

Employer  
Administration  
Manual



Administering COBRA

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## Section 1: Summary of PacificSource Administrators

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The following flow chart summarizes the COBRA procedures of PacificSource Administrators.

### COBRA Qualifying Event Occurs

For example, your employee terminates employment and loses coverage.



You send the COBRA Notice of Qualifying Event Form (located in Section 5) to PacificSource Administrators. PacificSource Administrators must receive notification within 30 days of the qualifying event.



PacificSource Administrators sends information regarding COBRA rights to the Qualified Beneficiaries (QB) within 14 days.



The Qualified Beneficiary must notify PacificSource Administrators of election within 60 days of their qualifying event date, or loss of plan coverage, whichever is later.



The Qualified Beneficiary has 45 days from the date of their election to pay the first month's premium. The payment must be retroactive, so there is no break in their coverage.



PacificSource Administrators will fax the election notification to you or the carrier, as specified in your initial set-up with PacificSource Administrators. PacificSource Administrators will send premium payments with a payment remittance report to you or the carrier on a monthly basis as PacificSource Administrators receives premiums.



PacificSource Administrators will notify you or the carrier of the COBRA participant's election. PacificSource Administrators will pay premiums to you or the insurance carrier(s).



Around the 10<sup>th</sup> of each month, you will receive a COBRA Administration bill with the following monthly reports:

- 1. Paid Through Report.** This report provides premium receipt information within specified date spans.
- 2. Member Status Report.** This report shows the current enrollment status. E: enrolled, P: pending, TP: terminated pending status, TE: terminated from enrolled status

## PacificSource Administrators Contacts

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### Main Office:

COBRA Customer Service 877.355.2760 / 541.225.2760

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## Section 2: Getting Started

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### Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

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Provided by the U.S. Department of Labor

#### Introduction

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Health insurance programs allow workers and their families to take care of essential medical needs. These programs can be one of the most important benefits provided by an employer.

There was a time when group health coverage may have been terminated when a worker lost his/her job or changed employment. That changed in 1986 with the passage of health benefit provisions in the Consolidated Omnibus Budget Reconciliation Act (COBRA). Now, terminated employees or those who lose coverage because of reduced work hours may be able to buy group coverage for themselves and their families for limited periods of time.

If you are entitled to COBRA benefits, your health plan must give you a notice stating your right to choose to continue benefits provided by the plan. You have 60 days to accept coverage or lose all rights to benefits. Once COBRA coverage is chosen, you may be required to pay for the coverage.

This booklet is designed to:

- Provide a general explanation of COBRA requirements
- Outline the rules that apply to health plans for employees in the private sector
- Spotlight your rights to benefits under this law

#### What is the Continuation Health Law?

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Congress passed the landmark consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

COBRA contains provisions giving certain former employees, retirees, spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage.

The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local

governments. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

Group health plans sponsored by private sector employers generally are welfare benefit plans governed by ERISA and subject to its requirements for reporting and disclosure, fiduciary standards and enforcement. ERISA neither establishes minimum standards or benefit eligibility for welfare plans nor mandates the type or level of benefits offered to plan participants. It does, however, require that these plans have rules outlining how workers become entitled to benefits.

Under COBRA, a group health plan ordinarily is defined as a plan that provides medical care for the employer's own employees and their dependents through insurance or another mechanism such as a trust, health maintenance organization, self-funded pay-as-you-go basis, reimbursement, or combination of these. Medical benefits provided under the terms of the plan and available to COBRA beneficiaries may include:

- Inpatient and outpatient hospital care
- Physician care
- Surgery and other major medical benefits
- Prescription drugs
- Any other medical benefits, such as dental and vision care
- Employee assistance program (EAP)
- Flexible spending account (FSA) and health reimbursement arrangement (HRA)

Life insurance, however, is not covered under COBRA.

## **Who is Entitled to Benefits?**

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There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plans, beneficiaries and events that initiate the coverage.

## **Plan Coverage**

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Group health plans for employers with 20 or more employees on more than 50 percent of the working days in the previous calendar year are subject to COBRA. The term "employee" includes all full-time and part-time employees, as well as self-employed individuals. For this purpose, the term employees also includes agents, independent contractors, and directors, but only if they are eligible to participate in a group health plan.

## **Beneficiary Coverage**

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A qualified beneficiary generally is any individual covered by a group health plan on the day before a qualifying event. A qualified beneficiary may be an employee, the employee's spouse and dependent

children, and in certain cases, a retired employee, the retired employee’s spouse and dependent children.

## Qualifying Events

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“Qualifying events” are certain types of events that would cause (except for COBRA continuation coverage) an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the required amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of coverage.

The types of qualifying events for **employees** are:

- Termination of employment for reasons other than “gross misconduct”
- Reduction in the number of hours of employment

The types of qualifying events for **spouses** are:

- Termination of the covered employee’s employment for any reason other than “gross misconduct”
- Reduction in the hours worked by the covered employee
- Covered employee’s becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

The types of qualifying events for **dependent children** are the same as for the spouse with one addition:

- Loss of “dependent child” status under the plan rules

## Periods of Coverage

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Qualifying Events	Beneficiary	Coverage
Termination Reduced Hours	Employee Spouse Dependent Child	18 months*
Employee Entitled to Medicare Divorce or Legal Separation Death of Covered Employee	Spouse Dependent Child	36 months
Loss of “Dependent Child” Status	Dependent Child	36 months

\*In the case of individuals who qualify for Social Security disability benefits, special rules apply to extend coverage an additional 11 months.

## **Your Rights: Notice and Election Procedures**

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COBRA outlines procedures for employees and family members to elect continuation coverage and for employers and plans to notify beneficiaries. The qualifying events contained in the law create rights and obligations for employers, plan administrators and qualified beneficiaries.

Qualified beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

## **Notice Procedures**

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### **General Notices**

An initial general notice must be furnished to covered employees, their spouses and newly hired employees informing them of their rights under COBRA and describing provisions of law.

COBRA information also is required to be contained in the summary plan description (SPD) which participants receive. ERISA requires employers to furnish modified and updated SPDs containing certain plan information and summaries of material changes in plan requirements. Plan administrators must automatically furnish the SPD booklet 90 days after a person becomes a participant or a beneficiary begins receiving benefits or within 120 days after the plan is subject to the reporting and disclosure provisions of the law.

### **Specific Notices**

Specific notice requirements are triggered for employers, qualified beneficiaries and plan administrators when a qualifying event occurs. Employers must notify plan administrators within 30 days after an employee's death, termination, reduced hours of employment or entitlement to Medicare. Multiemployer plans may provide for a longer period of time.

A qualified beneficiary must notify the plan administrator within 60 days after events such as divorce or legal separation or a child's ceasing to be covered as a dependent under plan rules.

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA coverage. These beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.

Plan administrators, upon notification of a qualifying event, must automatically provide a notice to employees and family members of their right to elect COBRA coverage. The notice must be provided in person or by first class mail within 14 days of receiving information that a qualifying event has occurred.

There are two special exceptions to the notice requirements for multiemployer plans. First, the time frame for providing notices may be extended beyond the 14 and 30 day requirement if allowed by plan rules. Second, employers are relieved of the obligation to notify plan administrators when employees

terminate or reduce their work hours. Plan administrators are responsible for determining whether these qualifying events have occurred.

## Election

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The election period is the time frame during which each qualified beneficiary may choose whether to continue health care coverage under an employer's group health plan. Qualified beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.

Each qualified beneficiary may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a qualified beneficiary before the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

## How COBRA Coverage Works

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### Example 1:

John Q. participates in the group health plan maintained by the ABC Co. John is fired for a reason other than gross misconduct and his health coverage is terminated. John may elect and pay for a maximum of 18 months of coverage by the employer's group health plan at the group rate. (See Paying for "COBRA Coverage")

### Example 2:

Day laborer David P. has health coverage through his wife's plan sponsored by the XYZ Co. David loses his health coverage when he and his wife become divorced. David may purchase health coverage with the plan of his former wife's employer. Since in this case divorce is the qualifying event under COBRA, David is entitled to a maximum of 36 months of COBRA coverage.

### Example 3:

RST, Inc. is a small business which maintained an insured group health plan for its 10 employees in 1987 and 1988. Mary H., a secretary with six years of service, leaves in June 1988 to take a position with a competing firm which has no health plan. She is not entitled to COBRA coverage with the plan of RST, Inc. since the firm had fewer than 20 employees in 1987 and is not subject to COBRA requirements.

## Covered Benefits

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Qualified beneficiaries must be offered coverage identical to those received immediately before qualifying for continuation coverage.

For example, a beneficiary may have had medical hospitalization, dental, vision, and prescription benefits under single or multiple plans maintained by the employer. Assuming a qualified beneficiary has been covered by three separate health plans of his former employer on the day preceding the qualifying event, that individual has the right to elect to continue coverage in any of the three health plans.

Non-core benefits are vision and dental services, except where they are mandated by law in which cases they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

If a plan provides both core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

A change in the benefits under the plan for active employees may apply to qualified beneficiaries. Beneficiaries also may change coverage during periods of open enrollment by the plan.

## Duration of Coverage

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COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and can end when:

- The last day of maximum coverage is reached
- Premiums are not paid on a timely basis
- The employer ceases to maintain any group health plan
- Coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary.
- A beneficiary is entitled to Medicare benefits.

Special rules for disabled individuals may extend the maximum periods of coverage. If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled, at the time of a termination of employment or reduction in hours of employment, and the qualified beneficiary properly notifies the plan administrator of the disability determination, the 18 month period is expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to qualified beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Some plans allow beneficiaries to convert group health coverage to an individual policy. If this option is available from the plan under COBRA, it must be offered to you. In this case, the option must be given for the beneficiary to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium is generally not a group rate. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the maximum period of entitlement.

## **Paying for COBRA Coverage**

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Beneficiaries may be required to pay the entire premium for coverage. The premium cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not incurred a qualifying event. The premium reflects the total cost of group health coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus two percent for administrative costs.

For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150 percent of the plan's total cost of coverage.

Premiums due may be increased if the costs to the plan increase, but generally must be fixed in advanced of each 12-month premium cycle. The plans must allow you to pay premiums on a monthly basis if you ask to do so.

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30-day grace period for payments.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January 1 and coverage for January could not be cancelled if payment is made by January 31.

Premiums for the rest of the COBRA period must be made within 30 days after the due date for each such premium or such longer period as provided by the plan. The plan however, is not obligated to send monthly premium notices.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to deductibles, catastrophic and other benefit limits.

## **Claims Procedures**

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Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures are to be included in the SPD booklet.

You should submit a written claim for benefits to whomever is designated to operate the health plan (employer, plan administrator, etc.). If the claim is denied, notice of denial must be in writing and

furnished generally within 90 days after the claim is filed. The notice should state the reasons for the denial, and additional information needed to support the claim and procedures for appealing the denial.

You have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the plan:

- Provides for a special hearing, or
- The decision must be made by a group, which meets, only on a periodic basis.

Contact the plan administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices. The carrier may charge a fee for copies of plan rules.

## Coordination with Other Benefits

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The Family and Medical Leave Act (FMLA), effective August 5, 1993, requires an employer to maintain coverage under any “group health plan” for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer’s obligation to maintain health benefits under FMLA ceases, such as when an employee notifies an employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories in U.S. Government, Department of Labor, Employment Standards Administration.

## Conclusion

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Rising medical cost has transformed health benefits from a privilege to a household necessity for most Americans. COBRA creates an opportunity for a person to retain this important benefit.

Workers need to be aware of changes in health care laws to preserve their benefit rights. A good starting point is reading your plan booklet. Most of the specific rules on COBRA benefits can be found with the person who manages your health benefits plan.

Be sure to periodically contact the health plan to find out about any changes in the type or level of benefits offered by the plan.

## Section 3: COBRA–The Developing Law

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### IRS COBRA Regulations

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Since they were issued in 1987, the now familiar IRS proposed regulations have been virtually the sole source of regulatory guidance on COBRA compliance. On February 3, 1999, the IRS issued these regulations in final form. The final regulations revamp the proposed regulations—conforming them to intervening changes in the COBRA statute, revising numerous well-settled issues, and clarifying others.

PacificSource Administrators has substantially condensed the comprehensive changes made by these new COBRA regulations. If you would like to view the final regulations in its entirety, and/or review the proposed regulations, please refer to the Department of Labor's website <http://www.dol.gov>.

#### 13 Significant Changes or Additions Made by Regulations

##### 1. Post-Geissal Guidance Regarding Dual Coverage.

COBRA may be elected for the maximum coverage period even if the qualified beneficiary has other coverage or Medicare at the time of the election. Under this regulation, a plan may terminate a qualified beneficiary's COBRA coverage (on account of her having other coverage) only if the qualified beneficiary becomes covered under another group health plan **after** the date of his or her COBRA election.

There are three guidelines to remember when a qualified beneficiary has (or obtains) coverage under another group health plan or Medicare:

1. If a qualified beneficiary has other coverage at the time of their qualifying event, he or she must still be offered COBRA and COBRA coverage cannot be cut off because of that other coverage;
2. If a qualified beneficiary does not have other coverage at the time of a qualifying event and is offered COBRA, then gets other coverage, then elects COBRA, COBRA coverage cannot be cut off because of that other coverage; and
3. If a qualified beneficiary does not have other coverage at the time of a qualifying event and is offered COBRA, then elects COBRA, then gets other coverage,

COBRA coverage can be cut off because of that other coverage (assuming the new plan has no exclusions or limitations that applied to pre-existing conditions of the individual).

##### 2. Core/Noncore Distinction Eliminated.

General rule: qualified beneficiaries must be offered the right to continue the exact coverage they had before their qualifying event (with the right to change their election at the next open enrollment), and they must be given a separate election for each group health plan they are covered on.

An employer must offer the COBRA plans, just as they offered to active employees. For instance, if an employer requires an active employee to take medical with dental, then the COBRA participant is required to take both medical and dental. If an employer allows active employees to choose whether they want medical and/or dental, then the COBRA participant can decide which coverage they would want and be allowed to take only dental.

If an employer has only one plan providing both dental and medical, then the qualified beneficiary needs only to be offered the right to continue whatever combination they had at the time of the qualifying event or no coverage at all.

**3. Plans Must Accept COBRA Premium Payments that are Short by an Insignificant Amount, Unless Special Notice Procedures are Implemented.**

The amount paid is deemed to satisfy the payment requirement, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A period of 30 days after the date the notice is provided is a reasonable period of time however; a shorter period may be reasonable as well.

COBRA administrators now have a clear procedure for dealing with minor shortfalls in premium payments. Either the administrator ignores the shortfall or follows the procedure in the final regulations. Unfortunately, the final regulations don't define the amount or percentage of premium that should be considered insignificant.

**4. Various Approaches Permitted for Handling Coverage during the Election Period While Waiting to See if the Qualified Beneficiary Elects and Pays For COBRA.**

An indemnity or reimbursement plan can either continue coverage during the election period (subject to retroactive cancellation if no election is made), or cancel coverage and retroactively reinstate it upon election of COBRA.

**5. Plans are Required to Disclose to Health Care Providers Relevant Information About an Individual's COBRA Status.**

For example, the individual is eligible for COBRA, but has not yet elected, or the individual has elected, but not yet paid.

**6. Elections, Waivers, and Premium Payments are Considered Made on the Dates they are Sent.**

One new risk created by the rule is that plans will have to consider payment timely even if it is lost in the mail and not actually paid until sometime after the grace period expires, assuming the qualified beneficiary can provide the date payment was sent.

**7. A Newborn or Child Placed for Adoption Becomes a Qualified Beneficiary Only If the Covered Employee is on COBRA.**

If a covered employee who is a qualified beneficiary does not elect COBRA continuation coverage during the election period, then any child born to or placed for adoption with the covered employee, on or after the date of the qualifying event, is not a qualified beneficiary.

**8. The Qualifying Event for Newborn or Adopted Child of Covered Employee on COBRA is the Covered Employee's Termination or Reduction in Hours, but a Second Qualifying Event May Trigger Additional Coverage for the Child Beyond the Basic 18-Month Period.**

If a second qualifying event occurs before the child is born or placed for adoption (such as the death of the coverage employee), then the second qualifying event also applies to the newborn or adopted child.

**9. The 60-Day Election Period Ends 60 Days after the Election Notice is "Provided" to the Qualified Beneficiary (or 60 Days from the Loss of Coverage, If Later).**

The U.S. Department of Labor (DOL) in Technical Release 86-1 issued in 1986 and some informational brochures available on its website, has taken the position that the 60-day period is measured from the date the election is sent. The DOL has jurisdiction over plan administrator COBRA notices, not the IRS.

Consider using standard mail for notices as an alternative to certified mail. Be sure to allow additional time for standard mail delivery.

**10. Qualified Beneficiaries have the Same Open Enrollment Rights as Actives, and Sometimes More.**

The regulations provide that a qualified beneficiary (whether a covered employee, spouse, former spouse, or former dependent child) has the same rights at open enrollment as any similarly situated active employee.

**11. Termination of Employment following a Reduction in Hours is Not a Multiple Qualifying Event.**

**12. Small Employer Exception: Count Foreign Employees; Count Only Common-Law Employees; Count Number on Typical Business Day.**

A small employer is an employer that had fewer than 20 employees on a typical business day of the preceding calendar year. (Proposed regulations used the term "working days")

Count all employees of all corporations (for trades or businesses under common control) with the employer that maintains the group health plan. There is no exception for foreign corporations or business entities. This means that you must count all employees of corporations outside the United States, and all foreign employees of a U.S. corporation. Though they must be counted to determine if the small employer exception applies, nonresident aliens with no U.S. source income do not have to be offered COBRA and they are not qualified beneficiaries.

You do not have to count self-employed individuals independent contractors, or members of a corporate employer's board of directors as employees.

**13. Various Premium Payment Rules Help Settle Some Uncertainties.**

Premium payments must be accepted on behalf of a qualified beneficiary, regardless of who makes the payments.

In the case of the disability extension, the plan can charge 150% of the applicable premium after the 18<sup>th</sup> month and can also charge 150% of the premium for the family rate as long as they are in the same coverage group as the disabled individual.

## Section 4: Initial Notice of COBRA Rights

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### General Notice Requirements for Group Health Plans

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Group health plans must provide covered employees and their spouses with written notice of their COBRA rights at the time coverage under the plan begins. This notice must include a description of the rules relating to pre-existing conditions.

The Department of Labor has issued a Model Notice which will indicate a reasonable good faith interpretation of the initial notice requirement (an example of this is included after this section). A plan will have made a good faith effort to comply with the notice requirements if the Model Notice is provided to each covered employee and spouse by first class mail delivered to the covered employee's last known address. The Model Notice is not the only means of achieving good faith compliance with a reasonable interpretation of the notice rules. Whether other methods of notification achieve compliance with the initial notice requirements, however, must be determined on a case-by-case basis.

### Summary Plan Description

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The initial notice of COBRA rights may be included in the summary plan description (SPD). Employers may elect to add the DOL Model Notice to their SPDs as a means of easily complying with this requirement. However, the DOL Model Notice must be updated to reflect later law changes.

### Distribution of Initial Information Notice

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The mere posting of notice at the employer's place of business does not constitute adequate notice. However, a method other than first class mail sent to the covered employee's last known address may be sufficient to satisfy COBRA. Thus, an employer's hand delivery of two notices to a covered employee with an instruction to provide one to his spouse was a good faith effort reasonably calculated to reach the spouse.

### Presumption of Receipt

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A letter properly addressed and mailed first class is presumed to have been received by a covered employee. Employers or plan administrators who send proper notice by first class mail to a covered employee's last known address are deemed to be in good faith compliance. The presumption of receipt may not apply if the employer does not produce a mailing label or other documentation to establish that a computerized system actually sent notice to an employee.

If the last known address of the spouse of a covered employee is the same as that of the covered employee, the DOL will accept a single mailing address to both the employee and the spouse as good faith compliance. However, if the employer knows that the spouse of the covered employee is not living at the covered employee's last known address, good faith compliance will require a separate first class mailing to the spouse's last known address.

Examples of the DOL Model Notice and Notice of Changes Under HIPAA to COBRA Continuation Coverage Under Group Health Plans letter follow this section. PacificSource Administrators will send copies of these letters by first class mail to the last known address of the covered employee and his/her spouse. The employer is responsible to notify PacificSource Administrators when the notices need to be sent and to what address they need to go.

## Letter Example

Mr. Dan Johnson & Family  
98654 15th St  
Springfield, OR 85454

9/22/2011

Dear Mr. Dan Johnson & Family:

**GENERAL NOTICE OF YOUR RIGHTS  
GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA  
THIS LETTER IS FOR YOUR INFORMATION ONLY. PLEASE RETAIN FOR FUTURE REFERENCE.  
THERE HAS NOT BEEN A CHANGE IN YOUR STATUS WITH YOUR COMPANY.**

This letter contains important information about your employee benefits plan(s). Please read the entire letter.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the [Company Name] group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's "Summary Plan Description" or contact the [Company Name] Plan Administrator at (503 555-12-12. Also, you may visit the Department of Labor website ([www.dol.gov](http://www.dol.gov)) for more information on COBRA.

### Qualifying Events

If you are an employee of [Company Name] covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you are the spouse of an employee covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

- The death of your spouse;
- A termination of your spouse's employment (for reason other than gross misconduct) or reduction in your spouse's hours of employment with [Company Name];
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

- The death of the employee
- A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with [Company Name];
- The employee's divorce or legal separation;
- The employee became entitled to Medicare prior to his/her qualifying event; or
- The dependent child ceases to be a dependent child under the Group health Plan.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [Company Name] and that bankruptcy results in the loss of coverage of any retired employees under the Group health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

### **Coverage Provided**

Under COBRA, the employee or a family member has the responsibility to inform the [Company Name] Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. [Company Name] has the responsibility to notify the administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the [Company Name] Plan Administrator that you want to continue coverage under COBRA.

If you elect COBRA, [Company Name] is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

### **Period of Coverage**

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, a qualified beneficiary must notify the [Company Name] Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the [Company Name] Plan Administrator within 30 days of any final determination that the individual is no longer disabled. If an original event causing the loss of coverage was a termination (other than for gross misconduct) or a

reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

- Divorce or legal separation
- Death
- Medicare Entitlement
- Dependent child ceasing to be a dependent

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the [Company Name] Plan Administrator within 60 days of the event. In no case, however, will COBRA last beyond 36 months from the date of the event that originally made the qualified beneficiary eligible for COBRA.

## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WAIVER OF**

### **ENROLLMENT NOTIFICATION REVISED 11/97**

#### **NOTICE OF SPECIAL ENROLLMENT RIGHTS**

If you/and or your dependents, if any, waive coverage due to coverage under another plan, and desire to participate in the plan offered at a later date, coverage may be subject to treatment as a late enrollee. If you decline enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after such marriage, birth of a child or placement of a child for adoption.

#### **PRE-EXISTING CONDITION EXCLUSION**

A pre-existing condition is an injury or sickness which was diagnosed or treated or for which prescription medications or drugs were prescribed or taken within the six months ending on the person's date of hire. A pre-existing condition does not include pregnancy or apply to newborn children or newly adopted children. To shorten or eliminate the period of time during which the pre-existing condition applies, you have the right to provide evidence of continuous creditable coverage. Any or all of the plans that provide prior coverage must give you a Certificate of Creditable Coverage. If necessary, the insurance carrier of this employer will assist in obtaining this certificate from the prior coverage. You will be notified of any pre-existing condition exclusion period, if one applies, upon receipt of a Certificate of Creditable Coverage. Limited or no coverage is provided for eligible expenses which result from a pre-existing condition until the earlier of the date you have had continuous creditable coverage for a period of six consecutive months and have not received treatment for the pre-existing condition or the date you have had continuous creditable coverage for 12 months.

#### **CERTIFICATE OF CREDITABLE COVERAGE**

If you have a Certificate of Creditable Coverage you should attach it to your enrollment form and submit it to your group administrator for processing. If you receive the certificate after submitting your enrollment form, please forward it to your group administrator at your first opportunity.

### **Health FSA Information**

COBRA coverage under the [Company Name] Health FSA will be offered only to Qualified Beneficiaries losing coverage that have under spent accounts. A qualified beneficiary has an under spent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the [Company Name] Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the [Company Name] Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the [Company Name] Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact PacificSource Administrators at (877) 355-2760 during business hours for more information.

### **Alternate Recipients Under QMCSOs**

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by [Company Name] during the covered employee's period of employment with [Company Name] is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

### **Plan Contact Information**

To ensure that all covered individuals receive information properly and timely, it is important that you notify our Customer Service Department at (877) 355-2760 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

If you have any questions about COBRA, please contact our Customer Service Department at (877) 355-2760 during business hours.

Sincerely,

PacificSource Administrators

## **Section 5: Notifying PacificSource Administrators of Qualifying Events**

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### **Notification by Employers**

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Employers must notify PacificSource Administrators within 30 days of the date of the qualifying event. An employer must provide proper notice sufficient to inform PacificSource Administrators that a qualifying event has occurred. Failure to give such notice can result in the employer's liability for the employee's medical expenses that would have been covered under the health plan if the employee had received COBRA coverage.

# COBRA Notice of Qualifying Event Form

## Step 1: Employee Information \* = Required

*Employer Name (do not abbreviate)		*Division Name (if applicable)	
*Employee Name (First, Middle Initial, Last)			*Gender (M/F)
*Date of Birth (mm/dd/yyyy)	*Hire Date (mm/dd/yyyy)	*Social Security Number	
*Mailing Address		Daytime Phone	
*City		*State	*Zip

## Step 2: \*Qualifying Event Information

*Date of Qualifying Event (mm/dd/yyyy)		*Original Enrollment Date/Hire Date	
<input type="checkbox"/> Voluntary Termination*	<input type="checkbox"/> Reduction in Hours	<input type="checkbox"/> Loss of Eligibility	<input type="checkbox"/> Reservist called to Active Duty
<input type="checkbox"/> Involuntary Termination*	<input type="checkbox"/> Retirement	<input type="checkbox"/> Employer Bankruptcy	

### \*Notice of Unavailability:

<input type="checkbox"/> N/A	<input type="checkbox"/> Yes, please indicate reason:
<input type="checkbox"/> Gross Misconduct*	<input type="checkbox"/> Termination prior to active benefit(s)
<input type="checkbox"/> Other, please explain: <span style="border: 1px solid black; display: inline-block; width: 200px; height: 15px;"></span>	

\*Please note: Termination due to gross misconduct makes an employee and family members ineligible for COBRA coverage. If termination is due to gross misconduct, please document the reason for gross misconduct in a separate letter to PacificSource Administrators and attach to this form.

## Step 3: Current Benefits

<input type="checkbox"/> <b>Health</b> *Plan Name <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Carrier Name <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Coverage Level <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Last Date of Coverage <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span>	<input type="checkbox"/> <b>Dental</b> *Plan Name <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Carrier Name <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Coverage Level <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Last Date of Coverage <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span>	<input type="checkbox"/> <b>Vision</b> *Plan Name <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Carrier Name <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Coverage Level <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Last Date of Coverage <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span>																
<input type="checkbox"/> <b>Flexible Spending Account</b> *Annual Election Amount \$ <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span> *Benefit Last Date of Coverage <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span> *Plan Year Start Date <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span> *Plan Year End Date <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>	<input type="checkbox"/> <b>Other Health Plan</b> *Plan Name <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Carrier Name <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Coverage Level <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span> *Last Date of Coverage <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span>	<input type="checkbox"/> <b>Severance</b> Enter the amount (flat rate or percentage) to be applied to the QB's monthly premium. <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%;">Amount</th> <th style="width: 15%;">Start Date</th> <th style="width: 15%;">End Date</th> </tr> </thead> <tbody> <tr> <td>Medical</td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> </tr> <tr> <td>Dental</td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> </tr> <tr> <td>Vision</td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> <td style="border: 1px solid black; width: 50px; height: 15px;"></td> </tr> </tbody> </table>		Amount	Start Date	End Date	Medical				Dental				Vision			
	Amount	Start Date	End Date															
Medical																		
Dental																		
Vision																		

## Step 4: Other Covered Family Members

*Spouse Name (First, Middle Initial, Last)			
*Date of Birth (mm/dd/yyyy)	*Social Security Number		
Mailing Address (If different from above)			
		State	Zip
*Dependent(s) Name	*Relationship (ex. child)	*Social Security Number	*Date of Birth

## Step 5: Employer Authorization

I hereby certify that the information contained above is accurate to the best of my knowledge. I understand that PacificSource Administrators will not be held liable for missing or inaccurate information.

*Completed By: <span style="border: 1px solid black; display: inline-block; width: 250px; height: 15px;"></span>	*Daytime Phone Number <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>	*Date: <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>
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# COBRA Notice of Dependent Qualifying Event Form

**Step 1: Dependent Information** \* = Required

<small>*Client Name (do not abbreviate)</small>	<small>*Division Name (if applicable)</small>
<small>*Name of Former Dependent to be offered COBRA (First, Middle Initial, Last)</small>	<small>*Gender (M/F)</small>
<small>*Date of Birth (mm/dd/yyyy)</small>	<small>*Initial Date of Active Coverage (mm/dd/yyyy)</small>
<small>*Mailing Address</small>	<small>Daytime Phone</small>
<small>*City</small>	<small>*State</small>
	<small>*Zip</small>

**Step 2: Qualifying Event Information**

<small>*Qualifying Event Date (mm/dd/yyyy)</small>	<small>*First Day of COBRA Eligibility (mm/dd/yyyy)</small>
<b>*Qualifying Event Type</b>	
<input type="checkbox"/> Death of Covered Employee	<input type="checkbox"/> Divorce / Legal Separation
<input type="checkbox"/> Child Losing Dependent Status	<input type="checkbox"/> Employee Covered by Medicare
<small>*Covered Employee Name (First, Middle Initial, Last)</small>	
	<small>*Employee Social Security Number</small>
<b>*Notice of Unavailability:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, please indicate reason:	

**Step 3: Current Benefits**

<input type="checkbox"/> <b>Health</b>	<input type="checkbox"/> <b>Dental</b>	<input type="checkbox"/> <b>Vision</b>
<small>*Plan Name</small>	<small>*Plan Name</small>	<small>*Plan Name</small>
<small>*Carrier Name</small>	<small>*Carrier Name</small>	<small>*Carrier Name</small>
<small>*Coverage Level</small>	<small>*Coverage Level</small>	<small>*Coverage Level</small>
<small>*Last Date of Coverage</small>	<small>*Last Date of Coverage</small>	<small>*Last Date of Coverage</small>
<input type="checkbox"/> <b>Flexible Spending Account</b>	<input type="checkbox"/> <b>Other Health Plan</b>	<input type="checkbox"/> <b>Severance</b> Enter the amount (flat rate or percentage) to be applied to the QB's monthly premium.
<small>*Annual Election Amount \$</small>	<small>*Plan Name</small>	<b>Amount</b>
<small>*Benefit Last Date of Coverage</small>	<small>*Carrier Name</small>	<b>Start Date</b>
<small>*Plan Year Start Date</small>	<small>*Coverage Level</small>	<b>End Date</b>
<small>*Plan Year End Date</small>	<small>*Last Date of Coverage</small>	

**Step 4: Other Covered Family Members**

<small>*Dependent(s) Name</small>	<small>*Relationship (ex. child)</small>	<small>*Social Security Number</small>	<small>*Date of Birth</small>	<small>*Gender</small>

**Step 5: Employer Authorization**

I hereby certify that the information contained above is accurate to the best of my knowledge. I understand that PacificSource Administrators will not be held liable for missing or inaccurate information.

<small>*Completed By:</small>	<small>*Daytime Phone Number</small>	<small>*Date:</small>

# Newly Covered Employee/Spouse Form

\*=Required

## Step 1: Employer Information

\*Employer Name (do not abbreviate)

\*Division Name (if applicable)

## Step 2: Employee Information

\*Newly Covered Employee/Spouse Name

 -  - 

\*Social Security Number

\*Mailing Address

\*City

\*State

\*Zip

\*Date of Birth (mm/dd/yyyy)

\*Gender (M/F)

Daytime Phone

## Step 3: Employer Authorization

\*Name (First, Middle Initial, Last)

\*Date

\*Phone Number

## Section 6: Notification by PacificSource Administrators

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PacificSource Administrators must notify each qualified beneficiary in writing of the right to continuation coverage within 14 days of receiving notice of the qualifying event from the employer. Continuation coverage is available only to covered employees who lose coverage under plan terms as the result of a qualifying event. Consequently, the administrator is not required to send notice to individuals who were not covered employees on the date of the qualifying event.

PacificSource Administrators will mail the qualifying event notice by first class mail to the last known address to the covered employee and qualified dependants. The employer is responsible for sending/faxing a Notification Form to PacificSource Administrators when a qualifying event occurs.

### Letter Example

Kevin Carlson & Family  
23 5th Ave W  
Springfield, OR 97407

1/23/2012

Dear Kevin Carlson & Family:

On 11/25/2011, you experienced an event of a/an termination which constitutes a qualifying event under the [Company Name] group health plan(s). As a result, your coverage, and that of your covered dependent(s), if any, will end on the date(s) set forth on the COBRA Continuation Election Form accompanying this letter. Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) this entitles you and your covered dependent(s) if any, to elect to continue coverage (referred to as COBRA coverage) under the plan(s) enrolled as active member(s). The first day of COBRA coverage and the maximum continuation period is determined by plan.

Please refer to your COBRA Election Form enclosed to determine your first day of COBRA coverage and maximum continuation period ("Last Day of COBRA").

### How to Elect COBRA Coverage

Under COBRA, you have a limited number of days to elect continuation coverage. Your election window is determined by the plan and is calculated from the date your coverage under the plan is lost because of the event described above or the date this notice of your election rights is sent to you, whichever is later. To elect COBRA coverage, you must complete and submit the enclosed election form to PacificSource Administrators - no later than the Election Period End date ("Last Day to Elect") listed on the enclosed COBRA Election Form.

This same notice is being sent separately to your spouse, if any; however, only one of you needs to elect continuation coverage for your spouse and dependent child(ren), if any, who wish to continue coverage.

Furthermore, because COBRA gives you the right to elect coverage independently, you, your spouse or dependent child(ren), if any, may elect single coverage and not include those individuals who do not wish to continue coverage.

### **Payment of COBRA Coverage Premiums**

The current amount of this premium and the due date for payment are explained in the enclosed COBRA Election Form. The premium may change in the future. We have used the information supplied by [Company Name] to calculate your maximum continuation period under the plan(s) you were insured prior to your qualifying event. If there is a discrepancy between our calculation and the underwriting insurance carrier, the insurance carrier always governs. Please contact your insurance carrier(s) to determine the exact end of your maximum continuation period.

### **Length of COBRA Coverage Period**

If you and your spouse or dependent child(ren), if any, elect coverage, it can last for a maximum continuation period ("Last Day of COBRA") described in the enclosed COBRA Election Form beginning on the date of your qualifying event, or loss of coverage, whichever is later. The first day of COBRA coverage will be determined by the plan. This period may be extended for the following reasons:

#### **1. Death of employee, divorce, legal separation or change in dependent status**

If these events occur during the original maximum continuation period of COBRA coverage, the period of coverage for your spouse and dependent child(ren), if any, may be extended. These events extend the original maximum continuation period of COBRA coverage only if they would have caused your spouse or dependent child(ren), if any, to lose coverage under the plan if the original qualifying event had not occurred. Note that to receive this extension, you and/or your spouse and dependent child(ren), must notify the [Company Name] Plan Administrator within 60 days of the occurrence of these events.

#### **2. Medicare entitlement of employee**

If you became entitled to Medicare BEFORE your qualifying event, COBRA laws allow you to remain eligible for up to 18 months of COBRA coverage. However, your spouse and dependent child(ren), if any, may receive extended COBRA coverage for up to the greater of either: (a) 36 months from the date of your Medicare entitlement; or (b) 18 months from the date of your qualifying event, or loss of coverage, whichever is later.

If you become entitled to Medicare AFTER your qualifying event but within the original maximum continuation

period of your qualifying event, your spouse and dependent child(ren), if any, may receive an additional 18 months of COBRA coverage. Note that a person generally has become entitled to Medicare when he or she has applied for Social Security income payments or has filed an application for benefits under Part A or Part B of Medicare.

#### **3. Disability determination**

If it is determined that you and/or your spouse or dependent child(ren), if any, were determined to be disabled (by the Social Security Administration) during the first 60 days of COBRA coverage and you are still disabled at the end of your original maximum continuation period of coverage, the original

maximum continuation period may be extended for an additional 11 months for all individuals covered under COBRA coverage from the date of the qualifying event. This extension only applies if the [Company Name] Plan Administrator is notified within 60 days of a disability determination and before the end of the original maximum continuation period. Federal law requires that you notify the [Company Name] Plan Administrator of a determination by the Social Security Administration that you, your spouse, or dependent child(ren) are no longer disabled within 30 days of such a determination. [Company Name] can be reached at (503) 555-1212 during business hours.

#### **4. Bankruptcy filing**

If the employer files for bankruptcy reorganization and retiree health coverage is lost within one year before or after the bankruptcy filing, COBRA coverage could continue until the death of a retiree (or a surviving spouse of a deceased retiree) or for 36 months from the retiree's death (after the bankruptcy filing) in the case of the spouse and dependent child(ren).

#### **5. Newborns and Adoptees**

A child who is born to or placed for adoption with you during a period of COBRA coverage will be eligible to become covered under the plan. In accordance with the terms of the [Company Name] group health benefits plan and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the [Company Name] Plan Administrator of the birth or adoption.

#### **Early Termination of COBRA Coverage**

COBRA coverage may terminate early if:

- The required premium payment is not paid when due.
- After the date of your COBRA election, you and your spouse or dependent child(ren), if any, become covered under another group health plan that does not contain any exclusion or limitation for any of your pre-existing conditions.
- After the date of your COBRA election, you, your spouse or dependent child(ren), if any, become entitled to Medicare benefits.
- All of [Company Name] group health plans are terminated.
- If coverage is extended an additional 11 months due to disability, a determination that the individual is no longer disabled.
- COBRA coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the [Company Name] group health plan may terminate your COBRA coverage.

Continuation coverage under COBRA is provided subject to your eligibility. The [Company Name] Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage. To be sure that you, your spouse and your dependent child(ren), if any, receive the necessary information concerning your rights, you should keep PacificSource Administrators informed of any address changes.

The Trade Act of 2002 provides an additional 60-day COBRA election period for certain individuals who become eligible for Trade Adjustment Assistance ("TAA"). A TAA-eligible individual who did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, may elect continuation coverage during a 60-day period that begins on the first day of the month in which he or she is determined to be a eligible individual, provided such election is made no later than six (6) months after the date of the TAA-related loss of coverage. Any continuation coverage elected during the TAA second election period will begin with the first day of the second election period, and not be counted for purposes of determining whether the individual has had a 63-day break in coverage. If you have any questions regarding the TAA, please contact the Health Care Tax Credit (HCTC) Customer Service department at (866) 628-4282.

TDD/TYY callers, please call (866) 626-4282. Or visit the HCTC on the Web at <http://www.irs.gov> (IRS keyword: HCTC).

Please be advised of your right to obtain a copy of the Summary Plan Description (SPD) for your group health plan by contacting the [Company Name] Human Resource Department at (503) 555-1212. The SPD contains a complete description of your benefits.

This notice is a summary of your COBRA rights. For answers to specific questions, please contact our Customer Service Department at (877) 355-2760 during business hours.

Sincerely,

PacificSource Administrators - COBRA

## **COBRA CONTINUATION COVERAGE ELECTION FORM**

**[Company Name]**

**IMPORTANT: PLEASE RETAIN A COPY OF THIS COBRA ELECTION FORM FOR FUTURE REFERENCE.**

**THIS FORM CONTAINS INFORMATION ABOUT YOUR RIGHTS UNDER COBRA.**

To continue coverage, you must complete and submit this election form to PacificSource Administrators no later than the Election Period End date ("Last Day To Elect") listed below. If this election form is not returned within the enrollment period described below for each plan, you will lose your right to elect coverage.

After you have elected to continue coverage under COBRA, you must pay the Initial Premium, which includes the premiums for the period of coverage from your First Day of COBRA to the date of your election and any regularly

scheduled monthly premiums that become due between your election date and the end of the Initial Premium Payment period. Your Initial Premium Period will end at the end of your Initial Grace Period which is listed below and which is measured as a number of days after the date of your election. To become "fully enrolled" under COBRA, you must "pay your account to current" no later than the end of your Initial Grace Period. You may certainly though "pay to current" and become fully enrolled under COBRA before the end of your Initial Grace Period. Paying to current is defined as paid to the month in which it currently is.

If you waive coverage under COBRA before the end of the enrollment period, you can change your mind and continue coverage by submitting your completed election form before the end of the enrollment period described below for each plan.

If you have questions about COBRA or need assistance to complete your election form, please contact our Customer Service Department at (877) 355-2760 during business hours.

**Qualified Beneficiary (QB):**

Joe Smith Event Date: 11/25/2011  
 123 First Ave.  
 Any City, OR 97407  
 Event Type: Termination  
 Second Event: No

COBRA gives you the right to elect coverage independently. You, your spouse or dependent child(ren), if any, may elect single coverage and not include those individuals who do not wish to continue coverage.

**Premium Information:**

<b>Plan Name:</b>	<b>Coverage Level</b>	<b>Monthly Premium</b>
PacificSource FSA	<b>QB</b>	\$102.00
PacificSource Medical	QB + Children	\$698.62
<b>Total Premium</b>		<b>\$800.62</b>

<b>Plan Name</b>	<b>First Day of COBRA</b>	<b>Last Day of COBRA</b>	<b>#Months of COBRA</b>	<b>Last Day To Elect</b>	<b>Initial Grace Period</b>	<b>Subsequent Grace Period Days</b>
PacificSource FSA	12/1/2011	12/31/2011	1	3/23/2012	45	30
PacificSource Medical	12/1/2011	5/31/2013	18	3/23/2012	45	30

**Election Options (Individuals Enrolled Prior to Qualifying Event):**

Please indicate the COBRA continuation coverage you are electing by checking the applicable box(es).

Name	Relationship	Date of Birth	SSN
Joe Smith	QB	7/3/1981	xxx-xx-7976

Accept Waive Manley Services FSA

Accept Waive PacificSource Medical

Maddy Carlson	Dependent Child	2/1/2002	xxx-xx-7777
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Accept Waive PacificSource Medical

**Alternative Election Options:**

Plan Name	Coverage Level	First Day of COBRA	Monthly Premium
PacificSource FSA	QB Only	12/1/2011	\$102.00
PacificSource Medical	QB + Children	12/1/2011	\$698.62
	QB Only	12/1/2011	\$379.70

Completed election forms and premium payments should be remitted directly to the address below. Payment must be in the form of a check or money order. DO NOT send cash.

PacificSource Administrators  
 PO Box 2440  
 Omaha, NE 68108-2440

For all other correspondence please use the following address:

PacificSource Administrators - COBRA  
 PO Box 2440  
 Omaha, NE 68108-2440

I have read this form and the notice of my election rights. I understand my rights to elect continuation coverage

and would like to take the action indicated above. I understand that if I elect continuation coverage, my continuation coverage will terminate under several circumstances according to COBRA regulations, including: non-payment of premium, the date I or a continued dependent become covered under another Group Health Plan or become entitled to Medicare after the COBRA election, or on the date which this Group Plan ends. I also understand that if I was determined to be disabled by the Social Security Administration within 60 days of my Qualifying Event, I may be eligible for extended continuation coverage and that any break in continued coverage of more than 63 days may cause loss of coverage portability.

I understand that future premiums are due the first of each month. I also understand that failure to pay the required premiums will result in termination of COBRA rights and coverage.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*NOTE: If signature line is on a second page, be sure to include all pages of the election form. We will not be able to process your election without the entire form.

## Section 7: Election by Qualified Beneficiaries

---

### Deadline for Making Elections

---

A qualified beneficiary may be denied continuation coverage if a “timely” election of coverage is not made. Generally, an election is timely if it is made during the election period.

The election period must be at least 60 days long and begins on either the date on which coverage under the plan terminates, because of a qualifying event, or the date the COBRA notice is sent by PacificSource Administrators, whichever is later. Therefore, depending upon when the employer or PacificSource Administrators provides the COBRA notice, the election period may in a number of instances, be delayed beyond the 60 days from the date coverage is lost. The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary.

### Independent Election of Continuation Coverage

---

Each qualified beneficiary must be allowed the opportunity to make an independent election to receive continuation coverage and to switch to another plan during an open enrollment period. The 1999 final regulations extend this right to children born to or placed for adoption with a covered employee during the COBRA coverage period.

### Payment of Premiums

---

A qualified beneficiary will be required to pay 102 percent of the applicable premium and PacificSource Administrators will retain 2 percent of the premium. Plans may terminate a qualified beneficiary’s continuation coverage on the first day of any period for which a timely payment is not made. PacificSource Administrators will look at the mailing date on the envelope to determine when the premium was mailed. If the date is after the 30-day grace period PacificSource Administrators will return the payment to the qualified beneficiary.

### Enrollment of Qualified Beneficiary

---

Upon receipt of a qualified beneficiary’s enrollment form and premium payment, PacificSource Administrators will record payment, and mail a premium check back to the employer or directly to the carrier, depending upon the group setup. Premiums are mailed the first week of the month following receipt of the full premium. The employer or PacificSource Administrators will be responsible to inform the insurance provider of any elections, terminations, and premium payments.

Coupons will be sent to the enrolled qualified beneficiaries that are to be detached and mailed monthly with premium payment. If a qualified beneficiary does not pay the monthly premium, a notice will be sent notifying them of the termination of coverage. A similar notice will be sent after the 60-day election period if a qualified beneficiary elects not to enroll.

## COBRA Premium Shortfalls

---

PacificSource Administrators will accept premium payment shortfalls of \$50.00 or less and apply it to the monthly premium. At that time, a separate billing will be sent notifying the qualified beneficiary of the deficit.



7/12/2012

First Last Name & Family  
 Street Address  
 City, State Zip

Dear First Last Name & Family:

We have received your full initial premium payment for enrollment in the [Company Name] COBRA continuation plan, and your premium is now paid through 8/31/2012. The benefits for which you are eligible are fully explained in the 'Summary Plan Description'. This document was given to all [Company Name] employees when they first became eligible for employee health benefits. If you need a copy of the 'Summary Plan Description', please contact the Customer Service Department of your insurance carrier or [Company Name].

You may be able to continue this COBRA continuation plan through [Company Name] if you and your covered dependents, if any, become covered under a new plan that limits benefits due to a pre-existing condition. If you have questions regarding the benefits or pre-existing condition clause of your new plan, please contact their Plan Administrator for more information.

Included with this letter please find your premium payment coupon booklet. To ensure proper posting of your payment, it is required that you return your coupon remittance stub with your payments. You should pay the premium before the due date. Please note that premium payments are due on the first day of each month regardless of receipt of a premium notice. You will have a grace period each month to remit your premium for that month's coverage. The grace period begins the day after the due date for that month's coverage. Please refer to the information below to determine the premium payment grace period for each plan under which you are enrolled. Failure to pay premiums by premium due dates will terminate your participation in the [Company Name] COBRA continuation plan.

Plan Name	Coverage Level	Paid Through Date	First Day of COBRA	Last Day of COBRA	Months of COBRA	Pmt Grace Period
Regence BCBS of OR Medical PPO	QB + Spouse	8/31/2012	7/1/2012	12/31/2013	18	30
Dearborn National Dental	QB + Spouse	8/31/2012	7/1/2012	12/31/2013	18	30

**Projected Plan Premiums**

Premium Due Date	Premium Amount	Employer Subsidy	Total Amount Owed
08/01/2012	\$1,259.93	\$1,259.93	\$0.00
09/01/2012	\$1,259.93	\$0.00	\$1,259.93
10/01/2012	\$1,259.93	\$0.00	\$1,259.93
11/01/2012	\$1,259.93	\$0.00	\$1,259.93
12/01/2012	\$1,259.93	\$0.00	\$1,259.93
01/01/2013	\$1,259.93	\$0.00	\$1,259.93
02/01/2013	\$1,259.93	\$0.00	\$1,259.93
03/01/2013	\$1,259.93	\$0.00	\$1,259.93
04/01/2013	\$1,259.93	\$0.00	\$1,259.93
05/01/2013	\$1,259.93	\$0.00	\$1,259.93
06/01/2013	\$1,259.93	\$0.00	\$1,259.93
07/01/2013	\$1,259.93	\$0.00	\$1,259.93



We have used the information supplied by [Company Name] to calculate your maximum continuation period under the plan(s) you were insured under prior to your qualifying event. If there is a discrepancy between our calculation and the underwriting insurance carrier, the insurance carrier always governs. Please contact your insurance carrier(s) to determine the exact end of your maximum continuation period.

COBRA premiums should be made payable to and mailed to:

PacificSource Administrators  
PO Box 2440  
Omaha, NE 68108-2440

Please pay only the amount due. If overpayment is made and you continue your COBRA coverage, the overpayment is applied to the next month's premium. To check the status of your payments, log into the member portal at <https://cobra.benefitsservice.com> or contact us at 877-355-2760 during business hours.

Acceptance of your COBRA payment, whether by check, credit card, debit, money order or any other method of payment, does not guarantee that you have COBRA coverage. Our billing system is automated. This means that, in most cases, we will automatically accept your COBRA payment before we are able to verify whether you are eligible for COBRA coverage. Once we receive your payment, we will review our records to confirm that you are eligible for COBRA coverage.

If you terminate COBRA with an overpayment balance remaining, you will only receive a refund check if the amount is greater than \$25.00. This is due to administrative costs associated with issuing refund checks. Standard processing of any refund is 15 business days from the date the written request for a refund is received by our office.

#### **SCHEDULED ACH PREMIUM PAYMENT OPTION**

Did you know you can set up scheduled ACH for your monthly payments? ACH is a safe, fast and secure way to ensure your monthly payment is made on time, every time. To sign up, login to your Member Portal and download the ACH form from the ACH tab and send it in for processing. Also, you may contact our offices and we will send you an ACH form and help with any questions or comments.

If you have questions about your COBRA coverage, please contact our Customer Service Department at (877) 355-2760 during business hours.

Sincerely,

PacificSource Administrators

PREMIUM PAYMENT COUPON



Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>9/1/2012</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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PREMIUM PAYMENT COUPON

Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>10/1/2012</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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PREMIUM PAYMENT COUPON

Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>11/1/2012</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



PREMIUM PAYMENT COUPON



Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>12/1/2012</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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PREMIUM PAYMENT COUPON

Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>1/1/2013</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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PREMIUM PAYMENT COUPON

Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>2/1/2013</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



PREMIUM PAYMENT COUPON



Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>3/1/2013</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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PREMIUM PAYMENT COUPON

Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>4/1/2013</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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PREMIUM PAYMENT COUPON

Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>5/1/2013</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



PREMIUM PAYMENT COUPON



Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>6/1/2013</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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PREMIUM PAYMENT COUPON

Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>7/1/2013</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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PREMIUM PAYMENT COUPON

Qualified Beneficiary
Name
SSN: xxx-xx-xxxx
Company Name
CustID: - MemberID:

COBRA Premium Due
Due Date: <b>8/1/2013</b>
Amount Due: <b>\$1,259.93</b>

Remit To
PacificSource Administrators
PO Box 2440
Omaha, NE 68108-2440

I hereby certify that any qualified beneficiaries, including myself, remain eligible for participation in [Company Name] COBRA continuation plan.

Signature \_\_\_\_\_

Date \_\_\_\_\_



## Section 8: Billing Procedures

---

Bills are sent out around the 10<sup>th</sup> of each month and are for the previous month's administration. . Billings are due by the 20th of the month with checks made payable to PacificSource Administrators and sent to:

PacificSource Administrators COBRA

PO Box 71096

Springfield, OR 97475

In addition to the invoice, a Member Status Report and Paid through Report will be sent.

The **Member Status Report** shows the member's status as of the date the report was run. It is broken down as follows:

- Plan Name/Carrier Name,
- Status (E=Enrolled, P=Pending, TP=Termed from Pending, TE=Termed from Enrolled)
- Full Name of QB
- Coverage Level
- First Day of COBRA
- Termination Date, if applicable.

The **Payment Status Report** lists a paid through date for all enrolled members.



## Paid Through Report

4/24/2013 5:47 PM

Client Group: N/A

Broker: N/A

Client:

Client Division:

Qualified Beneficiary Grand Total:	1
SPM Grand Total:	<u>0</u>
Grand Total:	1



**Paid Through Report**  
4/24/2013 5:47 PM

Client Name:

---

Division Name:

---

Member Type:    Qualified Beneficiary

Name	SSN	Qualifying Event Date	Paid Through Date
	i		

Qualified Beneficiary Total:    1

Division Total:    1

Client Total:    1

Grand Total:    1



**Member Status**

As of 4/24/13 5:46 PM

Client Group: N/A

Broker: N/A

Client:

Client Division:

Pending And Enrolled MemberTotal:	2
Terminated Member Total:	<u>3</u>
Member Grand Total:	5



**PacificSource**  
ADMINISTRATORS  
Member Status

Client Name:

Division Name:

Plan Name: MetLife Dental  
Carrier Name: MetLife

Status: E

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Status: P

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Status: TP

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Plan Name: Providence Medical Open Option/Vision/Rx  
Carrier Name: Providence

Status: E

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Status: P

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Status: TP

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Plan Name: Reliant Behavioral Health  
Carrier Name: EASE

Status: E

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date



**PacificSource**  
ADMINISTRATORS  
Member Status

Client Name:

Division Name:

Plan Name: Reliant Behavioral Health  
Carrier Name: EASE

Status: P

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Status: TP

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Plan Name: z EASE EAP  
Carrier Name: EASE

Status: TP

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Plan Name: z MetLife Dental  
Carrier Name: MetLife

Status: TP

Full Name	Type	SSN	Coverage Description	Event First Day of Coverage	Termination Date

Division Pending And Enrolled Member Total:	2
Division Terminated Member Total:	3
Division Member Total:	5
Client Pending And Enrolled Member Total:	2
Client Terminated Member Total:	3
Client Member Total:	5

## Section 9: Annual or Open Enrollments

---

COBRA qualified beneficiaries may participate in annual and open enrollments just as active covered employees do, as long as the employer maintains more than one health plan. If the employer maintains more than one plan, each qualified beneficiary is entitled to the same open enrollment period rights, such as a choice of coverage under another employer-sponsored plan or the addition or elimination of coverage for family members, as are similarly situated active employees for whom a qualifying event has not occurred.

If an employer makes an open enrollment period available to non-COBRA beneficiaries then the same open enrollment rights must be made available to COBRA beneficiaries, regardless of how many plans the employer maintains. This is in keeping with one of the primary goals of COBRA, i.e., to afford coverage that does not differ “in any way” from the coverage afforded to non-Cobra Beneficiaries.

Presumably, COBRA enrollees have the opportunity to elect coverage within the same time frames as active employees and for a cost calculated at 102 percent of the applicable premium. If qualified beneficiaries enroll for different coverage in advance of the effective date of the change, any premium change will occur as of the effective date rather than as the date of the enrollment.

At open enrollment, PacificSource Administrators - COBRA will send you an open enrollment information sheet. In order to have a smooth transition, the open enrollment information sheet needs to be filled out in its entirety and mailed to PacificSource Administrators - COBRA two weeks prior to the renewal date of your group health benefit plan(s).

### Sample COBRA Administrative Fee Renewal Letter

May 8, 2013

Sent via email

Company Name

Contact Name

Address

City, State Zip

RE: Company COBRA Administration Renewal

Thank you for your business! We value you as a customer and look forward to serving you this year.

In order to ensure that your COBRA administration renewal information is complete for August 1, 2013 we need your help before we can proceed.

Included with this letter is a *COBRA Administration Renewal Form*. When completing the *Renewal Form*, please keep in mind that, although we may have this information on file, we need you to complete each section to confirm our information is up-to-date. *It is important that PSA receives your renewal information as soon as possible, as we will need to notify current COBRA participants of any changes in your administration.* Please be aware that under COBRA law, if notification is not given to participants in a timely fashion, *the employer is responsible for any differences in premium payments.*

Please send your administration renewal information by email to our COBRA Team [cobra@pacificsource.com](mailto:cobra@pacificsource.com) or via fax to (541) 225-3684 **no later than July 1, 2013.**

PacificSource Administrators is happy to assist you in any way to make this process as smooth as possible. If you have any questions regarding the COBRA Administration Renewal process, please contact your Client Service Representative at: (877) 355-2760 or email at COBRA@pacificsource.com and they will be happy to assist you.

Thank you,

*Liz Manley*

Liz Manley  
Sales Representative  
PacificSource Administrators

## PacificSource Administrators - COBRA

### Company Name

### COBRA Administration Renewal Form

	Current Fees	Renewal Fees Effective: August 1, 2013
Annual Fee:	\$0.00	\$0.00
Minimum Monthly Fee:	\$0.00	\$0.00
PEPM Fee:	\$0.00	\$0.00
Initial Rights Notice Fee (for over 20 New Hires):	\$0.00	\$0.00

Please sign below and return to [cobra@pacificsource.com](mailto:cobra@pacificsource.com) or send via fax to (541)-225-3684.

We are renewing our service agreement with PSA COBRA effective August 1, 2013 with the renewal rates above. We will provide PSA COBRA with any plan changes as soon as possible. We understand that renewal enrollment sent later than 20 days prior to renewal may delay the renewal set-up.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

### Sample COBRA Benefit and Rate Renewal Form

Please complete this form and email/fax it to PacificSource **no later than 45 days prior to the start of your determination period**. Once received, PacificSource will communicate the changes to the COBRA continuants along with new payment coupons.

To maintain compliance with COBRA regulations, an employer may not retroactively increase COBRA premiums after the start of the determination period except in limited instances. In no event may a change be made retroactively. IRS COBRA regulations “explicitly require that the determination of the applicable premium be made for a period of 12 months and that the determination be made before the beginning of the period. Therefore, the final regulations do not permit an increase in the applicable premium during the 12-month determination period.” Any shortfall in premium payments by COBRA continuants that is due to late notification of rate changes to PacificSource is the responsibility of the employer. This may result in the plan being cancelled by the carrier if not paid.

Please verify the following information and make any necessary changes to the information provided.

#### Section 1: Company Information

1.1	Company Name:	
1.2	Tax ID:	
1.3	COBRA Renewal Contact	
	Name:	
	Email Address:	
	Phone Number:	

#### Section 2: Carrier Change Information

2.1	Will any of your plans be administered by a different carrier? <input type="checkbox"/> Yes (complete section 3) <input type="checkbox"/> No
2.2	Are there any new plans with existing carriers? <input type="checkbox"/> Yes (complete section 3) <input type="checkbox"/> No (skip to section 4)
2.3	If there are new plans should the participants automatically be transferred/rolled over to these new plans? <input type="checkbox"/> Yes <input type="checkbox"/> No

New Plan 1

#### Section 3: New Plan Information

<b>3.1</b>	Plan Naming Convention (ex. ABC medical HMO plan)		
<b>3.2</b>	Policy Identification Number (required for plan set up)		
<b>3.3</b>	COBRA Sub Code(s) (for reporting eligibility, if applicable)		
<b>3.4</b>	Carrier Name		
<b>3.5</b>	Carrier Enrollment Contact		
<b>3.6</b>	Carrier Enrollment Contact Information:  Send Eligibility Updates via:  <input type="checkbox"/> Fax <input type="checkbox"/> Email	Phone Number	
		Fax Number	
		Email Address	
<b>3.7</b>	Customer Service Contact	Phone:	Fax:
<b>3.8</b>	When a qualifying event occurs, when does the benefit end?  <input type="checkbox"/> On the day of the event <input type="checkbox"/> Last day of the month		
<b>3.9</b>	Is the benefit:  <input type="checkbox"/> Fully-Insured <input type="checkbox"/> Self-Insured		
<b>3.10</b>	Plan Renewal Month		
<b>3.11</b>	Plan Effective Dates	Start Date: (mm/dd/yyyy)	
		End Date: (mm/dd/yyyy)	
<b>3.12</b>	Remittance Contact Information:	Name	
		Phone Number	

	Premiums are remitted to:	Fax Number			
	<input type="checkbox"/> The Carrier	Email Address			
	<input type="checkbox"/> The Employer	Mailing Address			
<b>3.13</b>	Additional Remittance Instructions				
<b>3.14</b>	Rates	Are rates member specific? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>3.15</b>	Monthly Rates (without the 2% administrative fee)	Employee Only	\$	Employee + 1	\$
		Employee + Spouse	\$	Employee + 2	\$
		Employee + Child	\$	Employee + 3	\$
		Employee + Children	\$	Spouse Only	\$
		Employee + Family	\$	Child Only	\$

**New Plan 2** \*If there are additional plans please copy and paste the above section as many times as needed.

<b>3.16</b>	Plan Naming Convention (ex. ABC medical HMO plan)	
<b>3.17</b>	Policy Identification Number (required for plan set up)	
<b>3.18</b>	COBRA Sub Code(s) (for reporting eligibility, if applicable)	
<b>3.19</b>	Carrier Name	
<b>3.20</b>	Carrier Enrollment Contact	
<b>3.21</b>	Carrier Enrollment	Phone Number

	<p>Contact Information:</p> <p>Send Eligibility Updates via:</p> <p><input type="checkbox"/> Fax    <input type="checkbox"/> Email</p>	<p>Fax Number</p>	
		<p>Email Address</p>	
<b>3.22</b>	Customer Service Contact	Phone:	Fax:
<b>3.23</b>	<p>When a qualifying event occurs, when does the benefit end?</p> <p><input type="checkbox"/> On the day of the event    <input type="checkbox"/> Last day of the month</p>		
<b>3.24</b>	<p>Is the benefit:</p> <p><input type="checkbox"/> Fully-Insured                      <input type="checkbox"/> Self-Insured</p>		
<b>3.25</b>	Plan Renewal Month		
<b>3.26</b>	Plan Effective Dates	Start Date: (mm/dd/yyyy)	
		End Date: (mm/dd/yyyy)	
<b>3.27</b>	<p>Remittance Contact Information:</p> <p>Premiums are remitted to:</p> <p><input type="checkbox"/> The Carrier</p> <p><input type="checkbox"/> The Employer</p>	Name	
		Phone Number	
		Fax Number	
		Email Address	
		Mailing Address	
<b>3.28</b>	Additional Remittance Instructions		

<b>3.29</b>	Rates	Are rates member specific? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	<b>3.30</b>  Monthly Rates  (without the 2% administrative fee)	Employee Only	\$	Employee + 1	\$
Employee + Spouse		\$	Employee + 2	\$	
Employee + Child		\$	Employee + 3	\$	
Employee + Children		\$	Spouse Only	\$	
Employee + Family		\$	Child Only	\$	

**Section 4: Open Enrollment Information**

<b>4.1</b>	Is there an open enrollment period? <input type="checkbox"/> No (skip to Section 5)		
<b>4.2</b>	<input type="checkbox"/> Yes (must be future end date)	Start Date (mm/dd/yyyy)	
		End Date: (mm/dd/yyyy)	
<b>4.3</b>	Do you want PacificSource to send the Open Enrollment letter and form to all current COBRA participants? (Both are included in the cost of our administration) <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>4.4</b>	What is your policy for accepting late open enrollment forms? <input type="checkbox"/> Never accept <input type="checkbox"/> Accept for 10 days after open enrollment end date		
<b>4.5</b>	If you have separate divisions, please indicate which divisions these changes apply to: <input type="checkbox"/> All <input type="checkbox"/> Division Names:		

**Section 5: Benefit Change Information**

<b>5.1</b>	Are there any benefit/carrier changes? <input type="checkbox"/> Yes <input type="checkbox"/> No (skip to Section 6)
<b>5.2</b>	If benefits/carriers are changing, the new benefit information describing the benefit/carrier

	change(s) will be sent by:  <input type="checkbox"/> <b>Employer/Consultant:</b> (Please provide to PacificSource a copy of the information being sent for our records.)  <input type="checkbox"/> <b>Website that hosts benefit information:</b> (link will be included on open enrollment letter)
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**Section 6: Rate Change Information**

<b>6.1</b>	Are any premium rate(s) changing?		
	<input type="checkbox"/> No		
<b>6.2</b>	<input type="checkbox"/> Yes	Start Date (mm/dd/yyyy)	

Please see the plans and rates below that we currently have for your company. Please enter any new rates in the provided column. **\*Please indicate if any of the plans listed below have terminated. If so, please also list the effective termination date\***

**Plan Name:**

<b>6.3</b>		Coverage Level	Current Rate	New Rate
	Monthly Rates  <b>(without the 2% administrative fee)</b>	Employee Only		\$
		Employee + Spouse		\$
		Employee + Child		\$
		Employee + Children		\$
		Employee + Family		\$

**Plan Name:**

<b>6.4</b>		Coverage Level	Current Rate	New Rate
	Monthly Rates  <b>(without the 2% administrative fee)</b>	Employee Only		\$
		Employee + Spouse		\$
		Employee + Child		\$
		Employee + Children		\$
		Employee + Family		\$

**Plan Name:**

6.5		Coverage Level	Current Rate	New Rate
Monthly Rates <b>(without the 2% administrative fee)</b>		Employee Only		\$
		Employee + Spouse		\$
		Employee + Child		\$
		Employee + Children		\$
		Employee + Family		\$

**Plan Name:**

6.6		Coverage Level	Current Rate	New Rate
Monthly Rates <b>(without the 2% administrative fee)</b>		Employee Only		\$
		Employee + Spouse		\$
		Employee + Child		\$
		Employee + Children		\$
		Employee + Family		\$

**Determination Period:** The determination period can be any 12-month period selected by the plan, but it must be applied consistently from year to year. Most plans use the plan year as the determination period. The determination period can differ from the plan year. For example, if the plan year of an insured plan differs from the insurance policy's coverage period (i.e., the period for which the insurer sets premiums), the employer may prefer to use the policy coverage period as the determination period, rather than the plan year.

A determination period may start a few weeks or months after the end of the policy coverage period (e.g., the policy coverage period could end December 31 and the new determination period could begin February 1). This would give the employer more time to obtain new insurance rates, set the applicable premium based on those rates, and advise qualified beneficiaries of changes in their COBRA premiums before the determination period begins. An employer taking this approach would want to keep any difference between the determination period and the policy coverage period to a minimum (i.e., no more than a few weeks).

COBRA regulations do not expressly prohibit or permit changes to a plan's determination period. The IRS COBRA regulations state only that the determination period must be a 12-month period that is applied consistently from year to year. Because of the lack of guidance and authority on changing a

plan's determination period, employer should consult with legal counsel before changing a determination period.

In general, if the plan documents clearly provide that COBRA premiums will be 102% of the applicable premium, and if there has been a clear clerical or mathematical error, it should be permissible to increase COBRA premiums to correct the error on a prospective basis during the determination period.

**Remittance:** PacificSource will continue the same process of sending benefit premiums (to the carrier or the employer) unless otherwise notified. PacificSource recommends that changes to remittance processes are only made during annual renewal prior to new rates/plans being added for the upcoming plan year.

Please return this form to PacificSource at least 45 days prior to any benefit change, rate change and/or open enrollment effective date. Failure to do so will result in the employer being responsible to cover a shortfall in premium payments to the carrier. It is the employer's responsibility to advise qualified beneficiaries and PacificSource of any changes to their benefits. PacificSource will send notice of any rate change and open enrollment information to all current qualified beneficiaries as indicated above.

### Section 7: Client Signature

I hereby certify that the information contained in this COBRA Benefit and Rate Renewal Form is current and accurate to the best of my knowledge.

Client Signature:	
Print Name:	
Date:	

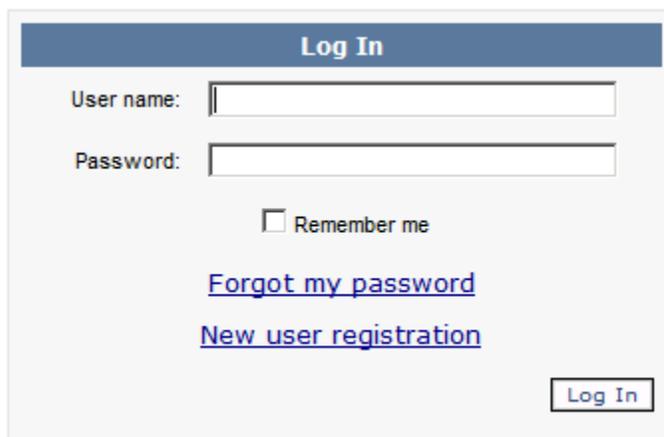
*\*Electronic signature is sufficient*

## Section 10: COBRA Employer Web Portal

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### Logging into the Portal for the First Time

- ✓ Proceed to the COBRA Web Log in screen, accessed by visiting:
  - <https://cobra.pacificsource.com>
  - Under the Employer section, click on “**Account Log In**” link.
    - Click on “**COBRA-Employer Login\***” link.
- ✓ You will be taken to this log in screen:



- ✓ Click on “New user registration” link:
  - You will then be prompted to enter the **Registration code** that you received from PacificSource Administrators (via email and by mail).
  - **Note:** If possible, copy and paste your registration code to prevent entering code incorrectly.

### Enter Registration Code

- Example: 9JietaLN

### Enter TAX ID

- Example: 12-3456789

### Create Unique Password

- Example: Restaurant1!

### Username is email address

- Example: [sanderson@companyname.com](mailto:sanderson@companyname.com)

## Codes

- QB Qualified Beneficiary
- SPM – Special Plan Member
- NPM – New Plan Member

## Adding a New Qualified Beneficiary

Ensure the radio button is selected for QB then click “add a new QB.”

All red fields are required.

1. General
  - a. If the fields are pre-populated, leave the default. When complete click Next.
2. Event
  - a. Event date: date of the actual qualifying event
  - b. Date of Hire/Enrollment: must be at least one day prior to event date.
  - c. Legacy QB: will not be used.
  - d. When complete click Next.
3. Plans
  - a. Each plan must be individually selected (i.e., medical, dental, vision, FSA)
  - b. Add a Plan
  - c. Select Plan and coverage level.
  - d. Leave pre-populated dates.
  - e. Insert each plan
  - f. When complete click Next.
4. Dependents
  - a. If there are dependents click Add a Dependent
  - b. General Tab – enter the relationship, First and Last Name.
  - c. After entering the name, click the Plans tab
  - d. Plans tab – Click Add Dependent Plans
  - e. Select the appropriate plan(s) and click “Add Plans”
  - f. Once dependent plans are added click OK

- i. Additional dependents will be added the same way.
  - g. The last three steps are rarely used. If no subsidy is being added, click Finish
- 5. Subsidies
  - a. If the company is paying all or part of the premium this will need to be completed. Please also notify the COBRA department by email [cobra@pacificsource.com](mailto:cobra@pacificsource.com)
- 6. Letter Inserts
  - a. This is additional information regarding individual state regulations
- 7. Notes
  - a. Not used

