums in unpaid medical expenses and attorney fees.

HealthEquity/WageWorks monitors pertinent court cases, analyzes results, and integrates necessary changes into administrative forms and procedures. HealthEquity/WageWorks performs compliance duties with exacting detail and precision to minimize client exposure to lawsuits and COBRA non-compliance penalties.

SECTION 2 – COBRA CONTINUATION COVERAGE GUIDELINES

Introduction

COBRA continuation coverage involves numerous statutory rules and regulations. While clients are not expected to know every detail of the law, it is necessary to be familiar with general COBRA provisions and concepts in order to understand COBRA administrative procedures.

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

Qualified Beneficiaries

In general, an individual is a qualified beneficiary eligible for COBRA continuation coverage if he or she was covered under an employer-sponsored group health plan on the day before a qualifying event. A qualified beneficiary can be a covered employee, the federally recognized spouse of a covered employee, or a dependent child of a covered employee (as defined by the plan). Any child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA continuation coverage is also a qualified beneficiary if added within the time frame allowed.

On June 26, 2013, the Supreme Court held in *Windsor v. United States* that Section 3 of the Defense of Marriage Act (DOMA) was unconstitutional, and under federal law, the definition of "spouse" now includes a spouse of the same sex. In September 2013, the IRS issued [Revenue Ruling 2013-17](#), which defined a "spouse" and stated legally married same-sex spouses would be treated as married for tax purposes, regardless of the couples' state or residence. The regulations also noted that the recognition of each couple's marriage is retroactive.

Under COBRA, covered same-sex spouses will now qualify as "qualified beneficiaries" and are independently entitled to COBRA if coverage is lost due to a qualifying event.

Employees

An employee can be a qualified beneficiary if he or she had group health plan coverage through employment with the employer on the day before a qualifying event. A retiree or former employee may also be a qualified beneficiary if he or she has coverage with a group health plan that results in whole or in part from his or her previous employment.

An employee who declines group health coverage when he or she is eligible for plan participation or an employee who voluntarily requests coverage termination from the plan is not entitled to COBRA continuation rights if he or she is still without group health plan coverage upon the occurrence of one of the qualifying events (e.g., termination of employment).

Spouses

A covered, federally recognized spouse can be a qualified beneficiary if he or she is married to a covered employee the day before a qualifying event.

An individual who marries a qualified beneficiary after a qualifying event and is added to COBRA continuation coverage as a new spouse is not considered a qualified beneficiary. This individual may receive COBRA continuation coverage as a covered dependent. However, coverage is only possible because of the qualified beneficiary's concurrent COBRA participation.

Please note: A covered spouse whose coverage is voluntarily terminated during annual/open enrollment, does not experience a COBRA qualifying event and should not be offered continuation coverage.

Dependents

A covered dependent child can be a qualified beneficiary if he or she is a covered dependent child of a covered employee (as defined by the plan) on the day before a qualifying event. A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA continuation is deemed a qualified beneficiary. In such case, the newborn or adopted child must be added as a dependent within the time frame allowed by the plan and is entitled to COBRA continuation for the remainder of the applicable coverage period from the date of the original qualifying event.

Please note: A covered dependent whose coverage is voluntarily terminated during annual/open enrollment, does not experience a COBRA qualifying event and should not be offered continuation coverage.

Individuals Who Have Other Coverage

An individual covered under another group health plan or Medicare (under Part A, Part B, or both) at the time he or she elects COBRA is a qualified beneficiary and cannot be denied COBRA continuation coverage. These qualified beneficiaries may choose COBRA as long as the other group health plan coverage existed prior to their COBRA election date.

Domestic Partners and Domiciled Adults

COBRA law states that a qualified beneficiary entitled to continuation coverage is limited to covered employees, their spouses, and dependent children. Some employers design their group health plans to enable domestic partners and/or domiciled adults (non-minor individuals, usually an elderly parent, who resides with the covered employee) to be covered under the plan. When these individuals are eligible for coverage under an employer's group health plan, the question arises as to whether they should also have COBRA continuation coverage rights. However, the Federal statute does not recognize a domestic partner or a domiciled adult as a spouse or dependent child of the covered employee. Therefore, those individuals – even if covered under the group health plan – will not be qualified beneficiaries and are not required to be offered COBRA continuation coverage under federal law. Seek legal counsel and/or consult with the insurance carrier to determine if the plan allows non-COBRA continuation coverage that would extend coverage for domestic partners or domiciled adults beyond the time when coverage would otherwise end.

Qualifying Events

A qualifying event is any of a set of specified events that occurs while a group health plan is subject to COBRA that causes a covered employee (or the spouse or dependent child of the covered employee) to lose coverage under the plan. There are specific qualifying events that affect employees, spouses, and dependents.

Employees

For a covered employee, qualifying events include:

- Voluntary or involuntary termination of employment with the company, except for reasons of gross misconduct (see section on Gross Misconduct)
- A reduction in hours of employment resulting in a loss of group health benefits (e.g., strikes, layoffs, workers compensation, leaves of absence). See section on Client Paid Alternative Coverage and Family and Medical Leave Act (FMLA)

Spouses

For a covered spouse, qualifying events include:

- The voluntary or involuntary termination of the employee's employment with the company except for reasons of gross misconduct (see section on Gross Misconduct)
- A reduction in hours of the employee's employment resulting in a loss of group health benefits (e.g., strikes, layoffs, workers compensation, leaves of absence)
- Death of the covered employee
- Divorce or legal separation from the covered employee
- Employee's entitlement to Medicare benefits (under Part A, Part B, or both)
 - Typically, this will not be a qualifying event for spouses of active employees due to the Medicare Secondary Payer rules

Dependents

For a covered dependent, qualifying event includes:

- The voluntary or involuntary termination of the employee's employment with the company, except for reasons of gross misconduct (see section on Gross Misconduct)
- A reduction in hours of the employee's employment resulting in a loss of group, health benefits (e.g., strikes, layoffs, workers compensation, leaves of absence)
- Death of the covered employee
- Divorce or legal separation between the covered employee and spouse
 - Determined by the terms and conditions of the plan, as oftentimes a divorce or legal separation will not – by itself – cause a dependent child to lose coverage
- Employee's entitlement to Medicare benefits (under Part A, Part B, or both)
 - Typically, this will not be a qualifying event for dependent children of active employees due to the Medicare Secondary Payer rules
- Loss of dependent child status as defined by the plan

Life Status Changes

A life status change is an event that causes coverage (active or COBRA) to change. All members' life status changes must also be communicated to HealthEquity/WageWorks. The following life status changes can cause active or COBRA coverage to change:

- Birth/adoption
- Marriage
- Divorce/legal separation (where legally recognized)
- Dropping/adding coverage
- Death of covered employee or dependent

Gross Misconduct

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

Gross misconduct must actually cause the employee's termination of employment. If an employer allows an employee involved in a gross misconduct situation to voluntarily resign, one court has held that the gross misconduct exception – and subsequent withholding of COBRA election rights – only applies to an employee actually terminated for gross misconduct, not an employee that could have been terminated for gross misconduct. [*Conery v. Bath Associates*, 803 F. Supp. 1388 (N.D. Ind. 1992)]

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

While the near-consensus opinion of courts is that misconduct disqualifies the employee's spouse and dependent children as well, some courts have ruled that the intent of the gross misconduct rule was to inhibit only an employee's ability to receive continuation coverage, not hinder his or her spouse's and dependents' access to COBRA. Hence, even in a verifiable gross misconduct situation, an employer may still have an obligation to offer COBRA to the employee's eligible dependents. In turn, the spouse could then add the employee to the plan at the next annual/open enrollment.

Ambiguity associated with the gross misconduct rule leaves many to question whether it is wise to exercise this provision at all when it risks exposure to possible litigation. Most employers conclude that there is little to lose by offering COBRA continuation, even in circumstances of gross misconduct. Please consult legal counsel for guidance if your company plans to exercise the gross misconduct rule under COBRA.

Plans and Benefits Subject to COBRA

A group health plan subject to COBRA is any plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employee, employee organization, or the employee's family. This includes any employer-sponsored medical, dental, vision, or prescription drug program.

Group health plans subject to COBRA include certain health flexible spending accounts (FSAs), mental health plans, drug or alcohol treatment programs, health-related employee assistance plans (EAPs), chiropractic programs, and any self-insured arrangements that provide similar benefits. One or more individual insurance policies may constitute a group health plan if the arrangement involves the provision of health care to two or more employees.

Health Flexible Spending Accounts Under COBRA

Employers who maintain FSAs may limit the COBRA coverage period, with respect to the health FSA, to the end of the FSA plan year in which a qualifying event occurs (see Exception 1, below) or deny COBRA altogether (where the employee has overspent his or her account; see Exception 2, below).

There are two limited exceptions from COBRA for health FSAs:

- **Exception 1** — applies if a health FSA satisfies three conditions. With this exception, the health FSA need not make COBRA coverage available to a qualified beneficiary for any plan year after the plan year in which the qualifying event occurs.
 - **Condition 1:** The health FSA must not be subject to HIPAA portability provisions. A health FSA is not subject to HIPAA portability provisions when the employer also provides other group health plan coverage for the year and the other coverage is not limited to excepted benefits (e.g., limited-purpose dental and vision).
 - **Condition 2:** The maximum reimbursement under the health FSA is not greater than two times the employee's salary reduction election (or if greater, the employee's salary reduction election plus five hundred dollars).
 - **Condition 3:** During the plan year that the qualifying event occurs, the maximum amount that the health FSA could require to be paid for a full plan year of COBRA coverage equals or exceeds the maximum benefit available under the health FSA for that year. This is typically met by most health FSAs. For example, if a health FSA limits reimbursements to employees' salary reduction amounts, this condition is always met because the maximum amount that the health FSA could require as payment for the full plan year of COBRA (102 percent of salary reduction) always exceeds the maximum benefit for the year (100 percent of salary reduction).
- **Exception 2** — provides that COBRA should not be offered to a qualified beneficiary for the current plan year unless the benefits available during the remainder of the year will exceed the amount the FSA can charge for the coverage. For example, Employer X offers its employees a calendar-year Health FSA in addition to a major medical plan. Employees can elect up to \$1,200 in salary reductions to contribute to their Health FSAs. Therefore, Employer X – which has determined that a reasonable estimated cost of providing the Health FSA coverage is equal to the employee's salary reductions for the year – can charge 102 percent of that amount as a COBRA premium for that year. If an employee elected to make the maximum contribution of \$1,200 the annual COBRA premium is \$1,224 (= \$1,200 x* 102%); the monthly COBRA premium is \$102. If an employee has received reimbursements of \$1,000 at the time of her termination on June 30, she is eligible to receive an additional \$200 of benefits for that year. However, Employer X can charge her \$612 (= \$102 * 6) for her COBRA coverage for the remainder of the year.
Employer X does not have to offer her COBRA continuation of her Health FSA for the remainder of that year because the plan can charge her more for the coverage (\$612) than her remaining benefit (\$200).

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

Election Period

When a qualifying event occurs, a qualified beneficiary generally has a 60-day election period during which continuation coverage can be chosen. This election period begins no later than the date coverage is lost due to the qualifying event and continues until at least 60 days after coverage is lost or – if later – the date the COBRA election notification is provided to the qualified beneficiary.

Other Coverage Prior to COBRA Election

A qualified beneficiary retains COBRA rights when other group health coverage or Medicare (under Part A, Part B, or both) exists, as long as the individual had that coverage before the COBRA election date.

Separate Election Rights

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

If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate election among such types of coverage. For example, if an employee had family medical and dental coverage as an active employee, upon a COBRA qualifying event he or she may decline COBRA for him- or herself and elect continuation coverage for only his or her spouse.

Qualified beneficiaries have the same rights as active employees with respect to annual/open enrollment, plan or benefit changes, and adding or deleting dependents.

Claims Incurred During Election Period

Indemnity or reimbursement plans that terminate a qualified beneficiary's coverage upon a qualifying event and allow retroactive reinstatement are not required to process payment for claims incurred by a qualified beneficiary during an election period. Instead, the plan can wait until a timely election and premium payment has been made before processing suspended claims.

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

Duration of Continuation Coverage Periods

In general, a qualified beneficiary may continue group health coverage under COBRA for up to 18 months in the event of a covered employee's termination of employment for any reason (other than for gross misconduct on the employee's part) or a covered employee's reduction in hours of employment. A qualified beneficiary can continue group health coverage under COBRA for up to 36 months in the event of the death of the covered employee, the divorce or separation of the covered employee from his or her spouse, the covered employee's becoming entitled to Medicare benefits, or a dependent child's ceasing to be a dependent under the plan.

Extension of Continuation Coverage Periods

An 18-month COBRA continuation coverage period may be extended to 29 or 36 months, respectively, if a qualified beneficiary is disabled (for Social Security purposes) prior to or at any time within the first 60 days of COBRA continuation coverage, or has a 36-month qualifying event during the original 18-month continuation coverage period or 29-month disability extension period.

Social Security Disability Extension

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

The disabled individual may be any qualified beneficiary (former employee, spouse, or dependent) who became eligible for COBRA continuation due to an employee's termination or reduction in hours of employment. The disability extension applies to all qualified beneficiaries with respect to the qualifying event, not only to the disabled qualified beneficiary. This means if the requirements for a Social Security disability extension are met, the disabled qualified beneficiary need not elect COBRA continuation for the other related qualified beneficiaries to receive the extension.

To qualify for the extension, written notice generally must be provided to the Plan Administrator¹ within 60 days after the latest of (1) the date of the determination of disability by the Social Security Administration; (2) the date of the covered employee's termination of employment or reduction of hours of the covered employee's employment; (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the aforementioned qualifying event; or (4) the date on which the qualified beneficiary is notified, by furnishing of the COBRA General Notice or the plan's Summary Plan Description, of his or her obligations to provide written notice of the disability determination. In addition, notice of the Social Security Administration's determination of disability must be provided before the end of the original 18-month continuation coverage period (irrespective of when the 60-day period would otherwise end).

Any disability notification requirement can only be enforced if the individual has been previously advised through written materials such as the initial COBRA rights notification, the Summary Plan Description, and COBRA election notice.

In the event that the disability notification is not provided during the applicable 60-day notice period and within 18 months after the covered employee's termination of employment or reduction in hours of the covered employee's employment, then the qualified beneficiary may be determined to be ineligible to receive the disability extension. This determination is at the sole discretion of the Plan Administrator.

The Plan Administrator must be notified within 30 days after the individual is determined to no longer be disabled. In such cases, coverage for all qualified beneficiaries ends with the first month beginning more than 30 days after the Social Security Administration determination or, if later, at the end of 18 months of continuation coverage.

¹ HealthEquity/WageWorks will – as part of its contracted COBRA administrative services – accept notification from qualified beneficiaries of disability determinations on behalf of the Plan Administrator unless the Summary Plan Description provides otherwise.

See “Process: Disability Extension” (below) for more information.

Process: Disability Extension

Description: Process followed when members request to continue coverage after the initial COBRA eligibility period ends due to a disability extension.

Step	Timing	Responsibility
The member provides the administrator with documentation declaring disability by the Social Security Administration (SSA).	Within 60 days after the latest of (1) the date of the determination of disability by the Social Security Administration; (2) the date of the covered employee's termination of employment or reduction of hours; (3) the date the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the qualifying event; or (4) the date the qualified beneficiary is notified, by furnishing of the COBRA General Notice or the plan's Summary Plan Description, of his or her obligations to provide written notice of the disability determination and before the end of the original 18-month continuation coverage period.	Member or Qualified Beneficiary
The extension information is received date stamped and scanned into the appropriate member's account with a case.	Day of receipt	HealthEquity/WageWorks
The information is forwarded to Document Control for processing.	Day of receipt	HealthEquity/WageWorks
After processing, the administrator sends the member the new eligibility end date and payment information.	Within 30 days from receipt of the request	HealthEquity/WageWorks
The member remits monthly premium by deadline date.	Monthly	Member or Qualified Beneficiary
The administrator notifies the carrier of extension via eligibility reports.	As scheduled by client	HealthEquity/WageWorks
The carrier updates coverage.	N/A	Carrier
The client confirms updated coverage by reconciliation with billing statement from carrier.	Monthly	Client

Table 2-1: Disability Extension Timetable

Multiple Qualifying Event Extension

The length of continuation coverage may be extended from 18 months (or 29 months for disability extensions) to 36 months if a 36-month qualifying event occurs during the original 18- or 29-month continuation coverage period. An extended 36-month continuation coverage period is measured from the original qualifying event date and applies to any spouse or dependent who is a qualified beneficiary.

This multiple qualifying event extension is only applied when the first qualifying event gives rise to an 18-month maximum COBRA eligibility period (i.e., termination of employment, reduction of hours). Furthermore, this extension is only available when the second qualifying event (occurring within the original 18- or 29-month maximum COBRA eligibility period) is one that gives rise to a 36-month maximum COBRA eligibility period (i.e., death of the covered employee, divorce or legal separation of the covered employee from his or her spouse, the covered employee's becoming entitled to Medicare

benefits [under Part A, Part B, or both]², or a dependent child's ceasing to be a dependent under the terms of the Plan). Thus, a reduction in hours – for example - followed by termination of employment is not a second qualifying event that extends the maximum 18- or 29-month COBRA period to 36 months.

To receive the extension, a qualified beneficiary generally must notify the Plan Administrator³ in writing within 60 days of the later of (1) the date of the second qualifying event; (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the aforementioned qualifying event*; or (3) the date on which the qualified beneficiary is notified, by furnishing of the COBRA General Notice or the plan's Summary Plan Description, of his or her obligations to provide written notice of the qualifying event.

* It is noteworthy that this date is problematic when considering notices of a second qualifying event, as a qualified beneficiary has already lost active coverage on account of the first qualifying event. Furthermore, none of the 36-month qualifying events are listed in the IRS COBRA Regulations as events allowing for termination of COBRA coverage (see "Termination of COBRA Continuation" [below] and Treas. Reg. § 54.4980B-7, Q&A-1 for more information). The DOL has informally commented that a plan should only consider the date of the second qualifying event and the date on which the qualified beneficiary is notified – through the COBRA General Notice or the plan's Summary Plan Description – of his or her obligations to provide written notice of the qualifying event when applying this deadline.

The Plan Administrator has the sole discretion of determining the sufficiency of a qualified beneficiary's notice of the second qualifying event.

In no event does COBRA continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

Premiums for Continuation Coverage

During a standard 18- or 36-month continuation coverage period, COBRA allows a client to charge up to 102 percent of the applicable premium. The applicable premium is the cost to offer the plan to a similarly situated non-COBRA member. The administrator retains a two percent administration fee.

A qualified beneficiary has the right to pay for COBRA continuation coverage in monthly installments. The qualified beneficiary cannot require the plan to apply the first payment for COBRA continuation coverage prospectively from the date payment is made. Instead, it is applied to the period of coverage beginning immediately after the date that coverage under the plan would have been lost due to the qualifying event.

² Typically, a covered employee's entitlement to Medicare benefits (under Part A, Part B, or both) will not be a qualifying event for spouses or covered children of active employees due to the Medicare Secondary Payer Rules. In such a case, this extension is not available when a former employee becomes entitled to Medicare benefits after his or her termination of employment or reduction in hours of employment.

³ HealthEquity/WageWorks will – as part of its contracted COBRA administrative services – accept notification from qualified beneficiaries of second qualifying events on behalf of the Plan Administrator unless the Summary Plan Description provides otherwise.

Premium Due Dates

A qualified beneficiary has 45 days after the date on which he or she elected COBRA to make an initial payment. Group health plans must allow qualified beneficiaries to make monthly premium payments. Semi-annual, quarterly, and weekly payments are permissible, but not required. COBRA premiums are subject to a 30-day grace period after the due date, but plans may be more lenient.

Insignificant Premium Shortfall

In the event that a qualified beneficiary makes a premium payment that is short by the lesser of \$50 or 10 percent of the premium amount required by the plan, the final regulations require that payment of such an amount will be deemed by the plan to satisfy the COBRA premium payment requirement unless the plan notifies the qualified beneficiary of the shortfall and allow a 30-day safe harbor period after the qualified beneficiary is notified to pay the required premium. For example, if the required COBRA premium payment is \$510, and the payment received is deficient by \$51 (exactly 10 percent of the premium), the qualified beneficiary would not be entitled to the 30-day safe harbor period because the shortfall exceeds the stipulated \$50 cutoff by one dollar, even though the premium shortfall is within 10 percent of the premium.

The automated system generates premium shortfall notifications to qualified beneficiaries on a daily basis to keep the length of the payment period to a minimum.

Process: Insignificant Premium Shortfall Payments

Description: Process followed when a member remits an insignificant premium shortfall payment.

Step	Timing	Responsibility
Member remits premium that is short by an insignificant amount.	N/A	Member or Qualified Beneficiary
Administrator processes the payment.	Within 48 hours of receipt	HealthEquity/WageWorks
A notice is mailed to member, explaining balance due and due date.	Within 72 hours of payment processing	HealthEquity/WageWorks
If remaining balance is not received by the grace period, member is canceled retroactively back to most current paid through date.	Grace period typically = 30 days	Carrier
Administrator sends a cancellation notice (and mails COBRA HIPAA Certificate if contracted) to member's last known address.	Within 48 hours of cancellation	HealthEquity/WageWorks
If payment meets 90%/\$50 rule the administrator marks payment as acceptable. If not, the member may remit remaining payment if still within the grace period.	N/A	HealthEquity/WageWorks

Table 2-2: Insignificant Premium Shortfall Payment Timetable

Premiums During A Disability Extension

In the case of a disability extension, the plan can charge up to 150 percent of the applicable premium during the 11 months of the extension (months 19 through 29) when the disabled individual is part of the coverage group. If only non-disabled qualified beneficiaries are in the coverage group, no more than 102 percent of the applicable premium would apply for months 19 through 29.

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

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

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

Third Party Premium Payments

The client can require payment for continuation coverage. However, the law does not require premium payments be made only by the qualified beneficiary covered by the plan. In fact, regulations intentionally exclude any reference as to who must make a required premium payment. It can be implied that any person (or entity) may make a COBRA payment on behalf of a qualified beneficiary.

An active employee, hospital or health care provider, new employer, or state Medicaid programs are potential sources for third party payments of COBRA premiums on behalf of a qualified beneficiary. For example, a divorce decree may require an active employee to provide health care coverage for a specified period to his or her ex-spouse. A hospital or health care provider may choose to pay COBRA premiums to make certain that coverage exists for a qualified beneficiary's medical expenses.

It is feasible that a qualified beneficiary may negotiate for a new employer to pay for COBRA premiums during a probationary or eligibility period required by the new plan. Qualified beneficiaries may also be entitled to certain state-run programs in which Medicaid agencies pay the cost to maintain COBRA premiums.

In any of these examples, it is important to stress that the qualified beneficiary has ultimate responsibility for maintaining the desired COBRA continuation coverage, even if a third party fails to make a timely payment. Unless a qualified beneficiary is in regular contact with its designated third party to assure that timely payment has been made, it is possible for a COBRA member's coverage to end unknowingly and without recourse. Qualified beneficiaries should be mindful of these risks when arranging for third party COBRA premium payments.

Determination Period

By law, an employer must establish a 12-month determination period to be applied consistently from year to year. Generally, the applicable premium must be calculated and fixed by a group health plan before the 12-month determination period begins. The determination period is a single period for any benefit package.

During a determination period, a plan can increase the amount it requires for continuation coverage in the following three cases:

1. The plan has previously charged less than the maximum amount permitted and the increased amount does not exceed the maximum amount permitted.
2. The increase occurs during a disability extension and the increased amount does not exceed the maximum amount permitted.
3. A qualified beneficiary changes coverage.

Whenever a plan allows a similarly situated active employee to change coverage (such as during annual/open enrollment or under special enrollment rules), the plan must allow each qualified beneficiary to change coverage on the same terms as similarly situated active employees. Because of certain changes to coverage, the applicable premium may be affected. For example, a shift from one benefit package to another or adding/eliminating family members from the plan may cause the applicable premium to increase or decrease. The statutory guidelines allow for changes in premium related to a change in coverage to be passed on to qualified beneficiaries without regard to any determination period.

Please note: *Although neither the statute nor the DOL regulations specifically state advance notice of a COBRA premium increase is required, the DOL has commented that COBRA continuation coverage should not be terminated for insufficient payment if affected COBRA qualified beneficiaries are not provided reasonable advance notice of increased premiums and a reasonable opportunity to pay the premiums. As a result, we require advance written notice no later than 30 days prior to the date of an applicable premium increase to be distributed to all affected qualified beneficiaries.*

Special Note for California Employers: *California Insurance Code Section 10199.1(b) prohibits fully-insured group health plans subject to California state insurance laws from increasing premiums without first providing written notice of the increase at least 60 days prior to the effective date of the increase. To help ensure your affected plan members are provided timely notice, HealthEquity/WageWorks strongly recommends that you provide the completed form no later than 75 days prior to the start of the determination period.*

Employer-paid Alternative Coverage

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

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

Should a 36-month qualifying event (e.g., death of the covered employee) occur that causes a spouse or dependent child to lose this alternative coverage, this event can be a COBRA qualifying event with

respect to the 36-month qualifying event. This is true even if COBRA coverage was waived at the time of the original 18-month qualifying event.

However, if the alternative coverage offered is identical to that which the employee had prior to the leave, COBRA is not required to be offered upon the occurrence of the qualifying event. This is because there has been no loss of coverage upon the – for example – termination of employment of the employee. Furthermore, there is no obligation to offer COBRA coverage at the expiration of this identical alternative coverage if it lasts as long as the applicable maximum COBRA coverage period.

On the other hand, if something causes a loss of the identical alternative coverage within the applicable maximum COBRA coverage period (e.g., 18 months following a termination of employment), then there has been a qualifying event and the qualified beneficiary is entitled to COBRA coverage for the remainder of the maximum applicable COBRA period.

For example, assume a covered employee terminates her employment on January 1. As part of her severance package, she is provided group health plan coverage identical in both benefits and cost (the total premium she is required to pay is the same as when she was an active employee). After six months, her severance package expires and her coverage terminates June 30. The former employee is now entitled to a COBRA election for the period beginning July 1 and ending the following June 30 (the remainder of the 18-month maximum COBRA coverage period in connection with her termination of employment).

An employer could also treat the period of identical alternative coverage separately from COBRA continuation coverage. This would extend the length of time an individual remains on the group health plan by starting the COBRA coverage period after alternative coverage ends. In any case, the employer must clearly describe the alternative coverage policy in the Summary Plan Description (SPD) and notify the insurance carrier any time that alternative coverage begins to achieve full disclosure with the plan.

HealthEquity/WageWorks can assume billing and collection responsibilities only when the period of alternative coverage is applied toward the period of COBRA continuation coverage.

Severance Agreements

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

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

Where the severance agreement and COBRA continuation coverage run concurrently, the qualified beneficiary should be provided a COBRA election notice. The terms of the severance agreement would govern the method and form of premium payments (employer-subsidized premiums) for the period of severance. Different rules apply for leaves defined under the Family and Medical Leave Act of 1993. (See FMLA section.)

Business Reorganizations

The 2001 final IRS regulations set forth new rules that govern how COBRA applies when there is business reorganization. A high-level overview of the rules is as follows:

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

IMPORTANT: Consult legal counsel for advice on merger, acquisition, or business reorganization issues.

Voluntary Termination of Health Coverage

An employee with family coverage can request plan coverage to be terminated for his or her spouse or dependent(s). This request could be due to financial necessity or a result of the spouse or dependent obtaining other health coverage. Typically, this is a voluntary action on the part of the employee to end coverage and is not in connection with a COBRA qualifying event. The employer is generally not required to offer continuation coverage when plan coverage ends because of a voluntary request. However, under HIPAA requirements, this loss of coverage would trigger a certificate of creditable coverage to be issued by the plan⁴. (In general, COBRA continuation must only be offered to qualified beneficiaries who were covered on the day before a qualifying event.)

⁴ NOTE: The HHS, DOL, and IRS issued a 90-day waiting period limitation and technical amendments to certain health coverage requirements under the Affordable Care Act, which includes several changes to make HIPAA rules consistent with health care reform revisions. One of these is to eliminate the HIPAA Certificate requirement effective December 31, 2014.

An employee could intentionally request coverage to be terminated for a spouse in anticipation of a future qualifying event, such as divorce or legal separation. In such a case, termination of coverage could occur without knowledge or consent of the spouse (or dependent) whose coverage is affected. Similarly, an employer may intentionally reduce or terminate plan coverage for an employee in anticipation of the employment termination. In both examples, the qualified beneficiary would technically cease to have COBRA rights because he or she was not covered on the day before the qualifying event. However, a provision of COBRA law protects continuation coverage rights when coverage is lost or reduced in anticipation of a future qualifying event.

The IRS COBRA regulations provide that any reduction or elimination of coverage in anticipation of an event is "disregarded in determining whether the event results in a loss of coverage." In other words, a plan is required to make COBRA continuation coverage available, effective on the date of the qualifying event but not for any period before the qualifying event date. Of course, continuation coverage is conditioned upon a qualified beneficiary's timely notification of the qualifying event (by law, the later of either 60 days from the loss of coverage or 60 days from the qualifying event date) to the employer. The regulations do not address obstacles that exist when a gap in coverage is present between the time an employee requests termination of coverage for his or her spouse, and the actual qualifying event date.

The regulations also do not provide guidance as to the appropriate interval for determining when an action is no longer considered in anticipation of a qualifying event (three months vs. 12 months between spouse coverage termination and divorce). In the absence of statutory guidance, seek legal counsel on these issues.

HealthEquity/WageWorks does not perform any COBRA administrative duties related to a voluntary request for coverage termination. When an employee requests termination of plan coverage for a spouse or dependent, the group health plan and health insurance issuer (or the plan administrator for self-funded plans) must provide a certificate of creditable coverage to the individual(s) losing coverage. In addition, the health plan and health insurance issuer must send a confirmation letter that informs the spouse or dependent that health coverage has or will end at the employee's request.

Termination of COBRA Continuation

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

- Non-payment of premium
- Completion of 18-, 29-, or 36-month continuation coverage period
- Employer elimination of all group health benefits (including successor plans)
- Qualified beneficiary obtains other group health coverage after the date of COBRA election that does not include an applicable exclusion or limitation for any pre-existing condition (NOTE: There are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited starting with plan years that begin in 2014)
- Qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after the date of COBRA election
- For cause (gross misconduct), on the same basis that the plan terminates for cause of similarly situated non-COBRA beneficiaries
- For an 11-month disability extension, a final determination is made that the individual is no longer disabled

Process: First Level Reinstatement Request Process

Description: Process used when a member requests reinstatement of coverage due to cancellation.

Step	Timing	Responsibility
The member sends a written request for reinstatement of coverage to HealthEquity/WageWorks.	N/A	Member or Dependent
The document is date stamped and scanned into the member's record.	Within two business days of receipt	HealthEquity/WageWorks
The request is forwarded to the resolution department for review of facts and circumstances to determine if cancellation was consistent with applicable federal guidelines and/or the client's plan provisions.	Within two business days of receipt	HealthEquity/WageWorks
The resolution department opens a Case on the member's account to document the reinstatement request.	Within three business days of receipt	HealthEquity/WageWorks
The resolution department makes a determination. If they cannot process the reinstatement request within seven business days of receipt, a status letter will be sent to the member indicating receipt of the reinstatement request and the process.	Within seven business days of receipt	HealthEquity/WageWorks
HealthEquity/WageWorks updates the member's account and notifies him or her of the resolution in writing: reinstatement of coverage, or upholding the initial cancellation. <ul style="list-style-type: none"> • If the cancellation was inconsistent with applicable federal guidelines and/or client plan provisions, member's account is reinstated. An approval notice noting amount to remit and any applicable due date extension for premium payment(s), will be sent to the member. • If initial cancellation was consistent with applicable federal guidelines and/or client plan provisions, HealthEquity/WageWorks sends a denial notice to the member. If member elects to send a second reinstatement request, see Second Level Reinstatement Request process (skip following steps in First Level Reinstatement Request process). 	Upon determination	HealthEquity/WageWorks
The member remits premium due to bring account current.	Must be returned by the extended premium due date	Employee or Dependent
HealthEquity/WageWorks posts payment to the member's account.	Within two business days of receipt	HealthEquity/WageWorks
HealthEquity/WageWorks sends eligibility to the client via eligibility report.	As scheduled	HealthEquity/WageWorks
Notification to the carrier. If contracted for this service, HealthEquity/WageWorks will notify the carriers via eligibility report. If not contracted for this service, client will be responsible to notify the carrier.	As scheduled	HealthEquity/WageWorks Or Client
The carrier updates the member's coverage.	Upon receipt of report	Carrier

Table 2-3: First Level Reinstatement Request Process Timetable

Process: Second Level Reinstatement Request Process

Description: Process used when a member requests reinstatement of coverage due to cancellation, received a First Level Reinstatement Request decision by HealthEquity/WageWorks to decline the appeal, but wants to make a second request for reinstatement generally to be reviewed by the client.

Step	Timing	Responsibility
The member sends a second written request, along with any support documentation, to request reinstatement of coverage to HealthEquity/WageWorks because they don't agree with the first level reinstatement request determination.	N/A	Employee or Dependent
The document is date stamped and scanned into the member's record.	Within two business days of receipt	HealthEquity/WageWorks
Unless otherwise requested by the client, HealthEquity/WageWorks will notify client of Second Level Reinstatement Request and allow them to override the initial determination.	Within seven business days of receipt	HealthEquity/WageWorks
The client makes a determination and notifies HealthEquity/WageWorks.	No time limits	Client
HealthEquity/WageWorks updates the member's account and notifies him or her of the resolution in writing: reinstatement of coverage, or upholding of the initial cancellation. <ul style="list-style-type: none"> If client overturned the First Level Reinstatement Request decision, member's account is reinstated. An approval notice noting amount to remit and any applicable due date extension for premium payment(s), will be sent to the member. If client upholds the First Level Reinstatement Request decision, HealthEquity/WageWorks sends a denial notice to the member (skip following steps in Second Level Reinstatement Request process). 	Upon determination	HealthEquity/WageWorks
The member remits premium due, to bring account current.	Must be returned by the extended premium due date	Employee or Dependent
HealthEquity/WageWorks posts payment to the member's account.	Within two business days of receipt	HealthEquity/WageWorks
HealthEquity/WageWorks sends eligibility to the client via eligibility report.	As scheduled	HealthEquity/WageWorks
Notification to the carrier. If contracted for this service, HealthEquity/WageWorks will notify the carriers via eligibility report. If not contracted for this service, client will be responsible to notify the carrier.	As scheduled	HealthEquity/WageWorks Or Client
The carrier updates the member's coverage.	Upon receipt of report	Carrier

Table 2-4: First Level Reinstatement Request Process Timetable

COBRA and Health Maintenance Organizations (HMOs)

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

HMOs can create administrative challenges for employers with respect to COBRA continuation coverage. Most HMOs utilize a prepayment billing practice that directly conflicts with the premium grace period allowed under COBRA. Out of necessity, many employers must pre-fund their qualified beneficiaries' COBRA premiums in order to remain in good standing with the HMO for its active employees.

Problems can arise when an employer cancels its indemnity plan in favor of an HMO that cannot service a qualified beneficiary who resides outside of the service area. Employers are confused as to what their COBRA obligations are when a qualified beneficiary moves out of an HMO service area and can no longer receive services or treatment. In an attempt to address the latter, the IRS COBRA regulations state that a qualified beneficiary need only be given an opportunity to continue the coverage that he or she was receiving immediately before the qualifying event. This is true regardless of whether the coverage ceases to be of value, if the qualified beneficiary relocates out of an HMO's service region.

However, the qualified beneficiary must be given an opportunity to elect alternative coverage the employer makes available to similarly situated non-qualified beneficiaries or inactive employees. Availability cannot be conditioned upon the employer having covered employees where the qualified beneficiary has relocated. Instead, the relocating qualified beneficiary must have access to any alternative coverage made available to other employees (similarly situated or not) as long as the other coverage would provide coverage to that area.

Pursuant to the IRS COBRA regulations, an offer for alternative coverage must be made on the date of the relocation or, if later, on the first day of the month following the month in which the qualified beneficiary requests the alternative coverage. If the HMO is the sole plan made available to its employees, the employer is not required to make any other coverage available to the relocating qualified beneficiary.

SECTION 3 – HIPAA AND FMLA

Introduction

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

HIPAA

HIPAA was signed into law in August 1996. It amends and clarifies certain COBRA continuation rules and establishes additional administrative guidelines that affect all group health plans. The following is a summary of HIPAA provisions as they pertain to COBRA continuation coverage.

Portability Provisions Limitations on Pre-existing Condition Exclusions (PCEs)

HIPAA established certain rules that regulate how a group health plan can impose PCEs. These rules pertain to the duration, applicability, and criteria for identifying which medical conditions can be excluded.

For plan years beginning on or after September 23, 2010, group health plans cannot impose PCEs on enrolled children younger than age 19. In addition, for plan years beginning on or after January 1, 2014, PCEs are completely prohibited. These changes apply to grandfathered health plans and insurance coverage, but not to plans or benefits that are excepted from HIPAA's portability requirements.

To the extent that a medical condition is recognized as pre-existing, exclusions or limitations may only apply to conditions in which medical care or advice was recommended or received within the six-month period preceding the plan participant's enrollment date. Second, the pre-existing exclusion or limitation period cannot exceed 12 months (except if the plan participant is a late enrollee, in which case the maximum period is 18 months). Third, the maximum exclusion period can be reduced or eliminated by any period of prior continuous creditable coverage.

HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations on plan participants. The law provides that the length of a plan's pre-existing condition exclusion must be reduced by the period of an individual's prior continuous creditable coverage (including COBRA coverage). For example, suppose that Employee A was covered by a group health plan for four months prior to termination and elected COBRA coverage for an additional two months. Assume further that Employee A accepts a new job and enrolls in his new employer's group health plan that has a six-month pre-existing condition exclusion period.

In this example, the new plan's pre-existing condition exclusion period would be eliminated by Employee A's six months of prior creditable coverage (four months of coverage as an active employee plus two months of COBRA continuation coverage). The former employer may invoke COBRA's Other Group Health Plan Coverage rule in which continuation coverage may be terminated if a qualified beneficiary becomes covered under another group health plan that does not have any applicable pre-existing condition exclusion or limitation.

Notification Requirements to Impose a PCE

A group health plan or health insurance issuer must provide a notice to be distributed to all employees (or to their beneficiaries) who will be offered the opportunity to enroll in group health plans. The notice informs the recipients of any pre-existing condition provisions under the plan (as described above).

Special Enrollment Periods

Under the special enrollment period provisions of HIPAA, employers must permit an employee or any eligible dependent (except those who previously declined enrollment in group health coverage) to enroll for coverage later. Special enrollment privileges arise in the following situations:

- The employee or dependent loses eligibility for other group health coverage or health insurance coverage.
 - The employee or dependent must have had other group health plan or health insurance coverage at the time coverage was previously offered.
 - If required by the plan, the employee stated in writing that coverage was being declined due to coverage under another plan (if the employer notified the employee of such written request at the time coverage was being offered).
 - Other coverage was lost because:
 - It was COBRA coverage and reached the maximum period allowed;
 - The other coverage was terminated due to a loss of eligibility (e.g., a COBRA qualifying event); or
 - The other coverage was lost due to a termination of employer contributions.
 - The employee requested enrollment under the plan not later than 30 days after the date of the loss of other coverage.
- The employee adds a new family member (acquired through marriage, birth, or adoption) to the plan within 30 days of the event.

The final HIPAA regulations require group health plans to provide a notice summarizing these special enrollment rights at the time an employee is initially offered an opportunity to enroll in the group health plan.

HealthEquity/WageWorks uses its HIPAA Initial Notice service to satisfy both the HIPAA Initial Notice of PCE and Special Enrollment Notification requirements.

Process: New Hire (HIPAA Initial Notice)

Description: Process followed to notify a new hire of their HIPAA rights (when a client has selected this service from HealthEquity/WageWorks).

Step	Timing	Responsibility
Client notifies administrator of new hire via file transfer or website.	First day of employment	TPA and Client
Upon receipt, administrator dispatches HIPAA Initial Right Notice to member.	Within 48 hours of date of hire or date of entry	HealthEquity/WageWorks
Document is imaged and posted to website.	Within 48 hours of date of hire or date of entry	HealthEquity/WageWorks

Table 3-1: HIPAA Initial Notice Timetable

Creditable Coverage

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

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

HIPAA provides two methods of determining how to apply creditable coverage. The standard method is to apply creditable coverage without regard to the specific benefits covered during the period. The alternative method allows the employer to compare creditable coverage with respect to a specific class or category of benefits. If the alternative method is chosen, the plan must prominently disclose such method to each plan participant and within plan documents, summary plan descriptions (SPDs), and other documents that describe the plan. Employers are cautioned to await more specific regulations on this matter before applying rigid restrictions on plan benefit exclusions under the alternative method.

Process: HIPAA Certificate of Creditable Coverage (when a client has selected this service from HealthEquity/WageWorks)

Description: Process used to distribute the HIPAA Certificate of Creditable Coverage (also referred to as the HIPAA certificate).

Step	Timing	Responsibility
HIPAA certificate queues automatically upon successful qualifying event process.	Within 48 hours after file is loaded or entered via website	HealthEquity/WageWorks
Auto-generated HIPAA certificates are placed in the automated system print queue.	Daily	HealthEquity/WageWorks
Document specialist batches the notices.	Daily	HealthEquity/WageWorks
System electronically images to member record and prints document on plain paper.	Daily	HealthEquity/WageWorks
Document specialist performs quality review.	Daily	HealthEquity/WageWorks
Quality review begins. Document specialist and client services representative review 20% of all printed notices for accuracy and content. If an error is found, 100% of the batch is reviewed.	Immediately after documents are printed	HealthEquity/WageWorks
When appropriate, the client services representative researches and resolves the error(s).	Within 24 hours	HealthEquity/WageWorks
The document specialist and client services representative repeat steps and conduct quality review on 100% of the corrected notices.	Daily	HealthEquity/WageWorks
If the quality review is acceptable, the document specialist performs the additional steps necessary to mail the documents.	Same day notice prints	HealthEquity/WageWorks
The document specialist applies postage to envelopes.	Immediately after the print job is complete	HealthEquity/WageWorks

Step	Timing	Responsibility
The documents are placed in United States Postal Service (USPS) collection tray and couriered to the main post office every business day. An Advanced Shipping Notice (ASN) accompanies each batch. The ASN is stamped by a US postal representative for verification of receipt.	Daily	HealthEquity/ WageWorks
A file is created and uploaded via an encrypted format to the USPS ftp site. The USPS confirms each notice contained in the file was received and was mailed from the post office.	Daily	HealthEquity/ WageWorks
The confirmed mail file containing a record of each piece of mail scanned at the USPS is downloaded from the USPS and entered into the system.	Daily	HealthEquity/ WageWorks

Table 3-2: HIPAA Certificate of Creditable Coverage Timetable

All documents queued are batched and printed the same day. Documents are mailed on the same day unless an error has occurred, or the quality review process causes a necessary delay.

Certificate of Creditable Coverage Requirements

Under HIPAA, employers are required to provide plan participants with a written Certificate of Creditable Coverage that certifies any period of prior coverage. This certificate must be provided in the following situations:

1. When the individual loses coverage under the plan, for any reason (including due to a COBRA qualifying event)
2. When the individual ceases to be covered under COBRA continuation
3. Upon request, if requested within 24 months after plan coverage ends

Certificates of Creditable Coverage must include the period of creditable coverage under the plan (active employee coverage), the period of coverage under COBRA, and the waiting period (and affiliation period, if applicable) imposed under the plan. Each family member within the plan may need a separate Certificate of Creditable Coverage since it is possible that coverage will begin or end at different times for different family members.

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

NOTE: The HHS, DOL, and IRS issued 90-day waiting period limitation and technical amendments to certain health coverage requirements under the Affordable Care Act, which make several changes to make HIPAA rules consistent with health care reform revisions. One of these is to eliminate the HIPAA Certificate requirement effective December 31, 2014.

Until this date, Certificates of Creditable Coverage must be provided under the following conditions:

A certificate must be provided to an individual who:	A certificate must be sent:	Responsibility
Is entitled to elect COBRA continuation coverage.	At a time no later than when a notice is required to be provided for a COBRA qualifying event	HealthEquity/WageWorks [†]
Has ended COBRA continuation coverage.	Either within a reasonable time after the plan learns that COBRA continuation coverage ceased, or if applicable, within a reasonable time after the individual's grace period for the payment of COBRA premiums end	HealthEquity/WageWorks [†]
Loses coverage under a group health plan and is not entitled to elect COBRA continuation coverage.	Within a reasonable time after coverage ceases	Client*
Has requested it and has not yet lost coverage or is within 24 months of having lost coverage.	Within a reasonable time after a request is made	HealthEquity/WageWorks [†] or Client*

Table 3-3: Certificate of Creditable Coverage Table

[†] If provision of HIPAA Certificates of Creditable Coverage is selected within the applicable Service Schedule between HealthEquity/WageWorks and the client.

**EMPLOYER: You are responsible for providing a Certificate of Creditable Coverage for all loss of coverage situations that are NOT related to a COBRA qualifying event. For example, if an employee requests plan termination because they are enrolling in the spouse's employer group health plan, it is not a COBRA qualifying event. However, it is a loss of coverage event, a Certificate of Creditable Coverage must be issued to the employee.*

Other Evidence of Creditable Coverage

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

Obtaining Employee Dependent Information

Detailed dependent information must be included on the Certificate of Creditable Coverage (dependent name, plan coverage type, duration of coverage). Clients should collect this information at the next annual/open enrollment period to track required dependent data. The tracking system should have archival capabilities for quick retrieval of aged data.

Family and Medical Leave Act

The following is a summary of FMLA. For more specific details about the law, contact the Department of Labor (www.dol.gov) to obtain a copy of the statute.

FMLA allows eligible employees to take up to 12 weeks of unpaid leave during a 12-month period for any of the following four reasons:

1. To care for a child within 12 months of his or her birth
2. To care for a child within 12 months of his or her foster care placement or adoption
3. To care for the employee's spouse, child, or parent if the person has a serious health condition
4. Because of a serious medical condition that makes the employee unable to perform his or her job

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

Employers of 50 or more employees in one location must comply with the provisions of FMLA. The law also applies to employers with fewer than 50 employees at one location but at least 50 employees within a 75-mile radius (distributed among different work sites or locations). Employees are eligible if they worked for the employer for at least 12 months and worked at least 1,250 hours during the previous 12-month period.

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

It is the plan sponsor's responsibility to identify and track FMLA leaves within the company and, when necessary, report to HealthEquity/WageWorks that a COBRA qualifying event has occurred.

SECTION 4 – THE CLIENT EXPERIENCE TEAM

Introduction

The following sections describe the client experience team, the most effective ways to communicate with HealthEquity/WageWorks, and our account management and implementation processes.

Client Experience Team

The client experience team integrates sales, implementation, and account management to ensure a consistent, positive client experience. Our sales and implementation teams work hand-in-hand with the employer to collect profile, plan, and rate information during the conversion process.

Some of the tools utilized during the implementation process and ongoing client services include process flows, project plans, checklists, audits, action items, and decision logs.

Once implementation is complete, the client services team is available to answer questions specific to your account. Client services team members have extensive backgrounds and experience in benefits and are trained to assist clients with the day-to-day process of administration with access to extensive details of your specific account.

Client Services team members are available toll-free Monday through Friday (excluding holidays) from 7 a.m. to 7 p.m. CT.

Implementation: The implementation representative is responsible for obtaining and entering the data necessary to activate the organization's account.

Client Services: The client services representative is the personal liaison between the client and our various support units. This individual becomes familiar with the organization and its particular COBRA and Direct Bill requirements, allowing them to respond quickly and thoroughly, to specific client needs.

File Transfer Processing: HealthEquity/WageWorks will accept weekly file transfers from employers with more than 1,000 active employees. The advanced file transfer specification is designed for employers who want to automate most COBRA and HIPAA communications.

Website: The home page has information about HealthEquity/WageWorks and the services it provides. Each authorized user that the client submits will be issued a secure password allowing them to obtain access beyond the home page. Once logged in, the user can communicate information to HealthEquity/WageWorks concerning new hires, qualifying events, or changes. Users can also check the status of members or COBRA continuants.

Member Services Department: The member services department is dedicated to responding to questions and concerns of the COBRA qualified beneficiaries in a proficient and timely manner. This unit answers qualified beneficiary and health care provider inquiries regarding COBRA continuation coverage, premium payments, eligibility, elections, etc. Once the client has signed up for administrative services with HealthEquity/WageWorks, the qualified beneficiaries should be instructed to address any of their questions to the member services department. Qualified beneficiaries have access to the HealthEquity/WageWorks automated 24-hour interactive voice response (IVR) system for access to detailed account information. Beneficiaries can also submit a message on the member website and receive a timely response.

Communicating with HealthEquity/WageWorks

Clients can provide information through the website, which is the most effective method to communicate a specific need or ask a member-related question. This method gives clients the flexibility to communicate with HealthEquity/WageWorks at a time that is most convenient to them, while simultaneously documenting the written request in case notes for tracking purposes.

Communication systems are accessible 24/7. A member of the client services team who oversees that account will address questions submitted. This approach assures that clients receive the utmost attention and dedication to service from individuals within the organization who are most familiar with their company.

SECTION 5 – COBRA ADMINISTRATION SERVICES

Introduction

The following sections describe the reporting responsibilities and services performed to maintain COBRA compliance.

Plan Sponsor Role as the COBRA Plan Administrator

HealthEquity/WageWorks relies on the client to properly communicate information, carry out the instructions regarding member coverage, and conform to all COBRA guidelines.

HealthEquity/WageWorks strictly adheres to the time frames and eligibility rules for continuation coverage. This protects the client and assures that all qualified beneficiaries receive equal, fair, and consistent treatment. As clients receive information from HealthEquity/WageWorks about terminations, elections, or payments received, they may be inclined to extend leniency toward certain COBRA members who are ineligible for continuation coverage. For example, clients may wish to authorize an exception for HealthEquity/WageWorks to accept a late payment or election. HealthEquity/WageWorks strongly recommends that clients avoid any actions or decisions that are inconsistent with standard policy and could possibly set an undesirable precedent for future qualified beneficiaries.

COBRA General Rights Notice to Active Employees

Even prior to a qualifying event, COBRA law requires an initial notification of COBRA rights to be sent to each insured employee, and/or covered spouse. HealthEquity/WageWorks refers to this notice as the COBRA General Rights Notice, formally known as the COBRA General Notice of Continuation Coverage.

This notice must be mailed according to applicable DOL disclosure regulations (29 Section CFR 2520.104b-1) to all covered employees and spouses when an organization first becomes subject to COBRA. In addition, on an ongoing basis, an initial COBRA notification must be provided whenever an individual is added to the plan as in any of the following cases:

1. A new hire who becomes covered under the group health plan
2. An employee and/or spouse who becomes covered under the group health plan during annual/open enrollment
3. An employee who marries and adds his or her spouse to the plan

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

NOTE: Neither the COBRA statute nor the DOL COBRA regulations require only that the COBRA General Notice be provided to the covered employee and spouse. While there is no formal requirement for a group health plan to provide a COBRA General Notice to a dependent child (whether or not he or she shares a residence with the covered employee or a covered employee's spouse), the plan administrator may expose itself to risks associated with not informing such covered dependents of their

continuation coverage rights and responsibilities if it does not include dependent children in the COBRA General Notice distribution.

Process: Newly Covered on COBRA Eligible Plan (COBRA General Rights Notice)

Description: Process followed to distribute the COBRA General Rights Notification to employees and dependents when a client selects this service from HealthEquity/WageWorks.

Step	Timing	Responsibility
Client notifies administrator of employee’s election of benefits via file transfer or website.	Within 14 days of member electing benefits	TPA and Client
Dispatch COBRA General Rights Notice to member.	Within 7 days from coverage begin date	HealthEquity/WageWorks
Document is imaged and posted to the website.	When printed	HealthEquity/WageWorks
An Abstract Syntax Notation (ASN) file is created and uploaded to the USPS.	Daily	HealthEquity/WageWorks
The confirmed mail file containing a record of each piece of mail scanned at the USPS, is downloaded from the USPS and entered into the system.	Daily	HealthEquity/WageWorks

Table 5-1: COBRA General Rights Notice Timeline

Plan Sponsor Responsibility

When the organization first becomes subject to COBRA, an initial COBRA notification should be sent to each insured employee and covered spouse. On an ongoing basis, the employer should provide an initial COBRA notification to any employee and/or spouse who becomes covered under the group health plan.

With the dynamic nature of COBRA legislation, even subtle changes to continuation coverage law can require numerous revisions to the initial COBRA notification. If it has been some time since the employer performed its original distribution of initial COBRA notifications or are uncertain of the accuracy of the notification, re-distribution should be considered.

HealthEquity/WageWorks provides an optional service to perform the initial COBRA notification requirement on the employer’s behalf. Unless this optional service is requested, the employer is responsible for distributing the initial COBRA notification to the active insured employees and their covered spouses.

HealthEquity/WageWorks is not responsible for developing, maintaining, or updating the contents of the initial COBRA notification when clients choose to self-administer this COBRA requirement.

Recommendations for distribution and mailing are outlined below.

Guidelines for Distributing COBRA General Rights Notice

Federal law requires employers subject to COBRA to distribute an initial COBRA notification to each employee and spouse covered under the group health plan. Clients are discouraged from distributing initial COBRA notifications in person or as a payroll stuffer because these methods do not serve to inform a covered spouse of his/her COBRA rights. Similarly, simply posting the notice on a company bulletin board does not satisfy good faith COBRA compliance.

Instead, good faith compliance requires that clients address the initial COBRA notification to the last known mailing address of each insured employee and covered spouse. The notice should be sent in a manner consistent with the DOL’s generally applicable requirements using measures reasonably

calculated to ensure actual receipt of the material. If the employee and spouse reside at the same address, one notice addressed to all individuals will suffice. If the employee and spouse live at different addresses, a separate notice must be mailed to each address.

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

Optional COBRA Administration Service

As an optional service, HealthEquity/WageWorks will distribute the initial COBRA notifications on behalf of the plan sponsor. Note that separate initial COBRA notifications must be sent to family members who reside at a different mailing address from the employee.

This optional service includes:

- Reports that comply with COBRA and are available to the client for documentation and archival purposes
- Reports available to the client that indicate all notices returned by USPS due to invalid mailing addresses
- Customer service support via the website, email, telephone, and fax
- Process and information available for employees and dependents to report divorce, legal separation, or loss of dependent status qualifying events to the employer

Contact a HealthEquity/WageWorks representative to obtain more information about this optional service.

When a Qualifying Event Occurs

Clients or employers are responsible for identifying and communicating qualifying events to HealthEquity/WageWorks. The most common qualifying event is employee termination or reduction in hours of employment. However, qualifying events can also include divorce or legal separation, employee death, employee Medicare entitlement (under Part A, Part B, or both), or a child ceasing to be a dependent under the plan.

In the case of a divorce, legal separation, or a child losing dependent status under the plan, the employee or family member must notify the employer or plan administrator within 60 days after the date of the qualifying event or the date on which the qualified beneficiary would lose coverage because of the qualifying event, whichever is later. Timely notification from either the employee or a qualified beneficiary would satisfy the notice requirement to report a qualifying event. If timely notification is not made, COBRA continuation does not need to be offered. However, be aware that this 60-day notification requirement to inform the plan administrator of a qualifying event may not be enforced if the employer failed to provide an initial COBRA notification to the employee and/or spouse upon plan coverage.

Generally, an employer has 30 days to notify the plan administrator of a qualifying event. Once notified, the plan administrator must provide a COBRA election notice to the qualified beneficiary within 14 days. Clients or employers should communicate qualifying events to HealthEquity/WageWorks immediately so that COBRA time frames can begin promptly. HealthEquity/WageWorks requests notice of qualifying events within 14 days of the event.

Upon notice of a qualifying event, HealthEquity/WageWorks sends a COBRA election notice to eligible qualified beneficiaries. This notification provides detailed information about COBRA continuation coverage and includes specific instructions for electing continuation coverage, lists available group health benefits, and discusses premium guidelines.

Plan Sponsor Responsibility

Perform one of the following actions immediately after a qualifying event:

1. **Website Notification** - Immediately following a qualifying event, access the HealthEquity/WageWorks website and submit a qualifying event. The confirmation page may be printed and kept with the employee records for future reference.
2. **File Transfer Notification** – Immediately following a qualifying event, process the termination as appropriate in the organization’s Human Resource Management System (HRIS)/Payroll system. A file should be sent to HealthEquity/WageWorks on at least a weekly basis. The file will be processed, and appropriate notices mailed to qualified beneficiaries. It is important to review the processing report in a timely and thorough manner.

Alternative Coverage

Qualified beneficiaries do not have to purchase COBRA continuation coverage to have health insurance. Other coverage options are available to them through the [Simply Covered program – a key component of our COBRA administrative services](#). Simply Covered is a turnkey program that does not require additional administrative support from your staff. Your former employees can benefit from:

- Free printed materials and access to www.simplycovered.com, an online resource that offers in-depth information about COBRA, exchanges and Medicare.
- Knowledge advocates who answer COBRA-related questions and transfer calls to experienced, licensed benefits advisors.
- No-cost no-obligation access to licensed benefits advisors who can help individuals:
 - Understand all of their coverage options, including COBRA, individual and family plans (both on and off exchanges), and Medicare
 - Determine eligibility for a subsidy from the government, and if so, how much.

Alternatives to COBRA include the following:

- **Health Insurance Marketplaces** - Health insurance marketplaces (known as “Exchanges”) give individuals the option to purchase coverage from insurance carriers participating in the marketplace. Depending on their income, they may qualify for federal tax credits to help pay for coverage purchased through the marketplace.
- **Individual and Family Plans** – Individuals can purchase plans that cover themselves, their spouse or life partner, just their children, or their entire family.
- **Coverage through a New Client** – Individuals may find coverage with a new employer’s plan. Depending on the plan rules, there might be a gap in coverage. If they don’t want to go without coverage, they may elect COBRA continuation coverage for this brief span or purchase a short-term medical plan through SimplyCovered.com.
- **Coverage through a Spouse’s Plan** – If a spouse is employed, the individual may be eligible for coverage under their spouse’s employer plan. HIPAA mandates that group health plans provide special enrollment rights to individuals in certain circumstances. These special enrollment rights allow enrollment in the plan without having to wait until the plan’s next regular enrollment period.
- **Coverage as a Dependent** – Qualified beneficiaries may be able to get coverage under their parent’s plan until they turn age 26. As part of health reform, group health plans that offer coverage to dependents extend coverage to “young adults” until their 26th birthday.
- **Medicare** - Medicare is health insurance for people age 65 or older or people under age 65 with certain disabilities. Medicare is also available to anyone with end-stage renal disease, regardless of age.

Administration Services

Upon receipt of a qualifying event via file transfer or website entry, HealthEquity/WageWorks will:

- Send an election notice and Certificate of Creditable Coverage via USPS Certificate of Mailing to the qualified beneficiary (addressed to all covered dependents)
- Make available a report indicating incorrect or undeliverable addresses
- Provide additional notices to dependents living at different addresses (as the address is made available by client or member) and archive proof of all efforts to mail required notices
- Automatically track election periods and time frames related to electing or declining continuation coverage
- Review and process election
- Apply payment to appropriate accounts as applicable and return payments that are not within COBRA guidelines
- Report elections and non-elections to client
- Update eligibility as established by the client (upon appropriate date and to appropriate contacts)
- Answer telephone, email, and fax inquiries from qualified beneficiaries

Process: When a Qualifying Event Occurs (when a client has selected this service from HealthEquity/WageWorks)

Description: Process that takes place when a qualifying event occurs and HealthEquity/WageWorks is notified.

#	Step	Timing	Responsibility
1.	Client sends a file to administrator via email, FTP or website.	Weekly	TPA and Client
2.	Qualifying event processed via file transfer (unless via website).	Within 48 hours of receipt	HealthEquity/WageWorks
3.	HIPAA certificate and COBRA election notices are queued automatically.	Within 48 hours after file is loaded	HealthEquity/WageWorks
4.	The auto-generated HIPAA certificate is placed in the system document print queue.	Daily	HealthEquity/WageWorks
5.	Document specialist will batch the notices.	Daily	HealthEquity/WageWorks
6.	The automated system will electronically print two records: (1) imaging attached to and viewable on the member's record on the website, and (2) sent to printer.	Daily	HealthEquity/WageWorks
7.	Printer prints the notice on plain paper.	Daily	HealthEquity/WageWorks
8.	The document specialist reviews notice for quality assurance.	Daily	HealthEquity/WageWorks
9.	The quality assurance process begins with the document specialist and client services specialist/account manager reviewing 10-20% of the printed notices for accuracy of content. If an error is found, 100% of the batch is reviewed.	Immediately after documents are printed	HealthEquity/WageWorks
10.	The client services manager researches and resolves the error(s).	Within 24 hours	HealthEquity/WageWorks
11.	For all incorrect notices, the document specialist removes the selected printed forms and destroys them before moving those notices from a print status back into a queue status to be reprinted with the correct information.	Daily	HealthEquity/WageWorks
12.	The document specialist and client services specialist/account manager repeats steps 5 through 10 and conducts quality assurance on 100% of the corrected notices.	Daily	HealthEquity/WageWorks

#	Step	Timing	Responsibility
13.	If the quality assurance check is acceptable based on current policy and procedure, the document specialist will place the notices in the document processor to be folded and stuffed in an envelope.	Same day notice prints	HealthEquity/ WageWorks
14.	The document processing machine applies postage to the envelope.	Immediately after the notice is placed in the envelope	HealthEquity/ WageWorks
15.	The documents are then placed in the USPS collection trays and couriered to the U.S. Post Office by 6 p.m., Monday – Friday.	Daily	HealthEquity/ WageWorks
16.	An Abstract Syntax Notation (ASN) file is created and uploaded to the USPS.	Daily	HealthEquity/ WageWorks
17.	The confirmed mail file containing a record of each piece of mail scanned at the USPS is downloaded from the USPS and entered into the system.	Daily	HealthEquity/ WageWorks

Table 5-2: Qualifying Event Timetable

Please note: Documents queued are generally batched and printed on the same business day. The file is a record for the USPS of notices that have been mailed.

Process of Qualifying Event in the System

Health Care Provider Inquiries

HealthEquity/WageWorks is required to make a complete response to any inquiry from a health care provider regarding a qualified beneficiary’s right to plan coverage during the 60-day COBRA election period. Similar requirements exist to provide the status of COBRA coverage when health care provider inquiries are made during applicable monthly premium grace periods.

Process: COBRA Non-response Timing

Description: Process followed if the member does not return the COBRA Election Notice.

Step	Timing	Responsibility
The member is sent a COBRA Election Notice and plan alternative	Within 44 days of the qualifying event	HealthEquity/ WageWorks
The member must return the notice within 60 days from the date of the notice (or date of loss of coverage, if later)	Within 60 days of the notice	Employee or Qualified Beneficiary
The system automatically issues COBRA election expiration date to member’s account based on date the notice was mailed	After the notice has been marked mailed	HealthEquity/ WageWorks
If the Election Notice is not returned, the system automatically cancels the member’s account	The day following the expiration date	HealthEquity/ WageWorks

Table 5-3: COBRA Non-response Timetable

Please note: If Election Notice service is selected and the Election Notice is received after the account has been canceled with a postmark date on or before the expiration, the account will be reinstated and the election will be processed.

Document Control

All legal communication notifications are sent to members via the USPS Certificate of Mailing Service.

HealthEquity/WageWorks uses a batch-controlled, fully logged process for queuing and tracking notices required by COBRA and HIPAA law. Before a notice can be queued by the system, the following variables must be in place:

- A client record must be created, and an administrative contact record added.
- A contract must be configured for the client, including a contract start date.
- For each service to be performed, a contract item must be added to the system contract.

HealthEquity/WageWorks queues each of its notices on a variety of criteria, depending on the notice type. Once a notice is queued, it goes into the HealthEquity/WageWorks notice queue pending printing. Notices can also be manually queued by HealthEquity/WageWorks personnel or by client request.

Notice Type	Queuing Criteria
CLH01 – HIPAA Initial Rights Notification	Service is on client contract, and employee is loaded into the system with a hire date that is greater than or equal to the contract effective date. Hire date can be earlier if retro notices are contracted.
CLC01 – COBRA General Rights Notice	Service is on client contract and employee is loaded into the system with a coverage start date that is greater than or equal to the contract effective date. Hire date can be earlier if retro notices are contracted.
CLC02 – COBRA Election Notice and Plan Alternatives	Service is on client contract; qualifying event is processed; employee was covered day prior to the qualifying event on a COBRA eligible plan. Notice is not queued until after the qualifying event date unless otherwise requested by client.
CLH02 – HIPAA Certificate	Service is on client contract; qualifying event is processed; employee had creditable coverage at the time of the qualifying event. Notice is not queued until after the qualifying event date unless otherwise requested by client.
CLH03 – HIPAA Certificate after COBRA	Service is on client contract, when an employee elects and pays for at least one month of COBRA and then is canceled from COBRA.
CLC04 – Cancellation Notice	Notice is sent when a member is canceled from COBRA.
CLC29 – Rate Change Notice	When a rate change occurs, this notice is mailed to active continuants affected by the rate change.
CLC27 – Member Invoice	Monthly invoice is sent when an employee elects COBRA or is entered into the system as a continuant.
CLC09 – Past Due Notice*	Notice is sent 15 days before the deadline date for past due members, if contracted.
CLC11 – Rate Change Notice For Election Period Members	When a rate change occurs, this notice is mailed to terminated employees in their election period.
CLC13 – COBRA Expiration Notice	Notice is sent when a member’s 18, 29, or 36-month COBRA period will expire within 60 days.
CLH07 - Women’s Health and Cancer Rights Act (WHCRA) Notice	Service is on client contract and employee is loaded into the system with a coverage start date that is greater than or equal to the contract effective date; sent annually thereafter for the duration of the client contract or employee’s enrollment in the health plan, whichever date is earlier.

Table 5-4: Queue Criteria by Notice Type

**Not sent via USPS Certificate of Mailing Service*

HealthEquity/WageWorks generally batches and prints everything on the same business day that it is queued. The document server creates a print batch of all the queued notices by form type. Included with each form is also a printed proof of mail document, an image file that is attached to the member’s record, and a copy of the document.

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

The monthly activity and billing statements reflect the notices that HealthEquity/WageWorks has sent to members.

When a Qualified Beneficiary Elects and Pays for COBRA Continuation

When COBRA continuation coverage is elected, HealthEquity/WageWorks will send the qualified beneficiary a monthly invoice. A qualified beneficiary has 45 days from the postmarked date of the election by which to remit the initial premium.

Administration Services

Upon receipt of a qualified beneficiary’s election form, HealthEquity/WageWorks will:

- Verify timeliness of election
- Send a premium invoice to the qualified beneficiary
- Communicate eligibility to appropriate insurance carriers (if contracted)
- Return incomplete election notice
- Collect, record, and process all premiums

Process: Electronic Eligibility Feed for COBRA (when a client has selected this service from HealthEquity/WageWorks)

Description: Process followed to manage electronic eligibility feed for COBRA members.

Step	Responsibility
Eligibility codes are programmed in the system for a specific carrier, which include plan names, plan numbers, plan types, etc.	HealthEquity/WageWorks
The data exchange parameters are set up in the system. The encryption policy – PGP, WinZip with password, or static password, and the FTP server site, user ID, and password is set up.	HealthEquity/WageWorks
The delivery parameters are set up in the system as monthly, weekly, or daily scheduled eligibility reports.	HealthEquity/WageWorks
The system will generate the electronic eligibility report based on the frequency chosen in the above step, with the first report starting from the date the delivery parameters are set up. The electronic report is sent to the DocQ Server for delivery.	HealthEquity/WageWorks
The DocQ Server sends reports based on the time each report is received into the queue.	HealthEquity/WageWorks
The DocQ Server automatically audits itself to review all electronic reports not delivered and will continue to attempt delivery beginning with the oldest undelivered report.	HealthEquity/WageWorks
After three unsuccessful delivery attempts, an email report is dispatched to operations to take remedial action.	HealthEquity/WageWorks

Table 5-5: Eligibility Feed Process Table

Process: Urgent Eligibility Updates

Description: Process followed to manage urgent eligibility updates for COBRA members.

Step	Timing	Responsibility
For member calls requiring an urgent eligibility update, the member services advocate (PSA) will determine which carrier(s) will need to be updated and queues the Urgent Eligibility Update report.	During the phone call	HealthEquity/WageWorks
The Urgent Eligibility Report is delivered to the appropriate carrier contact within minutes after being successfully queued. The PSA advises the member the urgent update can take up to 2 to 3 business days for the carriers to update their systems.	Immediately	HealthEquity/WageWorks
When telephone contact is required, the PSA forwards the case to an eligibility representative for processing. When urgent updates are sent via email or fax, they are automatically processed.	Immediately	HealthEquity/WageWorks

Table 5-6: Urgent Eligibility Process Timetable

Premium Collection

By law, qualified COBRA beneficiaries may pay for continuation coverage on a monthly basis. COBRA premium payments are due on the first day of the month for the month of coverage, with a 30-day grace period. These guidelines are strictly followed. Qualified beneficiaries must remit premiums directly to HealthEquity/WageWorks, where they are collected throughout the month and deposited into a trust account.

Each month, a statement, remittance report and check (if applicable) is sent to the specified employer contact in the system. The ‘total premiums remitted’ amount on the Client Remittance Report shows the total premiums returned to the client.

When a premium payment received is insignificantly less than the amount due (i.e., the payment shortfall is less than or equal to the lesser of \$50 or 10 percent of the COBRA premium required by the plan), HealthEquity/WageWorks will notify the qualified beneficiary and allow 30 days to pay the deficit, according to the notice procedures described in the IRS COBRA regulations.

Please note: Clients utilizing the HealthEquity/WageWorks optional carrier remittance service will receive a separate summary report with their monthly activity report, which lists COBRA member names and carriers who have been forwarded the premiums.

Plan Sponsor Responsibility

The plan sponsor will be responsible for performing the following instructions upon receipt of a monthly premium statement and check from HealthEquity/WageWorks.

Please note: It is the employer’s responsibility to perform the reconciliation and immediately report any discrepancies back to HealthEquity/WageWorks (regardless of who forwards premiums to the carrier). Failure to do so may result in unnecessary costs to the employer.

Instructions	Explanation
Receive a monthly COBRA premium statement and check from the administrator.	This memorandum lists the qualified beneficiaries' names, types of coverage, and premiums we have collected throughout the month.
Remit premium payment to the insurance carrier according to the standard operating procedures.	If the optional service of carrier remittance has been selected, HealthEquity/WageWorks will remit to selected carriers as appropriate. If the optional service has not been selected the plan sponsor is responsible.
Review the monthly billing statement from the insurance carrier.	Confirm that the correct qualified beneficiary names and corresponding premiums listed on the premium statement also appear on the insurer's subscriber listing, and vice versa.

Table 5-7: Plan Sponsor Responsibility Table

By law, qualified beneficiaries are entitled to a 30-day grace period measured from the premium due date. HealthEquity/WageWorks sends the premium reimbursement on the 10th business day of the month for the prior month's premiums. Therefore, when continuation coverage is established for a COBRA member (the qualified beneficiary has elected coverage, paid initial COBRA premiums, and is reinstated on the plan), and if HealthEquity/WageWorks does not provide carrier remittance services, the employer will need to advance premium funds to the carrier on behalf of its qualified beneficiaries each month to avoid a lapse in coverage.

Advancing funds for COBRA members' premiums is a logistical necessity for many clients who want their active employees' premiums to be sent, received, and posted by the carrier on time without delay due to their COBRA members' 30-day grace period.

Administration Services

HealthEquity/WageWorks will carry out the following for each qualified beneficiary on COBRA continuation coverage:

- Send a courtesy invoice every month (unless ACH)
- Respond to verbal and written requests
- Enforce payment due dates and grace periods to discourage unacceptable partial or late payments
- Verify timeliness of postmark dates and process premium payments
- Administer corrective procedures for checks returned due to insufficient funds

Termination of COBRA Continuation

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

- A written request for termination made by the qualified beneficiary
- Late or non-payment of premium
- Completion of 18-, 29-, or 36-month continuation coverage period
- Client elimination of group health benefits (including successor plans)
- Qualified beneficiary obtains other group health coverage after the date of COBRA election that does not include an applicable exclusion or limitation for any pre-existing condition
- Qualified beneficiary becomes entitled to Medicare after the date of COBRA election
- On the same basis that the plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries

- For an 11-month disability extension, a final determination is made that the individual is no longer disabled

For protection of the plan, it is important that COBRA coverage be terminated promptly. The policy of most insurance companies is to allow a credit if requested within a limited amount of time.

Administration Services

HealthEquity/WageWorks will do the following tasks when a qualified beneficiary’s COBRA continuation coverage should be terminated or canceled:

- Prepare and send a termination letter to the qualified beneficiaries indicating the reason for termination and last date of coverage
- Address written requests for reinstatement by former continuants, including notifying the client when review or a determination concerning the terms and conditions of the plan is necessary. Notify qualified beneficiaries of their conversion option rights within the required time frame for COBRA members who have completed the maximum coverage period (18, 29, or 36 months)
- Report to employer, via the eligibility report, the demographic information of qualified beneficiaries for whom continuation coverage should be terminated or canceled (if this service is selected)
- Remit a HIPAA Certificate of Creditable Coverage to all appropriate parties (if this service is selected)

The following process flows describe the steps taken when a qualified beneficiary terminates coverage for any reason.

Process: Cancellation Request

Description: Process followed to cancel COBRA continuation coverage once a cancellation request is received by a member.

Step	Timing	Responsibility
Written request to cancel coverage is received from member.	N/A	Employee or Dependent
Upon receipt, request is sent to document processing.	Within 24 hours of receipt	HealthEquity/WageWorks
Administrator processes the request.	Within 72 hours of receipt	HealthEquity/WageWorks
Administrator cancels the coverage.	Within 72 hours of receipt	HealthEquity/WageWorks
Administrator sends eligibility file to carrier (if service is selected, otherwise client is responsible for notification to carrier).	Weekly change report, full monthly report	HealthEquity/WageWorks
The carrier cancels the coverage.	Upon receipt of the report	Carrier
Administrator sends early termination letter to member.	Within 48 hours of cancellation	HealthEquity/WageWorks
Administrator sends a post COBRA HIPAA Certificate (if service is selected).	Within 48 hours of cancellation	HealthEquity/WageWorks

Table 5-8: Cancellation Request Process Timetable

Process: Member Canceled

Description: Process followed to cancel COBRA continuation coverage due to non-payment by a member.

Step	Timing	Responsibility
The system cancels members account if premium is not paid by the grace period.	7 days after grace period	HealthEquity/ WageWorks
Administrator sends eligibility file to carrier (if service is selected, otherwise client is responsible for notification to carrier).	Weekly change report, full monthly report	HealthEquity/ WageWorks
The carrier cancels the coverage.	Upon receipt of the report	Carrier
Administrator sends early termination letter to member.	With 48 hours of cancellation	HealthEquity/ WageWorks
Administrator sends a post COBRA HIPAA certificate (if service is selected).	With 48 hours of cancellation	HealthEquity/ WageWorks

Table 5-9: Non-payment Cancellation Process Timetable

Process: COBRA Expiration

Description: Process followed to cancel COBRA continuation coverage due to expiration of the member's coverage.

Step	Timing	Responsibility
The system automatically generates a COBRA Expiration Notice to send to the member.	60 days prior to cancellation	HealthEquity/ WageWorks
The system automatically cancels the member's account.	Day after COBRA expires	HealthEquity/ WageWorks
Administrator sends eligibility file to carrier (if service is selected, otherwise client is responsible for notification to carrier).	Weekly changes file, full monthly report	HealthEquity/ WageWorks
The carrier cancels the coverage.	Upon receipt of the report	Carrier
Administrator sends a post COBRA HIPAA Certificate (if service is selected).	Within 48 hours of cancellation	HealthEquity/ WageWorks

Table 5-10: COBRA Expiration Cancellation Process Timetable

Please note: The notices are queued based on the COBRA eligibility end date and contain conversion rights information.

Benefit and Coverage Changes or Annual/Open Enrollment

Any benefit or coverage changes that affect the employer's group health plan must be communicated to COBRA members. Benefit changes may include changes to the deductible, stop-loss, or co-pay. Plan or coverage changes can include carrier changes, or a new plan being offered in addition to plan options already available. Similarly, as defined by COBRA, an annual/open enrollment period is a period during which a covered employee can choose to be covered under another group health plan, under another benefit package within the same plan, or add or eliminate coverage of family members.

Excessive Waiting Periods Eliminated

Public Health Service Act (PHSA) Section 2708, which was added by the Affordable Care Act, prohibits group health plans and insurers from applying a waiting period exceeding 90 days. The regulations apply to plan years beginning on or after January 1, 2014 for any individuals who are otherwise eligible to enroll in a plan based on the applicable plans and conditions. There are certain instances in which this prohibition does not apply. Two of these include:

- Excepted benefits such as a limited-scope dental plan that is otherwise exempt from PHSA requirements.
- Plans that require specified hours of work per week as a condition of eligibility, and if an employee’s hours vary, it cannot be reasonably determined the employee will regularly meet the plan’s terms.

Please note: Some states may have a shorter time frame requirement for plans subject to those state insurance laws. For example, California Assembly Bill 1083 prohibits insurers and HMOs from applying waiting periods that exceed 60 days for fully insured contracts issued for plan years beginning on or after January 1, 2014.

COBRA requires annual/open enrollment rights to be extended to qualified beneficiaries in any case when they are extended to active employees. Accordingly, when benefits and/or coverage changes or the company offers annual/open enrollment rights to active employees, the company must also provide the opportunity for COBRA qualified beneficiaries to make changes or modifications to their group health plan.

During annual/open enrollment, it is possible for a qualified beneficiary to add coverage for a family member who may have declined or was not entitled to continuation coverage during the original COBRA election period. Note that this individual, when added to the plan after the COBRA election period at annual/open enrollment, is not considered a qualified beneficiary.

The HealthEquity/WageWorks standard services include notification to COBRA members of rate changes for existing plans. For an additional fee, HealthEquity/WageWorks can distribute benefit plan materials and enrollment forms to the COBRA members. Otherwise, clients are responsible for duties related to carrier changes or other plan benefit modifications.

Contact your HealthEquity/WageWorks representative to coordinate the communication of the benefit plan changes to COBRA members.

Administration Services

Upon learning of the annual/open enrollment period, HealthEquity/WageWorks will:

- Generate and send an annual/open enrollment letter to the COBRA members
- Process annual/open enrollment elections
- Bill and collect premium adjustments as necessary

Process: Annual/Open Enrollment Process

Description: Process followed for large group open enrollment when conducted annually.

COBRA	Timing	Responsibility
The administrator sends annual/open enrollment agreement to client via email.	90 days prior to plan start date	HealthEquity/WageWorks
The client completes annual/open enrollment paperwork and returns it to administrator.	60 days prior to OE mail date	Client
Annual/open enrollment requirements meeting is held for administrator and client.	35 days prior to OE mail date	Client and HealthEquity/WageWorks
New plans and eligible employees/dependents are provided to administrator.	28 days prior to OE mail date	Client
New rates, plans, and eligibility are loaded.	28 days prior to OE mail date	HealthEquity/WageWorks

COBRA	Timing	Responsibility
COBRA rates and eligibility rules are reviewed.	21 days prior to OE mail date	Client
Correction period - applicable corrections are made by the administrator.	21 days prior to OE mail date	HealthEquity/WageWorks
Conduct final review for COBRA rates, available rules and eligibility rules.	14 days prior to OE mail date	Client
Approve COBRA rates and eligibility rules.	14 days prior to OE mail date	Client
COBRA custom text is provided to administrator for communications (if applicable).	14 days prior to OE mail date	Client
COBRA annual/open enrollment communications documents are generated and provided to client for review.	14 days prior to OE mail date	HealthEquity/WageWorks
Communications review - applicable changes are sent to the administrator.	14 days prior to OE mail date	Client
Correction period - corrections are made by the administrator (if applicable).	14 days prior to OE mail date	HealthEquity/WageWorks
Inserts for open enrollment packets are provided to the administrator.	2 weeks 14 days prior to OE mail date	Client
Final COBRA annual/open enrollment communications documents are generated and provided to client.	7 days prior to OE mail date	HealthEquity/WageWorks
Annual/open enrollment packet is approved.	7 days prior to OE mail date	Client
Annual/open enrollment packets are mailed.	14 days prior to OE go live date	HealthEquity/WageWorks
Go Live - annual/open enrollment for COBRA members.	Based on OE dates	Employee, Client, and HealthEquity/WageWorks
Members return annual/open enrollment notice to administrator for processing.	Based on OE dates	Employee
Administrator processes enrollments.	Daily as received	HealthEquity/WageWorks

Table 5-11: Annual/Open Enrollment Process Timetable

Please note: This timeline may require alterations depending on the complexity of the account.

Carrier Rates and Submission Deadlines

Some states require that members be given advance notice prior to any increase in rates. In order for HealthEquity/WageWorks to bill the increased rates as of their effective date, we must receive your final updated rate information no less than 45 days prior to the effective date of the increase.

HealthEquity/WageWorks understands that the carriers may not always provide the new plan rates 45 days prior to the renewal date; however, it is critical that employers work diligently to provide HealthEquity/WageWorks with the updated rates in order to meet the requirements. In accordance with this policy, the employer is responsible for absorbing the difference for any period in which HealthEquity/WageWorks is not able to bill the updated rate to members.

When submitting rates to HealthEquity/WageWorks, the cost of the plan should also include applicable fees (e.g., ACA-related fees). If this information is not provided during the initial submission, additional processing time will be required.

If further clarification is needed, please contact your HealthEquity/WageWorks Service Delivery Manager or Client Services team.

A Special Note for California Employers

California Insurance Code Section 10199.1(b) prohibits fully insured group health plans subject to California state insurance laws from increasing premiums without providing written notice of the increase at least 60 days prior to the effective date of the increase. To help ensure your affected COBRA participants are provided timely notice, we must receive this completed form **no later than 75 days prior to the start of your determination period.**

Adding a New Division

HealthEquity/WageWorks should be contacted when the company is part of a business reorganization that results in the merger or acquisition of a new division, affiliate, or subsidiary. The plan sponsor must inform HealthEquity/WageWorks if management reports and correspondence is to be sent separately to the new division or directed to the current company contacts. The plan sponsor must also notify HealthEquity/WageWorks of any qualified beneficiary takeovers for whom HealthEquity/WageWorks must assume continuation coverage tracking and billing.

COBRA and the Summary Plan Description

A Summary Plan Description (SPD) is a written document required by ERISA, which employers must distribute to employees who participate in company health and welfare benefit plans. An SPD provides employees with non-technical answers to general questions about employee benefits, company policies, and COBRA continuation coverage. An explanation of COBRA in an SPD informs employees of their continuation coverage rights in the same context as other employee benefits and must be included as mandated by 1998 proposed regulations issued by the Department of Labor (DOL).

Recent court cases reinforce the importance of incorporating a thorough and meticulous discussion of COBRA in a company SPD. Even though an employer may use comprehensive initial COBRA notifications and election notices, court decisions have hinged on COBRA omissions and inaccuracies within company SPDs to substantiate judgments against employers. For this reason, it is recommended that legal counsel review the SPD to ensure that information is accurate and consistent with other COBRA written materials.

At a minimum, the SPD should contain a description of COBRA rights and obligations related to continuation coverage for qualified beneficiaries and an explanation of qualifying events. Information about premiums, notices, election requirements, and duration of continuation coverage should also be included. Additionally, the plan sponsor may wish to incorporate information about relevant state laws that pertain to continuation coverage.

In 1998, the DOL proposed regulations that approve the use of the SPD as a means for satisfying the initial notification required by COBRA. However, employers that choose to furnish the initial COBRA notification in this manner should be aware of the difference in distribution requirements between the initial notification of COBRA and that of the SPD.

Under general ERISA requirements, an employer or administrator has up to 90 days after an employee becomes a participant in the plan to distribute an SPD. COBRA law, however, requires that the employer or plan administrator provide written notice of COBRA rights to each insured employee and covered spouse when coverage begins. Therefore, an employer or plan administrator that chooses to use an SPD that includes required COBRA disclosure information to satisfy the initial notice of COBRA

rights, must furnish the SPD to both the insured employee and covered spouse at the commencement of coverage (as opposed to distribution only to the employee during the 90-day period following the commencement of coverage).

Employers and administrators are advised to refrain from providing the initial COBRA notification solely by SPD distribution as described above and to maintain these as separate notice requirements.

SECTION 6 – THE HEALTHEQUITY/WAGEWORKS WEBSITE

Hardware Specification

An Internet connection is required to access our website. Valid access connections include dial-up, DSL, cable modem, and LAN (T1).

Firewall

If the user has a firewall, port 443 must be open to allow secure communications through the firewall. If you are not sure if your system has a firewall, go to our website and click the Clients link. If no message appears, your company probably has a firewall blocking this port, and the user must contact their network administrator for assistance.

Software Specification

Microsoft Internet Explorer version 6.0 or higher is needed to access our website. Upgrade at no cost by going to the Microsoft website (<http://windows.microsoft.com/en-US/internet-explorer/downloads/ie>). Mac users will need to download Internet Explorer for Mac (<http://internet-explorer-for-mac.en.softonic.com/mac>).

Login

HealthEquity/WageWorks will provide the client with a username and password to access the company's records through the website. Once you have received your username and password, you can log in to the website. For help with username and/or password problems, or other technical issues, please contact your Service Delivery Manager or Client Services team.

Home

The home page is where to find general contact information, regulatory changes, and system enhancements. Take a moment to read any messages that identify new information. Once you log in to your account, you'll see the Client Access Homepage.

Client Setup

The Client Setup page allows the user to view client information. There are seven different sections within Client Setup. The sections are as follows:

- **General** – Plan sponsor information, member count, number of continuants, and historical turnover rate.
- **Services** – A summary list of services being provided by HealthEquity/WageWorks. If this list does not match the client's understanding of the services HealthEquity/WageWorks should be providing, please notify us immediately.
- **Contacts** – HealthEquity/WageWorks maintains a contact list for all key contacts associated with the relationship including executive, administrative, billing, and carrier contacts.
- **Divisions** – Displays the different divisions within the client's company.
- **Employee Classes** – Existing member classes currently in our system.

- **Security** – A list of users with access to the records. Administrative users can view this list. Administrators should visit this webpage periodically to verify that only authorized users have access to the records.
- **Configuration Summary** – A summary of all plan sponsor settings for client and health plan information.

Health Plans

Carriers

Carriers or TPAs for the company's health plans should be set up under the Carriers tab.

Plans

Health plans are the options that clients select when choosing their options such as a PPO or HMO.

Rates

The Rates tab gives users a list of all carriers, plans, and rates that are configured in the system. Clients are encouraged to print and validate these rates, since these are the amounts that will be billed to COBRA continuants and remitted to the plan sponsor.

Enrollment Periods

Under the Enrollment Periods tab, users can view enrollment periods defined for rate changes and/or annual/open enrollment periods.

Eligibility

This tab will give users the ability to verify existing eligibility notations by plan.

Plan Availability Rules

This section will allow users to view existing plan availability rules.

Reports

The Reports section includes a list of reports scheduled for delivery. Users can view new reports and see a history of reports. Common reports configured under this tab include eligibility reports, reinstatement notifications, and cancellation notifications. Our website gives the plan sponsor access to COBRA member reports, which are always available. Below is a list of the reports:

Eligibility

- **COBRA Continuation Pending Report** – List of members who are in their 60-day waiting period and their election expiration date (deadline)
- **Status of COBRA Continuants** – Shows COBRA member's payment status and coverage details; member inquiry can also be accessed through this option
- **Status of Direct Bill Members** – Shows direct bill member's payment status and coverage information; member inquiry can also be accessed through this option
- **Status of Direct Bill Members with History** – Shows direct bill member's payment status and coverage information, including history
- **Canceled Eligible Employees and Continuants** – This report includes members who were eligible to elect COBRA but never elected coverage; it also includes a list of members who were canceled for non-payment of premium

- **Future Qualifying Events** – The events will not be processed completely until the actual qualifying event date passes, depending on your account setup
- **Covered Members by Plan** – Displays historical information of members on a plan
- **All Covered Employees by Plan** – Lists all employees that are covered by plan
- **COBRA Continuant as of December 31 of the Prior Year by Plan** – Historical lists of members most frequently used for employers' 5500 form filing requirements, sorted by plan
- **COBRA Continuant as of December 31 of the Prior Year by Member** – Historical lists of members most frequently used for employers' 5500 form filing requirements, sorted by member
- **Members in COBRA Election Phase with Effective Dates Prior to December 31 of Previous Year by Member** – Historical lists of members in election phase who have effective dates prior to December 31 of previous year

Scheduled Reports

This area has a list of reports that have been scheduled for delivery. Users may view new reports and look up the history of scheduled reports that have been sent. Common reports configured under this tab include eligibility reports, reinstatement notifications, and cancellation notifications.

Exception Reports

- **Returned Mail Report** – If mail is returned to HealthEquity/WageWorks as undeliverable, the information will be available in this report. If the address needs to be updated, go to the Member Search webpage, click Update, and enter the new information.
- **Ineligible Dependents of Employee Report** – Run this report at least once a month to stay current as to when a dependent ceases to be eligible for active or COBRA benefits due to the limiting age. A qualifying event may be processed directly from this report. HealthEquity/WageWorks will NOT automatically terminate an ineligible dependent due to limiting age.
- **Ineligible Dependents of COBRA Members Report** – This report uses the earliest non-student and student age limits based on the configuration of each of your carriers. If you have different age limits for your various carriers, some of the dependents on this report may not be ineligible. A qualifying event may be processed directly from this report to remove a dependent from the report.
- **Ineligible Dependents of Direct Bill Members Report** – This report uses the earliest non-student and student age limits based on the configuration of each of your carriers. If you have different age limits for your various carriers, some of the dependents on this report may not be ineligible.
- **COBRA Members with Impending Medicare Eligibility Report** – This report should be used to determine when COBRA eligibility should end because of Medicare eligibility. This report could potentially display Medicare-eligible members, who should not be canceled. Please consult with legal advisors before canceling COBRA based on information contained in this report.
- **Dependent Coverage Exception Report** – When dependent information is not complete and accurate or when a dependent's coverage option does not match the family configuration, users can either update the HealthEquity/WageWorks records here or mark them as acceptable to remove this exception from the report.
- **Active Employee Compliance Status for Initial Rights Notifications** – General summary showing purchased or unpurchased Initial Rights Notification compliance status for active employees.

Client Activity

Users can use the Client Activity webpage to retrieve statistical COBRA member information, found under the Reports tab, Activity Reports page. Data can be retrieved by a submission date range or time period. Users then have the option to sort the data by date, employee name, activity type, or Social Security number. For example, if the DOL wants to see all of the HIPAA notices sent out to a particular employee, the company would select the activity type option. Then select HIPAA Rights Sent by Client from the pull-down menu. After displaying the results, the view option can be used to access the Member Inquiry webpage for a particular client.

Employees

Users may generate a report that lists the plan sponsor members by employee name, COBRA continuants, employee and continuants, and selected division.

Monthly Reports

- **Premium Statements** – Monthly statements listing qualified beneficiaries' names, types of coverage, and premiums collected throughout the month.
- **Fee Invoices** – Monthly plan sponsor account fee invoice using a breakdown of administration, activity, and setup fees.
- **Divisional Premium Statements** – Monthly premium statements by division.
- **Divisional Fee Invoices** – Plan sponsor account fee invoice by division.
- **Client Remittance Report** – Provides detail to support the net settlement check for COBRA and Direct Bill clients.
- **Carrier Remittance** – Shows members who have elected and paid for COBRA continuation coverage through the active coverage period. If there is more than one health plan, the report will have multiple pages.
- **Supplemental Fee Invoice** – Lists members that make up Direct Bill billing line item in fee invoice.
- **Select Monthly Reports by Time Frame** – Allows you to select a specific month (via dropdowns) for Premium Statement, Fee Invoice, and Carrier Remittance.
- **Severance Statements** – Invoices applicable to pay carrier clients when a member is on severance.
- **941 Subsidy Reports** – Historical reporting used during American Recovery and Reinvestment Act (ARRA).
- **Subsidy Admin Fee Detail Report** – Lists members that make up administrative fees line item in Premium Statement.

Please note: Adobe Acrobat Reader software is needed to view and print statements and fee invoices. Adobe Acrobat Reader is available to download at no cost from www.adobe.com.

Cases

This section provides tools for viewing client and member case history.

Members

The Member Search webpage is used to view or update employee or dependent records. It is also used to process employee or dependent qualifying events, rehires, disability extensions, and takeovers. Member's information may be found by using several different search criteria. Users can search by Social Security number, employee name, and hire date.

Tips: Social Security numbers can be entered with or without hyphens. Also, when searching by name, users do not need to enter the whole name - searching for "At" in the last name field would return members with last names beginning with "At."

When the appropriate member information has been retrieved, the following options are available:

- **View** – View all history at the member level. Email can be sent to HealthEquity/WageWorks with any questions or concerns about the member.
- **Update** – Make necessary changes to the employee or dependent information including, but not limited to, address, date of hire, date of birth, dependent address, and dependent qualifying event.
- **Qualifying Events** – Process a qualifying event.
- **Rehire** – Make changes to the member information for rehired employees (i.e., address or dependent changes).
- **Disability Extension** – If a qualified beneficiary meets legal requirements for a disability extension, the information can be added in this section.
- **Takeover** – Client will send to HealthEquity/WageWorks the files containing employees with different company numbers. If the client realizes that an employee was listed under a certain company number by mistake, they can go into the takeover option from the Member Inquiry page to correct the mistake.

Data Entry

This is the section where administrative users can enter all new employees, qualifying events, dependent qualifying events, and takeover continuants. Please visit the data entry interface for COBRA and HIPAA compliance communication page any time activity has taken place that requires action on our part.

New Employee: Enter the Social Security number of the employee to be added. If this employee is already present, users will be able to view the records; otherwise, users will be taken to a form for entering the employee information.

Qualifying Event: Enter the Social Security number of an employee who has been terminated. If HealthEquity/WageWorks already has records for this employee, users will be able to update those records; otherwise, users will be taken to a form for entering employee and qualifying event information at the same time.

Dependent Qualifying Event: A dependent qualifying event consists of a dependent losing coverage on a COBRA eligible plan. The most common types of dependent qualifying events are divorce/separation and ineligibility of a dependent child. Before a qualifying event can be processed for a dependent, that dependent must already be present in the system as a dependent of the employee. Dependents can be added under employees using member search, clicking the Update link, and adding the dependent information. Locate the dependent information by searching by the employee or

dependent's Social Security number on the Dependent Qualifying Event Form. Press the QE radio button in order to process a dependent qualifying event.

Takeover: A takeover should be entered when a continuant that has previously elected coverage through a prior administrator should be billed by HealthEquity/WageWorks. The billing start date entered on this form determines when HealthEquity/WageWorks will begin billing and remitting premiums for this continuant.

New Employee

Clients have the opportunity to enter new employee's compliance information into the system through the HealthEquity/WageWorks website. If an employee is a rehire, the information should be entered in the Member Inquiry section.

After logging on to the website, select Members and then select Add. Enter the new employee's Social Security number, and the system will perform a search for a duplicate Social Security number. All fields should be completed. The Next button will take users to the Data Verification page. Select Finish to save the new employee's data. A confirmation page will appear showing that the employee and associated dependent(s) were processed into the system.

Qualifying Event

The purpose of the Qualifying Event webpage is to enter a COBRA qualifying event as soon as the employer is notified of the event. The Qualifying Event webpage allows the plan sponsor to view and update member setup information at the same time they are processing a qualifying event. Qualifying events that are submitted via the website are mailed the following business day.

To process a member qualifying event: Log in to the website and select COBRA/HIPAA, and then select the Qualifying Event menu option. Users will be prompted to enter the Social Security number for the member. When the member information appears on the page, select Process QE (if not present, fill in missing information). Then enter and select the event information and all the benefit plan coverage for the member. The Data Validation webpage will appear showing the information that will be processed. It will also show any invalid or conflicting data that will interrupt the processing of the event. When all the event information is validated, you can continue processing the qualifying event. Once the event is processed, a window will appear showing that the event has been processed.

Please note: A qualifying event should be entered upon termination. If a member is already on COBRA when the contract goes into effect, he or she must be entered as a takeover continuant.

Dependent Qualifying Event

To process a dependent qualifying event: After logging in to the website, select the Member Inquiry menu option and create a search criteria for the employee, which will retrieve the employee's information. Next, select the QE option, enter the qualifying event information, and select all the benefit plan coverage for the dependent. The Data Validation webpage will appear showing the information that will be processed. It will also show any invalid and conflicting data that will stop the processing of the event. Error messages in red text will halt the event process. Error messages in blue text will warn of a potential problem that will not stop the processing. When all the event information is validated, the user will continue processing. Once the event is processed, a window will appear showing that the event has been processed.

Takeover Continuants

A takeover continuant should be entered when a member is actively on COBRA or in the waiting period at the time HealthEquity/WageWorks takes over COBRA administration. A takeover continuant can only occur when HealthEquity/WageWorks first becomes the COBRA/HIPAA administrator or when a new division is added as part of a business reorganization that results in the merger or acquisition of a new division, affiliate, or subsidiary. The billing start date will determine the date to begin billing the member. If members are within their 60-day waiting period when the contract goes into effect, they should be entered through the takeover continuant webpage when electing COBRA. The following is the procedure for setting up new takeover continuants.

Takeover continuant information decisions:

1. Who will send a letter to members, and those in their waiting period, advising them of the new COBRA administrator and effective date of change?
2. Will the previous COBRA administrator send HIPAA certificates to continuants for the time that they were under their administration?
3. What is the date that the previous administrator will stop billing members? What day will those bills be mailed?
4. How will the previous administrator communicate current COBRA members to HealthEquity/WageWorks? Which method (e.g., file transfer)? Which format, (e.g., Excel spreadsheet)?
5. How will the previous administrator communicate paid-through dates to HealthEquity/WageWorks?
6. How will the previous administrator communicate credits applied to an account to HealthEquity/WageWorks?
7. What will the previous administrator do with payments received via mail after the case has transitioned to HealthEquity/WageWorks?
8. On which dates will the previous administrator return election notices? Alternatively, will the previous administrator accept election and notify HealthEquity/WageWorks of election and paid-through dates?

Steps for member takeover setup:

1. Log in to the HealthEquity/WageWorks website.
2. Select COBRA/HIPAA, then COBRA Takeover.
3. Enter the member's Social Security number and fill out the information sheet.
4. The data validation webpage will appear showing the information that will be processed. The event process will halt if there are any invalid and conflicting data. Error messages in red text will halt the event process.

Error messages in blue text will warn of a potential problem that will not halt the event process. When all the event information is validated, the user will continue processing. Once the event is processed, a window will appear showing that the event has been processed.

Direct Bill

The Direct Bill section will be used to manage the employer's Direct Bill continuant population including retirees and continuants on leave of absence.

Add

Enter the Direct Bill continuant information to notify HealthEquity/WageWorks to perform direct billing services for a new member.

Reports

Direct Bill specific reporting. The past due report notifies you of Direct Bill members that are past due and gives you the option of canceling them from the plan. The Direct Bill Member with Impending Medicare Eligibility report notifies you when you have members who are approaching Medicare eligibility.

Member Website

Instructions

The member website allows members to access their COBRA or Direct Bill account information. Members are able to view their payment status, election options, and general account information. The website also allows members to make online payments and to add/modify recurring payments.

Login

Members will need to register and create a username and password at mybenefits.wageworks.com to access the member website. After they register and log in to the website, they will be asked to either verify or enter their email address and phone number.

Once enrolled and logged in, members will see the My Accounts page - also referred to as the COBRA home page - that provides a navigation bar on the left for easy access to the following:

- Quick Links – View other plan options offered, if available
- My Accounts – View account billing and payment details
- One Time Payments – View monthly premium due and make online payments
- Automatic Payments – View current selection or add/modify recurring payments
- Notices – View important account notices about account activity

Account Details

Members can view details of their account by clicking My Accounts from the navigation bar.

Billing Information

Members can make one-time premium payments using the One-time Payments webpage.

Members may also set up automatic payments via the Setup Automatic COBRA Payments webpage. Here they can add or modify their payments from either their checking or savings account.

Notices

Members may also view their account notices via the View My Notices webpage.

Resources

My Resources is a comprehensive section that lists resources available to members. This is where they will find the answers to the most frequently asked questions (FAQs).

Troubleshooting

If the member's account information questions are not addressed through the website, they can call the toll-free phone number or submit their questions through the Message Center on the website by clicking Message Center at the top of the webpage, then clicking Submit Online Support Request.

Note: For more details about the member website, ask your HealthEquity/WageWorks representative for our COBRA Continuation Coverage member website Navigation Guide.

SECTION 7 – DIRECT BILL ADMINISTRATION SERVICES

Direct Bill Services

As an extension of conventional billing services, our automated systems and administration resources fully support direct billing programs. Comprehensive, integrated notification, election, and accounting systems are the most cost-effective and efficient way to manage direct billing. Cutting-edge technology allows us to provide competitive billing administration services.

Members also have the option to have premiums deducted directly from their checking or savings account by submitting an Automated Clearing House (ACH) request form. Clients can request that ACH forms be sent to all Direct Bill members.

Direct Bill Administrative Process Overview

Process: Direct Bill Administration Services (if contracted)

Description: Process followed to administer invoices and process payments received for Direct Bill accounts.

Step	Timing	Responsibility
Client sends file of Direct Bill accounts to administrator via email or FTP.	Weekly or monthly	TPA and Client
Records are processed in the system by electronic file from client.	Weekly	HealthEquity/WageWorks
Billing invoice is automatically generated for the member's address on record around the 15 th of each month (if not ACH).	Monthly	HealthEquity/WageWorks
The auto-generated invoices for each member's record are placed in the system document print queue.	Monthly	HealthEquity/WageWorks
A document specialist batches Direct Bill invoices.	Daily	HealthEquity/WageWorks
The system electronically prints two records: (1) imaging attached to and viewable on the member's record on the system (website); (2) sent to printer.	Daily	HealthEquity/WageWorks
Printer prints the Direct Bill invoices on plain paper.	Daily	HealthEquity/WageWorks
Document specialist removes printed Direct Bill invoices from printer for quality assurance.	Daily	HealthEquity/WageWorks
Document specialist and account manager reviews 10-20% of the printed Direct Bill invoices for accuracy and content. If an error is found, 100% of the batch is reviewed.	Daily	HealthEquity/WageWorks
The client services representative/account manager researches and resolves the error(s).	Daily	HealthEquity/WageWorks
Document specialist removes and destroys any incorrect invoices, then moves those invoices from print status back to queue status to be reprinted with the correct information.	Daily	HealthEquity/WageWorks
Document specialist and client service representative/account manager repeats steps and conducts quality assurance on 100% of the corrected notices.	Daily	HealthEquity/WageWorks
If quality assurance check is acceptable, document specialist places notices in document processor for folding and envelope stuffing.	Daily	HealthEquity/WageWorks
Document processing machine applies postage to envelope.	Daily	HealthEquity/WageWorks

Step	Timing	Responsibility
Documents are placed back into USPS collection trays and couriered to U.S. Post Office by 6 p.m., Monday – Friday.	Daily	HealthEquity/ WageWorks
Direct Bill member receives billing invoice and sends premium payment	Monthly	Employee
Administrator receives premium payments from the U.S. Post Office by courier.	Daily	HealthEquity/ WageWorks
Payments are posted on the member's record in the system.	Daily	HealthEquity/ WageWorks
System automatically generates eligibility report (frequency chosen by the employer including paid-through date for member).	Daily	HealthEquity/ WageWorks
If member does not make premium payment within applicable deadlines as defined by group health plan, the member record is automatically generated to Direct Bill Past Due Report on the website.	Daily	HealthEquity/ WageWorks
If payment is not postmarked and received by deadline date, Direct Bill continuants are automatically canceled at midnight following the deadline date or manual terminations are processed on the website by employer or via file transfer.	Monthly	TPA, HealthEquity/ WageWorks, and Client

SECTION 8 – STATE CONTINUATION LAWS

Introduction

This section describes two state laws closely related to, but not technically part of, COBRA that we have incorporated into our administrative product offering as a service for employers who are subject to California and Texas state (post-COBRA) continuation laws.

This section also describes another continuation coverage law used in some states that applies to small employers with two to 19 employees. The Department of Insurance (or similar governing agency) for the state may mandate that health care service plans contracting with companies that meet the COBRA small employer exception must offer state continuation coverage similar to COBRA.

California Continuation Benefits Replacement Act (Cal-COBRA)

Effective January 1, 1998, every group health care service plan that provides coverage to small employers must offer continuation coverage to individuals upon certain qualifying events. A small employer, as defined by Cal-COBRA, is an employer with two to 19 employees during at least 50 percent of its working days during the preceding calendar year.

Cal-COBRA qualifying events include the following:

- Employment termination or reduction in hours of employment
- Divorce or legal separation
- Employee Medicare entitlement (if coverage is lost as an active employee)
- Death of the employee
- A child losing dependent status under a health plan

During the period of Cal-COBRA continuation, plans may charge up to 110 percent of the applicable group rate charged to similarly situated individuals.

While Cal-COBRA is similar to COBRA, it is not an employer mandate. The law obligates health care service plans and insurers to administer the bulk of the law's requirements. Client obligations are limited to notifying the health care service plan of employment terminations and reduction in hours of employment and notifying Cal-COBRA members of impending carrier changes.

With two distinct continuation coverage programs, Cal-COBRA and COBRA, small companies must carefully monitor their employee counts annually to determine which continuation coverage requirement applies for a particular calendar year.

The state of California, Assembly Bill 1401 (found in California Health and Safety Code Section 1363.06 et seq., and California Insurance Code Section 10127.14 et seq.) entitles any individual who experiences a qualifying event on or after January 1, 2003 to 36 months of continuation coverage. The law requires health care service plans, HMOs, and health insurance carriers to offer enrollees of employer-sponsored health care plans who have exhausted continuation coverage at the end of 18 months under federal COBRA guidelines the opportunity to continue coverage for up to 36 months from the date of the original COBRA qualifying event.

The additional 18 months of coverage falls under Cal-COBRA guidelines and charges the insurer with the responsibility of administration. All other Cal-COBRA regulations apply to this additional continuation period in the same manner that they apply to employer groups and individuals that are subject to Cal-COBRA. Please note that any qualifying event that requires 36 months of continuation under federal guidelines will be exempt from Assembly Bill 1401.

The law requires notification of eligibility of extended coverage to be included in the notice of pending termination of the primary 18-month continuation period under federal COBRA. This notice of pending termination was required before the new California law but must now include notice of this new law as well. HealthEquity/WageWorks issues these notices 60 days prior to the termination date and the notices already include an explanation of this entitlement to all eligible continuants who are approaching the end of the federal 18-month continuation period.

Plan Sponsor Responsibility

Clients must notify Cal-COBRA members of any impending carrier changes. Additional employer responsibilities are in the carrier benefits agreement. Check with the carrier on questions regarding specific plan requirements related to Cal-COBRA.

Administration Services

HealthEquity/WageWorks will prepare and mail a Cal-COBRA Continuation Notification letter to each eligible individual upon receipt of notification of a qualifying event, (to the extent that HealthEquity/WageWorks provides COBRA services under the agreement and that state continuation is applicable to the employer's health plan). HealthEquity/WageWorks will process eligible member elections that are received on time, and prepare and mail premium billing to the address of each member for all past and current amounts owed to activate the continuation of coverage. Additionally, HealthEquity/WageWorks collects premiums from members (or third parties on behalf of members where applicable).

California Assembly Bill 1401

The law, addressed in California Health and Safety Code Section 1363.06 et seq. and California Insurance Code Section 10127.14 et seq., extends the continuation coverage period to 36 months for all qualifying events occurring on or after January 1, 2003. The law requires health care service plans, HMOs, and health insurance carriers to offer enrollees of employer-sponsored health care plans, who have exhausted continuation coverage under federal COBRA law, the opportunity to continue coverage for up to 36 months from the coverage start date.

Both Cal-COBRA and federal COBRA laws require notification of the extended coverage be included in the notice of pending termination of COBRA coverage (more commonly known as the conversion notice). By law, this notice requirement is the responsibility of the insurer or HMO, unless otherwise delegated to the employer by contract. The additional 18-month period of continuation coverage is regulated by the same guidelines as Cal-COBRA. Please see the section above that describes Cal-COBRA regulations and procedures.

Plan Sponsor Responsibility

The plan sponsor will not have any administrative duties outside of those stipulated in the group contracts with each insurer.

Administration Services

HealthEquity/WageWorks mails an expiration letter notifying qualified beneficiaries in advance that their 18-month (or 29-month, in the case of a Social Security disability extension) eligibility under COBRA is about to end. This notice communicates options for obtaining coverage at the end of their eligibility period, including information about Assembly Bill 1401 and what it means to them.

HealthEquity/WageWorks will process eligible member elections that are received on time and prepare and mail premium billing to the address of each member for all past and current amounts owed to activate the continuation of coverage.

Additionally, HealthEquity/WageWorks collects premiums from members (or third parties on behalf of members where applicable) as well as communicates member eligibility.

California Health Insurance Premium Payment Program

Effective January 1, 1993, the state of California added Section 2807 to the Labor Code. This amendment requires all employers, public or private, to provide a standardized written description of the Health Insurance Premium Payment (HIPP) Program to all insured individuals who terminate employment.

The HIPP Program offers to pay insurance premiums for Medi-Cal recipients and/or disabled persons with HIV/AIDS who meet eligibility requirements established by the California Department of Health Services.

As the COBRA administrator, HealthEquity/WageWorks is contractually obligated to fulfill only federal requirements pertaining to COBRA, not state requirements, such as Section 2807. However, as a special service to our California clients, HealthEquity/WageWorks has expanded COBRA administration services to include mailing the standardized written notification described above.

For more detailed information regarding the HIPP Program, please read the sample notification from the California Department of Health Services entitled [Notice to Terminated Employees](#). This notification is located at <http://www.dhcs.ca.gov/services/Pages/HIPPOnlineForms.aspx>.

Plan Sponsor Responsibility

Plan sponsor does not have any additional administrative responsibilities.

Texas State Continuation

Under Texas Insurance Code, Article 3.51-6, Section 1(d) (3), continuation coverage privileges are required for any employee, member, or dependent whose insurance under a group policy has been terminated for any reason (except involuntary termination for cause), who has been continuously insured under the group policy (and under any policy with similar benefits it replaces) for at least three months immediately prior to termination.

The provisions apply to any insurer, or group hospital service corporation subject to Texas Insurance Code, Chapter 20, which issues policies providing hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense-incurred basis. The provisions do not apply to policies for specified disease(s) only, accident only, group Medicare supplement insurance, or group CHAMPUS supplement insurance.

If coverage ceases for any reason, the employee, member, or dependent shall have the right to continuation provided:

- (1) The person was continuously covered under the group policy for at least three consecutive months immediately prior to termination (or under any policy providing similar benefits which it replaced); and
- (2) Coverage terminated for any reason except involuntary termination for cause.

Continuation privileges under Insurance Code, Article 3.51-6, Section 1(d) (3) shall not be required for any person under the following circumstances:

- (1) Termination of the group coverage occurred because the person failed to pay any required premium.
- (2) Any discontinued group coverage was replaced by similar group coverage within 31 days.
- (3) The person is or could be covered by Medicare.
- (4) The person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy, or hospital or medical service subscriber contract, or medical practice plan, or any other prepayment plan or any other plan or program.
- (5) The person is eligible for similar benefits whether or not covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
- (6) Similar benefits are provided or available to the person under the requirements of any state or federal law.

A written election must be made no later than 60 days after the later of the date of the termination of insurance under the group policy or the date the employee gave notice. The first premium to the employer/group policyholder must be paid no later than 45 days after the date of the initial election. Subsequent premiums shall be payable to the employer/group policyholder on or before the 30th day after the first of the month in which each payment is due. Each employee, member, or dependent shall have the right to elect continuation coverage, and such election shall not be contingent upon an identical election of any other family member. The premium for continuation shall be the same premium charged for active employees, members, or dependents including any amount contributed by the employer/group policyholder, plus two percent.

Plan Sponsor Responsibility

The carrier is responsible for the timely offer of continuation options and shall provide the continuation notice no less than 30 days before termination or discontinuance; notification of coverage available shall be provided to each employee, member, or dependent whose coverage is terminating. In situations in which the employer or group policyholder becomes aware that coverage will terminate less than 30 days before actual termination, notification will be given to the affected employee, member, or dependent immediately.

In order to eliminate duplicate information requirements and ensure adequate notification to each eligible employee, member, or dependent, delivery of the mandatory notification to each individual within the specified time-period by either the carrier or the employer/group policyholder will satisfy the notification requirements of both the carrier and the employer/group policyholder.

Administration Services

HealthEquity/WageWorks will prepare and mail a State Continuation Notification letter to each eligible individual upon: (a) receipt of notification of a qualifying event, or (b) the expiration of the maximum COBRA coverage period, to the extent that HealthEquity/WageWorks provides COBRA services under the agreement and that state continuation is applicable to the employer's health plan. HealthEquity/WageWorks will process eligible member elections that are received on time, as well as prepare and mail premium billing to the address of each member for all past and current amounts owed to activate the continuation of coverage. Additionally, HealthEquity/WageWorks collects premiums from members (or third parties on behalf of members where applicable) as well as communicates member eligibility.

SECTION 9 – COBRA TERMINOLOGY AND NOTICE DEFINITIONS

Terminology

Carrier: Any commercial insurance company or underwriter that provides insurance protection such as medical, dental, life, and disability for employer benefit plans.

Certificate of Creditable Coverage: Certificate issued upon loss of coverage confirming the member's coverage period under plan sponsor's health plan.

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

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

Continuation Period: The time period a qualified beneficiary may continue their coverage under the employer's plan.

Continuant or COBRA Continuant: Any person entitled to receive continuation of coverage who has elected to do so.

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

Coverage Begin Date (Effective Date): First date of active coverage on a health plan.

Coverage Waiting Start Date (Date of Hire): First day of the waiting period.

Creditable Coverage: All forms of comprehensive individual or group health insurance coverage. For example, group, individual, Medicare, Medicaid, military, Indian Health Service, Peace Corps, CHAMPUS, Risk Pool, etc. It does not include disease-specific or limited coverage plans such as cancer, dental, vision, or hospital indemnity.

Dependent: Any person who is BOTH eligible for coverage and covered as a dependent, spouse, or child under the plan sponsor's health plan on the day prior to a qualifying event.

Disability: Inability to perform all or some occupational duties or, alternatively, any occupation due to a physical or mental impairment. Extension of COBRA benefits is limited to Social Security disabled members and non-disabled family members on coverage only.

Elected Member: An eligible member who has elected to continue health insurance coverage through his or her COBRA eligibility.

Election Period: Time period during which a qualified beneficiary must elect COBRA coverage. The election period must continue for 60 days after the date plan coverage terminates, or if later, 60 days after the date of the election notice from the administrator to the qualified beneficiary.

Eligible Member: A plan member who has experienced a qualifying event.

Elimination Period: The amount of time before benefits become payable under a disability or health plan for the onset of a covered illness.

Employee: Any person who is both eligible for coverage and covered as an employee under the plan sponsor's health benefit plan on the day prior to the qualifying event.

Fiduciary: Under ERISA, a fiduciary is any person who exercises discretionary authority or control over a plan or plan assets or renders investment advice for a fee or other compensation. ERISA fiduciaries must comply with four general rules of conduct:

1. The prudent person rule
2. The diversification rule
3. The adherence to plan documents rule
4. The discharge of his or her duties with respect to the plan solely in the interest of the members and beneficiaries

Grace Period: Time that follows the due date of the premium after which policy discontinuation is enforced.

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

HIPAA Certificate of Creditable Coverage: Certificate that is given to the employee and/or dependents that lose coverage. The certificate identifies the carrier and time the member had coverage.

Initial HIPAA Rights Notification: This notice explains that employees and their dependents may be eligible to receive pre-existing condition credit if they previously had health insurance benefits. It also explains that they are currently able to enroll in the insurance program. However, if they do not enroll during their initial enrollment opportunity, they may be limiting their eligibility for the coverage.

Late Enrollee: Individuals who previously declined coverage. Their enrollment opportunities may be limited to specified time periods as quoted in the employer's contract or plan document.

Look-Forward Period: The 12- or 18-month period during which preexisting condition exclusions may be exercised and begins with the enrollment date.

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

Medicaid: A medical benefits program for low-income people and non-elderly individuals with disabilities, paid for jointly by the federal government and the applicable state, and administered by the

applicable state. Medicaid provides medical benefits to persons who meet certain criteria and whose incomes fall below specified maximums.

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

National Association of Insurance Commissioners (NAIC): An organization that assists state insurance departments whose major function is to draft model laws.

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

Plan Member: An employee or a dependent who is both eligible and covered under the plan sponsor's health plan.

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

Qualified Beneficiary: An employee, spouse of the employee, or dependent child of the employee who became eligible for COBRA continuation because of a qualifying event that was covered on the health plan one day prior to the qualifying event. A "dependent child" of the employee, is defined by the group health plan. In addition, a child born to, adopted by, or placed for adoption with a covered employee during a period of the covered employee's COBRA coverage is considered a qualified beneficiary to the extent that such child is enrolled in accordance with the terms of the group health plan. Also, a child of the covered employee receiving benefits pursuant to a qualified medical child support order (QMCSO), to the extent that such child is enrolled in accordance with the terms of the group health plan, is entitled to the same rights to elect COBRA coverage as any other covered dependent child.

Qualifying Event: The occurrence of any of the following specific events that result in a loss of coverage by a member under the plan(s):

- a. Death of a covered employee or covered retiree
- b. Termination of employment of a covered employee (for reasons other than gross misconduct) or reduction in employee's hours
- c. Divorce and/or legal separation from the covered employee
- d. Covered employee/retiree becoming entitled to Medicare
- e. Dependent children who cease to be eligible as dependents under provision(s) of the plan(s)
- f. Client filing for bankruptcy resulting in loss or substantial elimination of benefits under plans(s) within one year before or after the commencement of bankruptcy proceeding
- g. Any other event resulting in a covered employee and/or dependent becoming qualified to continue coverage under the provisions of COBRA

Qualifying Event Notification: This notice is sent when a plan member (covered employee or dependent) loses insurance benefits because of one of the specified COBRA qualifying events; this notification advises them of their opportunity to continue the coverage. Each member has an opportunity to make a separate continuation decision. The continuation time is determined by the qualifying event.

Significant Break in Coverage: A period of 63 consecutive days during which the individual did not have any creditable coverage. Waiting periods are not taken into account in determining a significant break in coverage.

Special Enrollee: Individuals who become dependents through marriage, birth, adoption, or placement for adoption are allowed to enroll during special enrollment periods without having to wait for the plan's regular annual/open enrollment season.

Waiting Period: The time between an employee's hire and enrollment in a program (eligibility to receive benefits).

COBRA Notice Definitions

Notice	Purpose	Triggering Event	Time frame to Notify HealthEquity/WageWorks	Time frame to Send Notification
COBRA Coverage Election Notice (CLC02)	To offer plans to a member who was enrolled in COBRA eligible health insurance coverage at the time of the Qualifying Event	Loss of coverage due to termination, significant reduction in hours divorce, loss of student status, Medicare entitlement, death of employee or retirement	30 days from the date of the Qualifying Event	14 days from the date the employer notifies HealthEquity/WageWorks
Past Due Notice (CLC09)	To notify employees of late payments for COBRA and Direct Bill (optional service with additional charge)	Payments not received by the 7 th of each month	N/A (optional service - the IRS does not require this notice)	On the 15 th of the month
HIPAA Initial Rights Notice (CLH01)	To provide information about pre-existing conditions, consequences of declining health insurance enrollment, and the right of the covered employee and dependents to obtain a Certificate of Creditable Coverage upon termination from a group health plan; provides information concerning special enrollment opportunities	New hires eligible for the health plan	On or before the date the employee has the opportunity to enroll	Reasonable time frame (30 days)
COBRA General Rights Notice (CLC01)	To inform employee of rights and obligations under COBRA (including obligation to notify employer of hidden events, such as divorce and loss of student status)	Completion of coverage waiting period (employee eligible for enrollment under the health plan)	On or before the date employee has enrolled (usually in conjunction with CLH01)	Reasonable time frame (30 days)
Premium Invoice (CLC27)	Monthly statement for members (not necessary for payment)	Upon election of COBRA	N/A (the IRS does not require this notice)	On the 15 th of each month or based on when data is received
Rate Change Notice (CLC29)	To inform COBRA active continuants of rate increase or decrease	Client notifies HealthEquity/WageWorks of rate change	75 days prior to rate change	45 days prior to rate change
Rate Change Notice For Election Period Members (CLC11)	To inform terminated employees in their election period of a rate increase or decrease	Client notifies HealthEquity/WageWorks of rate change	75 days prior to rate change	45 days prior to rate change
Direct Bill Invoice	Statement for members (not necessary for payment)	Based on client rules	None	On the 15 th of each month

Notice	Purpose	Triggering Event	Time frame to Notify HealthEquity/WageWorks	Time frame to Send Notification
Certificate of Creditable Coverage (CLH02)	To provide evidence of prior health coverage by listing plans and coverage periods	Termination of coverage or member request	45 days from the date of the qualifying event	Reasonable time frame (30 days)
HIPAA Privacy Notice	Notice to employees of PHI requirements	New hires eligible for a self-funded health plan	On or before enrollment date	Reasonable time frame (30 days)
COBRA Expiration Notice (CLC13)	Notice of COBRA alternatives for continuants who have exhausted their COBRA period	Two months prior to COBRA cancellation	N/A	Within 2 months prior to COBRA cancellation
Women's Health and Cancer Rights Act Notice	Notice to inform plan members of their mastectomy-related rights and benefits	New hires upon enrollment and annually	On or before enrollment date	Reasonable time frame (30 days)