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29 CFR Part 2590

Health Care Continuation Coverage; Proposed Rule

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AA60

Health Care Continuation Coverage

AGENCY: Employee Benefits Security Administration, Labor.

ACTION: Proposed regulations.

SUMMARY: This document contains proposed regulations implementing the notice requirements of the health care continuation coverage (COBRA) provisions of Part 6 of title I of the Employee Retirement Income Security Act of 1974 (ERISA). The continuation coverage provisions generally require group health plans to provide participants and beneficiaries who under certain circumstances would lose coverage (qualified beneficiaries) the opportunity to elect to continue coverage under the plan at group rates for a limited period of time.

The proposed rules set minimum standards for the timing and content of the notices required under the continuation coverage provisions and establish standards for administering the notice process. This document also contains model forms for use by administrators of single-employer group health plans to satisfy their obligation to provide general notices and election notices. These proposed regulations, if finalized, would affect administrators of group health plans, participants and beneficiaries (including qualified beneficiaries) of group health plans, and the sponsors and fiduciaries of such plans.

DATES: Written comments on these proposed regulations should be received by the Department of Labor on or before July 28, 2003.

ADDRESSES: Comments (preferably at least three copies) should be addressed to the Office of Regulations and Interpretations, Employee Benefits Security Administration, Room N–5669, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210. Attn: COBRA Notice Regulations. Comments also may be submitted electronically to *e-ORI@EBSA.dol.gov.* All comments received will be available for public inspection at the Public Disclosure Room, N–1513, Employee Benefits Security Administration, 200 Constitution Avenue NW., Washington, DC 20210.

FOR FURTHER INFORMATION CONTACT: Lisa M. Fields or Suzanne M. Adelman, Office of Regulations and Interpretations, Employee Benefits Security Administration, (202) 693–8523. This is not a toll-free number.

SUPPLEMENTARY INFORMATION:

A. Background

The continuation coverage provisions, sections 601 through 608 of title I of ERISA, were enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which also promulgated parallel provisions that became part of the Internal Revenue Code (the Code) and the Public Health Service Act (the PHSA).[1] *See* Code section 4980B; PHSA, 42 U.S.C. 300bb–1 *et seq.* These provisions are commonly referred to as the COBRA provisions, and the continuation coverage that they mandate is commonly referred to as COBRA coverage. The COBRA provisions of title I of ERISA generally require that ''any group health plan''[2] offer ''qualified beneficiaries'' the opportunity to elect ''continuation coverage'' following certain events that would otherwise result in the loss of coverage (''qualifying events'').[3] Continuation coverage is a temporary extension of the qualified beneficiary's previous group health coverage. The right to elect continuation coverage allows individuals to maintain group health coverage under adverse circumstances and to bridge gaps in health coverage that otherwise could limit their access to health care.

COBRA, as enacted, provides that the Secretary of Labor (the Secretary) has the authority under section 608 to carry out the provisions of part 6 of title I of ERISA. The Conference Report that accompanied COBRA divided interpretive authority over the COBRA provisions between the Secretary and the Secretary of the Treasury (the Treasury) by providing that the Secretary has the authority to issue regulations implementing the notice and disclosure requirements of COBRA, while the Treasury is authorized to issue regulations defining the required continuation coverage.[4] Under its authority to interpret the COBRA provisions, the Treasury has issued final regulations that provide rules for determining which plans are subject to the COBRA provisions, who is or can become a qualified beneficiary, which events constitute qualifying events, what COBRA obligations exist in the case of mergers and acquisitions, and the nature of the continuation coverage that must be offered. *See* Treas. Reg. §§ 54.4980B–1 through 54.4980B–10. These proposed rules implementing the notice requirements of the COBRA provisions of Part 6 of title I of ERISA would apply for purposes of the COBRA provisions of section 4980B of the Code.[5]

B. COBRA Notice Requirements

Section 606(a)(1) requires group health plans to provide a written notice containing general information about COBRA rights to each covered employee and his or her spouse when coverage under the plan commences. Sections 606(a)(2) and 606(a)(3) require the plan administrator to be notified when a qualifying event occurs, and the nature of the qualifying event determines whether the employer or the covered employee and qualified beneficiary must give this notice to the plan

[1] The Code and PHSA COBRA provisions, although very similar in other ways, are not identical to the COBRA provisions in title I of ERISA in their scope of application. The PHSA provisions apply only to State and local governmental plans, and the Code provisions grant COBRA rights to individuals who would not be considered participants or beneficiaries under ERISA. *See* PHSA, 42 U.S.C. 300bb–8; Code section 5000(b)(1).

[2] A group health plan is not subject to the COBRA provisions for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. *See* section 601(b).

[3] Each of the quoted terms is specifically defined in the COBRA provisions. In particular, the term *group health plan* is defined in section 607(1) to mean an employee welfare benefit plan as defined in section 3(1) that provides medical care (as defined in section 213(d) of the Code) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. The Department notes that employee welfare benefit plans under ERISA include, *inter alia*, plans sponsored by unions for their members as well as plans sponsored by employers for their employees. Such union-sponsored plans would not involve employers in any sponsorship capacity, nor would they necessarily cover individuals all of whom are employees. Although the proposed regulations use the terms ''employer'' and ''employee,'' as do the COBRA provisions, in assigning duties, they are intended to apply to all group health plans, as defined in section 607(1), subject to COBRA.

[4] H.R. Conf. Rep. No. 99–453, 99th Cong., 1st Sess., at 562–63 (1985). The Conference Report further indicates that the Secretary of Health and Human Services, who is to issue regulations implementing the continuation coverage requirements for State and local governments, must conform the actual requirements of those regulations to the regulations issued by the Secretary and the Treasury. *Id.* at 563.

[5] As noted in footnote 1, above, certain COBRA provisions (such as the definitions of group health plan, employee and employer) are not identical in the Code and title I of ERISA. The Treasury has reviewed these rules and concurs that, in those cases in which the statutory language is not identical, §§ 2590.606–1 through 2590.606–4 would nonetheless apply to the COBRA provisions of sec. 4980B of the Code, except to the extent that such regulations are inconsistent with the statutory language of the Code.

administrator.[6] Section 606(a)(4) requires a plan administrator who has received a notice of qualifying event to provide each qualified beneficiary with a notice of such beneficiary's rights under the COBRA provisions. The provision of an election notice starts the running of the 60-day period during which qualified beneficiaries may elect continuation coverage. *See* section 605(1)(C).

The maximum period for which a plan is obliged to provide COBRA coverage is 36 months, but in certain circumstances a plan is required to provide only 18 months of continuation coverage (after a qualifying event that is termination or reduction in hours of a covered employee's employment). The COBRA provisions require an 18-month period of COBRA coverage to be extended to a longer period in only two circumstances: if a qualified beneficiary is or becomes disabled, or if a second qualifying event occurs. Sections 602(2) and 606(a)(3) require notice of a disability to be provided as a prerequisite to the disability extension. The right to an extension of continuation coverage based on the occurrence of a second qualifying event is based on providing notice of such second qualifying event pursuant to section 606(a)(3).

The Trade Act of 2002, Public Law 107–210, enacted on August 6, 2002, amended section 605 of ERISA to add a new subsection (b). This new subsection provides a second 60-day COBRA election period for certain individuals who become eligible for trade adjustment assistance (TAA) pursuant to the Trade Act of 1974.[7] New section 605(b)(1) provides that an individual who is either an eligible TAA recipient under section 35(c)(2) of the Code or an eligible alternative TAA recipient under section 35(c)(3) of the Code (collectively, a TAA-eligible individual), and 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,[8] 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 TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. The individual may elect coverage for both himself or herself and his or her family. Any continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed. However, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has had a 63-day break in coverage under section 701(c)(2) of ERISA (and corresponding provisions of the PHSA and the Code).

The new second COBRA election period is intended to assist individuals who become TAA-eligible in taking advantage of a new tax credit, also created by the Trade Act of 2002. Under the new tax provisions, individuals who become eligible for TAA assistance can take a tax credit of 65% of premiums paid for qualified health insurance. The Trade Act of 2002 provides for advance payment of the tax credit to health insurers, beginning in 2003. COBRA continuation coverage is one of the types of health insurance that qualifies for the tax credit. Because of the importance of the right to elect COBRA continuation coverage as a TAA-eligible individual, it is the view of the Department that information on the possible availability of a new second election period in the event of TAA eligibility should, pursuant to 29 CFR 2520.102–3(o), be included in the summary plan description of a group health plan as part of the discussion of continuation coverage provisions.

It is anticipated that information on the right to a second COBRA election, together with other information on trade adjustment assistance and the health coverage tax credit, will also be made available to potentially eligible individuals through the State Workforce Agencies in connection with the certification process for trade adjustment assistance.

C. Overview of Proposed Regulations

The provision of timely and adequate notifications regarding COBRA rights, the occurrence of qualifying events, and election rights is critical to the effective exercise of COBRA rights. Failure to meet notice requirements may cause a qualified beneficiary to lose COBRA rights or may conversely cause a plan administrator to be subject to fines or other adverse consequences. In the Department's view, regulatory guidance establishing clearer standards for the administration of the COBRA notice processes would reduce the risks both to plans and to qualified beneficiaries by providing certainty as to how the notice obligations can be met.[9] The attached proposed regulations are intended to provide the necessary guidance.

The proposed guidance comprises four separate regulations. Section 2590.606–1 covers the general notice. Section 2590.606–2 creates rules for employer-provided notices of the occurrence of a qualifying event. Section 2590.606–3 addresses the responsibilities of qualified beneficiaries to provide notice of a qualifying event or a disability. Finally, § 2590.606–4 deals with the election notice and other notices that plan administrators must provide subsequent to the election of COBRA coverage. As part of this proposal, the Department is also including, for public comment, model forms for two of the administrator's notices: the general notice and the election notice.[10] The model forms are appended, respectively, to § 2590.606–1 and § 2590.606–4. Each model allows for inclusion of plan-specific information to reflect the circumstances of a particular plan. It should be noted, however, that these models have been designed for use primarily by single-employer plans and do not reflect the special rules or practices that may apply in the case of other types of group health plans, such as multiemployer plans or plans sponsored by unions for their members.[11] The Department specifically requests comment on what, if any, changes should be made to the model

[6] When the qualifying event is the death of the covered employee, the termination or reduction of hours of the covered employee's employment, the covered employee's becoming entitled to Medicare, or a bankruptcy proceeding of the employer, the notice obligation falls on the employer. For the other qualifying events (divorce or legal separation or a dependent child's ceasing to be a dependent under the terms of the plan), the notice obligation falls on the covered employee or qualified beneficiary.

[7] Pursuant to the Trade Act of 1974 (19 U.S.C. 2101 *et seq.*), workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may become entitled to receive TAA, which primarily consists of career counseling, up to two years of training, income support during training, job search assistance, and relocation allowances.

[8] Section 605(a)(1) of ERISA provides that the election period is the period which: (A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event; (B) is of at least 60 days' duration; and (C) ends not earlier than 60 days after the later of the date coverage terminates or the date of the notice.

[9] On September 23, 1997, the Department issued a Request for Information (RFI) to assess public views on the advisability of developing regulations on the COBRA notice provisions. 62 FR 49894 (Sept. 23, 1997). The Department received 15 comments in response to that RFI. These proposed regulations take into account the views expressed in those comments.

[10] Of the 15 comments received in response to the COBRA notice RFI, 11 commenters advocated that the Department develop model plan administrators' notices.

[11] The model election notice, further, is not designed to be used when bankruptcy is the qualifying event.

forms to adequately reflect current practice and meet the needs of plan administrators, participants, and beneficiaries.

These proposed regulations establish minimum timing and content requirements for the required notices and set forth general rules for administering the COBRA notice process. The goal of this regulatory initiative is to create certainty and uniformity in this process, while also improving the consistency and quality of information provided to participants and beneficiaries about their COBRA rights. The Department believes that the proposed regulations, which would provide clear, uniform rules for the required notices, would make it easier for plans and employers to comply with COBRA notice requirements. The Department proposes to make these regulations, in their final form, effective and applicable as of the first day of the first plan year that occurs on or after January 1, 2004.

The Department notes that the Conference Report that accompanied COBRA states that ''pending the promulgation of regulations, employers are required to operate in good faith compliance with a reasonable interpretation of these [COBRA] substantive rules, notice requirements, etc.''[12] In the absence of final regulations, this continues to be the standard by which the Department will judge plan operations in this area. The publication of these proposed regulations should not be considered to relieve plan administrators of their obligation to meet this standard. In particular, the Department notes that, effective with publication of these proposed regulations, the Department will no longer consider use of the model general notice in ERISA Technical Release 86–2 (June 26, 1986) (TR 86–2) to be good faith compliance with the requirements of section 606(a)(1). [13]

Section 2590.606–1 General Notice

Section 606(a)(1) requires each group health plan covered under COBRA to provide a written notice ''at the time of commencement of coverage'' to each covered employee and spouse (if any) of the employee. Proposed § 2590.606–1 establishes rules for both when this general notice must be provided and what information it must contain.

Paragraph (c) of the regulation sets forth the required minimum content of a general notice. These content requirements cover basic information regarding COBRA and the rights and responsibilities of qualified beneficiaries that a participant or beneficiary would need to know before the occurrence of a qualifying event in order to be able to protect his or her COBRA rights. In particular, paragraph (c) requires the general notice to describe the plan's requirements for notices that must be provided by qualified beneficiaries, such as the notice of a qualifying event involving divorce, separation, or a dependent's becoming no longer eligible for coverage as a dependent.

Paragraph (b) of the regulation establishes a 90-day period for the furnishing of the general notice, beginning with the date on which the covered employee or spouse first becomes covered under the plan. If the plan administrator must provide an election notice to the employee or to his or her spouse or dependent during the first 90 days of coverage, however, paragraph (b) requires the general notice to be provided at that earlier time. This provision protects participants and beneficiaries during the first 90 days of coverage by ensuring that they receive all of the information they need to understand their rights when the information is most necessary.

Paragraph (e) further permits plans to satisfy the general notice requirement by including the information described in paragraphs (c)(1), (2), (3), (4), and (5) in the summary plan description (SPD) of the plan and providing the SPD at a time that complies with the timing requirements for the general notice. The Department anticipates that many, and perhaps most, plans would prefer to take advantage of the reduced cost and added efficiency of providing a single disclosure document that satisfies both the general notice requirement and the SPD requirement. If a plan chooses to satisfy both disclosure obligations by furnishing a single document, the plan must ensure that the document satisfies both the general notice content requirements and the SPD content requirements.[14]

Paragraph (f) provides that delivery of the general notice should be made in accordance with the standards of 29 CFR 2520.104b–1, including the standards for use of electronic media. Paragraph (d) permits delivery of a single notice addressed to a covered employee and the covered employee's spouse at their residence, provided the plan's latest information indicates that both reside at that address. A single notice would not be permitted, however, if a spouse's coverage under the plan begins at a different time from the covered employee's coverage, unless the spouse's coverage begins before the date on which the notice must be provided to the covered employee. Further, in-hand furnishing of the general notice at the workplace to a covered employee is deemed to be adequate delivery to the employee, although such delivery to the employee would not constitute delivery to the spouse.

The appendix to this section contains a model general notice that plan administrators may use to satisfy the content requirements of the regulation. The model general notice allows for inclusion of plan-specific information, including designation of the appropriate COBRA administrative contact and description of specific plan procedures, and provides alternatives to reflect the plan's practices regarding premium payment requirements, dates on which continuation coverage will begin, and whether bankruptcy could be a qualifying event under the specific plan. While the Department intends that use of an appropriately completed model notice, when finalized, would be considered compliance with the content requirements of the regulation, the Department does not intend to require its use and anticipates that a variety of other notices could satisfy the requirements of the regulation. The Department requests comment on whether the proposed model general notice adequately reflects current practice and provides plans with sufficient flexibility to describe individual plans' specific COBRA provisions.

Section 2590.606–2 Employer's Notice of Qualifying Event

Section 606(a)(2) requires an employer to provide notice to the plan administrator of a qualifying event that

[12] H.R. Conf. Rep. No. 99–453, at 563.

[13] On June 26, 1986, the Department issued TR 86–2 to provide guidance to employers on the then newly enacted COBRA provisions. The Department provided, with TR 86–2, a model general notice to assist group health plans with the immediate necessity of providing a general notice by the effective date of COBRA, which came into force as of the beginning of the first plan year on or after July 1, 1986. The Department indicated that use of the model notice would be considered good faith compliance with the requirements of section 606(a)(1). The TR 86–2 model notice was intended to inform participants and beneficiaries, for the first time, of the passage of COBRA and educate them about the new COBRA rights. Because of the variety of subsequent statutory amendments, the TR 86–2 model notice no longer adequately reflects the COBRA provisions.

[14] The SPD content regulation, § 2520.102–3, specifies other information, in addition to description of COBRA rights, that must be included in an SPD for a group health plan. See, *e.g.*, § 2520.102–3(j)(2), (3), (l).

is either the employee's termination of employment or reduction in hours of employment, the employee's death, the employee's becoming enrolled in Medicare, or the commencement of a proceeding in bankruptcy with respect to the employer. Proposed § 2590.606–2 addresses this notice obligation of employers.

Paragraph (b) of the regulation provides that an employer shall notify the plan administrator of a qualifying event no later than 30 days after the date of the qualifying event. However, paragraph (b) further provides that, for any plan under which continuation coverage begins, pursuant to section 607(5), with the date of loss of coverage, the 30–day period for providing the notice of qualifying event must also begin with the date of loss of coverage, rather than the date of the qualifying event. Paragraphs (b) and (d) also recognize that multiemployer plans may have different notice periods, as permitted under sections 606(a)(2) and 606(b).

Paragraph (c) of the regulation requires that an employer provide the plan administrator sufficient information to enable the administrator to determine the identity of the plan, the covered employee, the qualifying event, and the date of the qualifying event.

Section 2590.606–3 Qualified Beneficiary's Notices

Under section 606(a)(3), each covered employee or qualified beneficiary is responsible for notifying the plan administrator of a qualifying event that is either the divorce or legal separation of the employee from his or her spouse or a dependent's becoming no longer eligible to be covered as a dependent under the plan. This notice must be provided within 60 days after the occurrence of the qualifying event. Proposed § 2590.606–3 provides guidance with respect to this notice obligation and other notice obligations of qualified beneficiaries, such as the notice of disability or second qualifying event.

Paragraph (b) of the regulation requires plans to establish reasonable procedures for the furnishing of notices by covered employees and qualified beneficiaries and sets general standards for what will be considered reasonable.[15] A plan's procedures generally would be deemed reasonable if they are described in the plan's SPD, specify who is designated to receive notices and specify the means qualified beneficiaries must use for giving notice and the required content of the notice. Paragraph (b) further provides that, if a plan does not have reasonable procedures for qualified beneficiaries' notices, notice will be deemed to have been provided if certain information adequately identifying a specific qualifying event is communicated to any of the parties that would customarily be considered in charge of the plan. Paragraph (b) provides that plans may require notices to be submitted via a specific form, if the form is easily available to qualified beneficiaries without cost, and may require specific information to be provided.

Paragraph (d) provides that a plan may not reject an incomplete notice as untimely if the notice is provided within the plan's time limits and contains enough information to enable the plan administrator to identify the plan, the covered employee and qualified beneficiar(ies), the qualifying event or disability determination, and the date on which it occurred. However, if a timely notice fails to supply all of the information required under the plan's procedures, the plan administrator can require qualified beneficiaries to supply the missing information.

Paragraph (c) provides that the statutory time limits for the qualified beneficiaries' notices are minimum time limits and that plans can provide for longer notice periods. The proposed regulation specifies, however, that a plan's time limit for providing any of the qualified beneficiaries' notices could not begin to run unless and until the plan had satisfied the general notice requirements of section 606(a)(1) with respect to the affected qualified beneficiaries.

Paragraph (c) further requires that a plan structured in accordance with section 607(5) to begin continuation coverage with the date of loss of coverage, rather than the date on which a qualifying event occurs, must provide that the 60-day period for qualified beneficiaries' notices also begins with the date of loss of coverage.[16] Paragraph (e) provides that any of the qualified beneficiary notice obligations can be satisfied with respect to all qualified beneficiaries affected by a single qualifying event through a single notice and that any individual representing the qualified beneficiaries can provide the required notice.

With respect to the notice of disability required to be provided under section 606(a)(3), paragraph (c) specifies that qualified beneficiaries can be required by a plan to provide the disability notice within 60 days of the date of the Social Security Administration's determination of disability and before the end of the initial period of 18 months of continuation coverage. Under the proposed regulation, therefore, failure to provide the disability notice within those time limits, if required by the plan, could be a basis for concluding that notice had not been timely provided under section 606(a)(3). Paragraph (c) makes clear, however, that plans may not decline to provide the disability extension for failure to provide a timely disability notice unless the affected qualified beneficiaries were adequately notified, in advance, of the notice obligation. The regulation further specifies that plans may adopt more generous notice requirements.

Section 2590.606–4 Plan Administrator's Notice Obligations

Section 606(a)(4) requires a plan administrator to notify each qualified beneficiary who is entitled to elect continuation coverage of his or her COBRA rights. Section 606(c) requires a plan administrator to provide such notice within 14 days after the plan administrator is notified of a qualifying event. Proposed § 2590.606–4 provides guidance on the requirements of sections 606(a)(4) and 606(c). The regulation describes timing and content requirements for election notices, requires administrators to notify individuals if continuation coverage is determined not to be available, and requires plan administrators to provide notice when continuation coverage terminates before the end of the maximum period for such coverage.

Paragraph (b) of the regulation sets forth the information that must be included in an election notice.[17] In

[15] ERISA does not mandate that qualified beneficiaries provide notices of qualifying event. A qualified beneficiary may not wish to elect continuation coverage and may therefore decide to forgo providing the notice of qualifying event without violating the COBRA provisions.

[16] Section 607(5) requires coordination of the running of the employer's period for providing notice of qualifying event with the beginning of the continuation coverage period.

[17] The regulation requires an administrator to provide an election notice only when it has been determined that a qualified beneficiary is entitled to elect continuation coverage. In this regard, the Department notes that it is the administrator's responsibility, as a fiduciary, to determine whether individuals who are named in a notice of qualifying event are entitled to continuation coverage and that disputes may arise over the correctness of the administrator's determinations. These proposed regulations are not intended to provide guidance on the substantive rights provided by the COBRA provisions, as such issues are beyond the scope of the Department's authority. The administrator, in reaching decisions on COBRA issues, must apply the COBRA provisions as interpreted by the Treasury regulations. For example, Treasury has

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addition to identifying significant pertinent facts, such as the names and contact information for plan administrators and (if different) COBRA administrators and the qualified beneficiaries and qualifying event, the election notice must describe the continuation coverage being made available and the manner in which the qualified beneficiaries' COBRA rights must be exercised, making clear that each qualified beneficiary has an independent right to elect continuation coverage.[18] The notice must explain the plan's payment requirements, payment schedule, and payment policies (including grace periods and the consequences of late payment or non-payment). If the plan makes alternative coverage available or provides any conversion options, the notice must describe those options and alternatives and explain how choosing them would affect continuation coverage rights. The notice must also specifically state that it does not fully describe continuation coverage or other rights under the plan and that more complete information is available in the plan's summary plan description or from the plan administrator.

The notice must inform qualified beneficiaries of the consequences of not electing continuation coverage under the plan.[19] The Department is concerned that many participants and beneficiaries will not take into account the possible effects of not electing COBRA coverage on other rights they may have to secure health care coverage (*e.g.*, limitations on pre-existing condition exclusions, guaranteed right to purchase individual coverage without a pre-existing condition exclusion, special enrollment rights). The regulation (and model election notice, discussed below) are designed to remind participants and beneficiaries of these considerations as part of the continuation coverage election process.

If continuation coverage is offered for only a maximum of 18 months, the notice must also provide information on possible extensions of that period due to disability or second qualifying events, including detailed instructions on any notices required to be given by qualified beneficiaries.

Paragraph (b) of the regulation coordinates the running of the statutory 14-day time limit for providing an election notice with circumstances that could affect that period, such as a plan's adoption of the alternative limits permitted under section 607(5), or the special rules for multiemployer plans. Paragraph (e) further provides rules permitting a single election notice to be provided to multiple qualified beneficiaries who are part of a single family unit.

If a plan administrator receives a notice of a qualifying event pursuant to § 2590.606–3 from a participant or beneficiary not eligible to receive continuation coverage under the plan, paragraph (c) of the regulation requires the administrator to provide notice to the individual(s) explaining why he or she is not entitled to such coverage. When a participant or beneficiary submits a notice of qualifying event, there is an expectation of coverage on the part of the participant or beneficiary. Requiring notice in such circumstances is intended to avoid problems attendant to misunderstandings in this area. The notice is subject to the same timing requirements as those applicable to election notices.

Paragraph (d) of the regulation requires a specific notice to be provided to qualified beneficiaries in the event that the administrator terminates a period of continuation coverage before the end of its maximum duration. The COBRA provisions permit early termination of continuation coverage in a number of circumstances, such as when the employer ceases to offer group health coverage to its employees or when the required premium payment is not timely paid. In the Department's view, providing a notice of early termination serves an important administrative function and permits qualified beneficiaries to take appropriate next steps to protect their access to health coverage, either on a group or individual basis. Accordingly, the proposed regulation requires plan administrators to give specific notice of early termination of continuation coverage. Such notice must be provided as soon as administratively practicable after the termination decision is made, must explain why and when the continuation coverage is being terminated, and must describe any rights to other coverage the qualified beneficiaries will have upon termination. Nothing in these proposed regulations is intended to prevent a plan administrator from combining, for ease of administration, the furnishing of an early termination notice to a qualified beneficiary with the furnishing of the certificate of creditable coverage that must be provided to the qualified beneficiary under Part 7 of ERISA.

The appendix to this section contains a model election notice for plan administrators to use in discharging this notice obligation. The model election notice, like the model general notice, allows for inclusion of plan-specific information and provides alternatives, where appropriate, to tailor specific notices to reflect specific plan design. Among the alternatives, the model election notice includes language about the new 65% tax credit under the Trade Act that may be used if an administrator believes employees might be eligible for trade adjustment assistance. The model is intended for use only by single-employer group health plans and does not reflect the special rules that may apply to other plans, such as multiemployer plans or union-sponsored plans. Because of the complexity of the applicable rules, the model is also not intended for use when bankruptcy is the qualifying event.

Use of an appropriately completed model election notice under final regulations would be considered by the Department compliance with the content requirements of the regulation. However, the Department does not intend to require use of the model election notice and anticipates that plans could satisfy the requirements of the regulation through other types of notices. As with the proposed model general notice, the Department specifically solicits public comment on whether the model election notice adequately reflects current COBRA administrative practice and provides sufficient flexibility to be used by a majority of group health plans, as well as suggestions as to how the model could be improved.

D. Regulatory Impact Analysis

Summary

The Department expects these proposed regulations to benefit both plan sponsors and participants. They will dispel plan administrators' uncertainty about how to comply with COBRA notice provisions and reduce the risk of inadvertent violations. They will help participants and beneficiaries to understand how to exercise their COBRA rights thereby averting costly

determined that a qualifying event does not occur when an employee begins a family or medical leave from employment under the Family and Medical Leave Act (FMLA), but may occur if the individual does not return to work at the end of the FMLA leave. 26 CFR 54.4980B–10.

[18] The notice could either provide a full description of the offered coverage (including separate options) or make specific reference to relevant portions of the plan's SPD, along with information on how to obtain the SPD.

[19] In particular, paragraph (b) requires the notice to include an explanation of the effect of electing or not electing continuation coverage on rights guaranteed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became Part 7 of title I of ERISA. *See* § 2590.606–4(b)(4)(vi). The model election notice contains specific language that would carry out this requirement.

disputes and lost opportunities to elect COBRA coverage. This will result in an increase in the number of COBRA elections by qualified beneficiaries. These benefits of the regulation are expected to outweigh its costs.

New administrative costs imposed by these regulations are limited because plan sponsors and administrators already distribute notices pursuant to the COBRA statute, and many of their existing practices are likely to already satisfy the requirements of these proposed regulations. The Department estimates the new administrative costs to be $2.4 million in the first year that the regulations are effective and $0.9 million annually in subsequent years. The $0.9 million ongoing annual cost is attributable to the new requirements to notify qualified beneficiaries when continuation coverage is not available or has been terminated before the maximum period of coverage has ended. The additional $1.5 million first-year cost reflects the cost to plans to review existing notices and procedures, to make any necessary revisions, and to develop the new notices.

The Department also expects the number of COBRA elections to increase slightly, resulting in an increased subsidy from employers to COBRA enrollees, *i.e.,* those qualified beneficiaries who elect continuation coverage. Employers can charge COBRA enrollees the full average cost of coverage plus an administrative charge, but those electing continuation coverage tend to have higher than average costs and therefore as a group enjoy a subsidy from plan sponsors equal to about one-third of the cost of their coverage. If COBRA elections increase by between 0.5 percent and 1.0 percent, the amount of the subsidy will increase by a similar proportion, or between $12 million and $24 million annually. This cost to plan sponsors represents an even larger benefit to the new enrollees. Absent COBRA continuation coverage, these enrollees might purchase insurance individually, and such individual policies generally provide less coverage per dollar than the group policies continued under COBRA. Alternatively, they might go without any coverage and thereby place their finances and possibly their health at risk.

Executive Order 12866

Under Executive Order 12866, the Department must determine whether the regulatory action is ''significant'' and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a ''significant regulatory action'' as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, it has been determined that this action is ''significant'' within the meaning of section 3(f)(4) of the Executive Order and therefore subject to review by the Office of Management and Budget (OMB). Accordingly, the Department has undertaken an assessment of the costs and benefits of this regulatory action. The analysis is summarized below.

As noted earlier in this preamble, COBRA provides that under specific circumstances participants and beneficiaries may elect to continue group health coverage temporarily following events that would otherwise result in the loss of coverage. Within its authority to issue implementing guidance concerning the notice and disclosure provisions of COBRA, the Department is proposing these regulations to address concerns raised by plan administrators, participants, and beneficiaries about the content, timing, and format of the notices required by the statute.

Costs—The Department considered economic costs and benefits in its consideration of alternatives and formulation of this proposal. The Department estimates that the regulations will increase administrative costs by $2.4 million in the first year and $0.9 million annually in subsequent years. Reflecting instances in which clear guidance will avert a lost opportunity to elect COBRA coverage, the Department also expects the number of COBRA elections to increase slightly. As a result, a portion of the cost of health care coverage will transfer from those new COBRA enrollees to plan sponsors, thereby increasing the subsidy from employers to COBRA enrollees by between 0.5 percent and 1.0 percent, or between $12 million and $24 million annually. This transfer represents a cost to plan sponsors and a benefit to COBRA enrollees. Both the administrative cost and the transfer cost will be borne by the 415,000 group health plans, covering a total of about 111 million participants and their dependents, that are currently required to offer continuation coverage.

The administrative cost of these regulations is expected to be modest, primarily because COBRA's statutory provisions have been in effect since 1986. As a result, most group health plans, plan administrators, and health insurance issuers already have developed forms and procedures for the administration of COBRA notices. The Department's estimates recognize only the cost of changes to existing practices that are likely to be associated with these rules; they exclude the pre-regulation impact of the statute itself.

Economies of scale also tend to moderate COBRA administrative costs because the majority of notice obligations are met through the purchase of COBRA administrative services from a number of providers that is small relative to the number of group health plans they serve. Nonetheless, group health plan sponsors, plan administrators, and professional service providers have stated a need for guidance, the implementation of which is expected to result in their reconsideration of their notices and procedures in light of the specific provisions of these regulations and model notices. The estimate includes the cost of professional time for the entities administering continuation coverage for all group health plans to conduct such a review. The estimate is grounded in an assumption as to the entity expected to perform the needed work (*e.g.,* a health insurer or professional administrator); the assumption should not be interpreted to bear on any party's legal responsibility for COBRA compliance.

The Department assumes that the percentage of qualified beneficiaries who lose the opportunity to elect COBRA coverage because they receive inadequate notice is very small. A portion of the cost of health care for those qualified beneficiaries would be transferred to plan sponsors to the extent that the inadequacies would be corrected as a result of the adoption of clearer and more uniform standards in connection with this guidance. The transfer arises because surveys indicate that although qualified beneficiaries who elect COBRA coverage pay the applicable cost of coverage plus an administrative charge for continuation coverage, the average cost of continuation coverage to the sponsor is

somewhat higher than the amount paid by the qualified beneficiary. This normally constitutes a subsidy of the continuation coverage by the plan sponsor. However, where qualified beneficiaries have lost the opportunity to elect the COBRA coverage to which they are entitled, they may bear the entire cost of their health care rather than the cost and administrative charge for group coverage. Averting the lost opportunity would result in a transfer of cost from the qualified beneficiary denied coverage to the plan sponsor that is equivalent to the subsidy, assuming the former participant or dependent is paying the entire cost of his or her health care.

The amount of this transfer is estimated at between $12 million and $24 million per year. In deriving this estimate, the Department observed that the number of inquiries the Department receives annually concerning COBRA, about 59,000, is equivalent to just more than 1 percent of the estimated 5 million annual COBRA qualifying events. It is likely that some but not all of these inquiries reflect notice inadequacies that these regulations would correct. The Department also noted that approximately 19 percent of qualifying events result in elections, and that the average subsidy from plan sponsors to COBRA enrollees amounts to about $2,500. If between 0.5 percent and 1.0 percent of qualifying events involve missed opportunities due to inadequate notice, and 19 percent of those events would have resulted in elections, then the regulations would increase COBRA enrollees by between 4,750 and 9,500, increasing the aggregate subsidy by between $12 million and $24 million. Expressed in unit costs, for every one percent increase in the number of participants that were wrongfully denied continuation health coverage, there is an estimated incremental increase in cost of $24 million to plan sponsors or approximately $58 per plan.

The transfer cost, together with the $2.4 million in administrative costs, is equal to only one-hundredth of 1 percent or less of total group health plan costs to companies subject to COBRA. Because the magnitude of the overall increase in costs to plans is small, the Department believes that it will not have a consequential effect on the availability of health coverage for employees, but welcomes comment on these assumptions.

Benefits—The benefits of these proposed rules will arise from improved administrative efficiency, reduced exposure to risk, and from the potential avoidance of some unnecessary losses of group health plan coverage by otherwise qualified beneficiaries.

Inconsistent procedures, and notices that are not fully compliant as to content, timing, and form are known to generate questions, delays, disputes, and duplications of effort that require the expenditure of additional resources by both plan administrators and participants and beneficiaries to resolve. Although the magnitude of the costs and potential savings associated with administrative inefficiencies is unknown, clearer and more uniform standards should serve to avoid the otherwise unnecessary expense associated with rectifying procedural and substantive notice inadequacies.

Providing greater certainty to plan sponsors and plan administrators as to how their notice obligations can be met should also limit risks to both plans and qualified beneficiaries. Plan sponsors and plan administrators who comply with this guidance should be less likely to be subjected to costly disputes, litigation, or penalties as a result of their compliance with this guidance. Improvements in the consistency and quality of information provided to participants and dependents is expected to help them understand their rights and limit their risk of losing the opportunity to elect COBRA coverage.

The benefits of improved efficiency and reduced risk cannot be specifically quantified. The beneficial impact of preventing lost opportunities to elect continuation coverage can be estimated, however. The benefit to enrollees will exceed the financial value of the transfer insofar as the enrollees will gain access to high-value group coverage, rather than a choice between buying generally lower-value individual insurance or going without coverage altogether. Qualified beneficiaries who lose group health plan coverage due to inadequate notice may be faced with a choice between purchasing individual coverage at a rate significantly higher than a plan's group rate or going without coverage for a period of time. The uninsured bear the risk of catastrophic losses. They are also known to seek preventive care less frequently and to delay or forgo treatment, which may lead to less favorable health outcomes and higher social costs for acute care at a later time. Interruptions in group health plan coverage can ultimately limit the portability of group coverage, as well. A reduction of the numbers of losses of coverage that result from notification failures will also result in efficiency gains to the extent that the qualified beneficiaries elect group health plan coverage rather than individual coverage. Individual coverage is more costly and less efficient due in large part to significantly higher costs of individual policy administration.

Alternatives—The Department gave thorough consideration to the need for guidance on the COBRA notice provisions and to the alternative forms that guidance might take. Being aware that most plan administrators and service providers make use of established forms and procedures, the Department did not wish to impose the costs likely to arise from reviews and changes to forms and procedures likely to result from the issuance of guidance unless it was actually valuable to plan administrators and qualified beneficiaries. Public comments received in response to the 1997 RFI, and information received from a range of interested parties by the Department in the conduct of its compliance assistance, outreach, and enforcement activities, however, persuaded the Department that guidance would be beneficial.

The Department also considered whether an informational booklet or question and answer publication rather than regulatory guidance would serve to provide the needed general information and address administrative complexities. Ultimately, the Department determined that while such publications might be helpful, they would not provide plan administrators with the certainty to meet their stated needs. Similarly, in its deliberations concerning the inclusion of model notices, the Department concluded that promulgation of models would encourage improved uniformity and information quality while providing greater certainty to plan administrators that their notices and procedures conform to the requirements of the statute. Because use of the models is voluntary, it is considered to provide this greater certainty without unnecessarily restricting plan administrators' continued use of existing notices and procedures that are appropriate as to content and timing.

Because the direct costs of this proposal arise from disclosure provisions, additional details concerning the data and assumptions used in developing these estimates may be found in the Paperwork Reduction Act section of this preamble. As required, the paperwork burden estimates include an analysis of the cost of the statutory provisions underlying these proposed regulations.

Paperwork Reduction Act

As part of its continuing effort to reduce paperwork and respondent

burden, the Department of Labor conducts a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3506(c)(2)(A)). This helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed.

Currently, EBSA is soliciting comments concerning the proposed information collection request (ICR) included in this Notice of Proposed Rulemaking with respect to the Health Care Continuation Coverage Provisions of Part 6 of title I of ERISA. A copy of the ICR may be obtained by contacting the PRA addressee shown below.

The Department has submitted a copy of the proposed information collection to OMB in accordance with 44 U.S.C. 3507(d) for review of its information collections. The Department and OMB are particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503; Attention: Desk Officer for the Employee Benefits Security Administration. Although comments may be submitted through July 28, 2003, OMB requests that comments be received within 30 days of publication of the Notice of Proposed Rulemaking to ensure their consideration.

PRA Addressee: Address requests for copies of the ICR to Joseph S. Piacentini, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW., Room N–5718, Washington, DC 20210. Telephone (202) 693–8410; Fax: (202) 219–5333. These are not toll-free numbers.

The Department is issuing these proposed rules to set minimum standards for the timing and content of the notices required under the continuation coverage provisions of Part 6 of title I of ERISA, and to establish uniform standards for administering the notice process. In very general terms, the statute requires that qualified beneficiaries be offered the opportunity to elect to continue group health coverage after losses of coverage due to death of the employee, termination of employment or reduction of hours, divorce or legal separation of the covered employee from the employee's spouse, the covered employee's becoming entitled to Medicare, or bankruptcy of an employer that affects covered retirees. Qualified beneficiaries may include employees, the spouse of a covered employee and dependent children of the covered employee. Coverage can extend for 18 or 36 months, depending on the nature of the qualifying event. The plan administrator must notify COBRA participants when their coverage is terminated earlier than its maximum duration. Additional distributions of notices may be required when a COBRA enrollee experiences a second qualifying event.

Each of the sections of the proposed regulations includes an information collection request. The specific regulatory requirements of each section are described in detail earlier in this preamble. The information collection provisions are identified and very briefly described below. The actual provisions of the proposed regulation rather than this summary should be referred to for COBRA compliance purposes.

Section 2590.6061—General Notice. This section describes the plan administrator's obligation to provide a general notice of COBRA rights to participants and their spouses who newly become covered under a group health plan. These general notices may be included in the Summary Plan Description. A model general notice has been drafted to assist plan administrators with compliance and reduce compliance burden.

Section 2590.6062—Employer's notice of qualifying event. These notices are required to be provided by employers to plan administrators whenever a qualifying event occurs that is an employee's termination of employment or reduction of hours, death, or enrollment in Medicare.

Section 2590.6063—Qualified beneficiary's notices. Qualified beneficiaries are responsible for notifying the plan administrator of a qualifying event that is the divorce or legal separation of the employee and spouse, or a dependent's becoming no longer eligible for coverage as a dependent under the plan.

Section 2590.6064—Plan administrator's notice obligations. Plan administrators are required to notify each qualified beneficiary who is entitled to elect continuation coverage of his or her rights under COBRA. Paragraph (d) requires specific notice to be provided to qualified beneficiaries in the event that the administrator terminates continuation coverage prior to the end of its maximum duration. A single notice may be sent to multiple qualifying beneficiaries known to reside at a single address, although they each have separate COBRA election rights. A model election notice has been drafted to assist with compliance and reduce compliance burden.

In order to estimate the burden of compliance with the statute and these proposed rules, the Department used data from several sources and made a number of assumptions. It should be noted that this Paperwork Reduction Act analysis includes the cost of the statute as well as the cost of the discretion exercised in this rulemaking. These costs were developed in the manner described below.

In order to develop estimates of the cost of the review, revision, development, and distribution of COBRA notices, it was first necessary to determine the numbers of participants and dependents in plans that are required to offer COBRA coverage (generally plans with 20 or more participants), the numbers of dependents who reside at addresses that are different from other related participants, and the rates of the occurrence of the qualifying events that give rise to notice obligations. The participants and dependents identified in available data sets represent the group of qualified beneficiaries who will have qualifying events. Estimates of the number of entities such as group health insurance issuers and professional administrators that would review their COBRA notices, the number that would consequently revise their COBRA notices, and the time required to do so for each type of notice was also required.

The Department developed its estimates of 55,778,300 employees and 55,002,439 dependents, 67,000 of whom reside at different addresses, and 2,461,000 COBRA enrollees from the February and March 2001 Current Population Survey (CPS; Census Bureau household surveys), the 2000 Medical Expenditure Panel Survey, Household and Insurance Components (MEPS; joint Census Bureau and Agency for Healthcare Policy and Research surveys of households and private establishments), and the 1996 Panel of the Survey of Income and Program Participation (SIPP; a Census Bureau longitudinal household survey). Frequency rates for qualifying events were also developed from MEPS and SIPP.

An estimate of the number of plans covering these employees and dependents was also needed. About 50,000 group health plans file the Form 5500—Annual Return/Report of Employee Benefit Plan. These are generally plans with 100 or more participants that are defined for purposes of regulatory analyses as large plans. Because the majority of small group health plans are not required to file Form 5500, the number of such plans must be estimated from other data sources. CPS and MEPS data can be used to derive an estimate of the number of establishments that offer group health coverage by size of establishment. The establishments with fewer than 20 employees can be excluded based on establishment size variables. While the count of establishments with 20 to 99 employees that do offer coverage will vary to some degree from a count of plans because some plans include multiple establishments, it is considered to offer a reasonable proxy for the number of small plans and the distribution of participants and dependents between large and small plans. Using this approach, it can be assumed that these proposed rules would affect a total of about 415,000 plans, 50,000 of which are large, and 365,000 of which are small. The number of participants in large plans is estimated at 43.5 million. The number of participants in small plans is estimated to be 12.3 million.

The Department has assumed that all administrators for these plans will review their existing forms and procedures in response to promulgation of this guidance, and that some of those plan administrators will additionally need to revise their notices and procedures. The Department is aware that, for a large majority of plans, administration of COBRA general notices and election notices is performed by service providers rather than the plans themselves. In order to derive an estimate of the number of entities that will review forms and procedures, the Department looked at the number of health insurers offering group products and the number of professional administrators providing services to group health plans. This results in an estimate of about 3,000 entities that perform COBRA administration for the majority of all plans. All of these entities are expected to review all of their notices and procedures in response to regulatory guidance.

These reviews are assumed to require 2 hours each for the general notice and election notice requirements, and 1 hour each for the employer notice requirements, the employee notice requirements, and for development of a new notice of early termination of COBRA coverage. Employer and employee notices may need to be developed. These 3,000 reviews are expected to be conducted by professionals at the level of financial managers at a cost of $68 per hour.[20] No cost has been included for the new notice of unavailability of continuation coverage because there is currently no basis for determining the number of these notices that might be sent. The Department has assumed, however, that due to the clear and consistent information provided in the general notice, plan administrators will distribute a limited number of these notices annually, and that the associated cost would be very small.

In order to estimate the number of service providers that would be required to revise their existing notices, the Department examined its data pertaining to the nature of telephone inquiries it receives. These data show that about 59,000 inquiries pertaining to COBRA are received each year. Although the portion of these inquiries that pertain to notice provisions is unknown, as is the number of COBRA notification issues that do not give rise to contact with the Department, this number provides the only available proxy for a rate of notice-related difficulties. Given the roughly 5 million COBRA election notices provided each year, the rate of notice inadequacies is assumed to be about 1%. The actual rate might range from .5% to 1% because inquiries do pertain to issues other than notices, but 1% has been used for purposes of these estimates.

For the purpose of determining the number of service providers involved in preparing and distributing the 1% of COBRA notices that may require revision, the Department took into consideration the fact that service providers are known to use standardized forms, and that a small number of service providers are known to provide COBRA administration to a very large number of plans. Reasoning that the rate of notice inadequacies would be higher if the providers serving the majority of plans made use of notices and procedures that were not adequate as to content and timing, the Department assumed that more than 1% of the providers to the remaining fewer plans would be required to revise notices and procedures. Although the actual number is not known, the Department has assumed that 3%, or 90, service providers will need to make revisions. Modification is assumed to require an additional two hours at $68 for each notice in use.

The start-up costs that arise from this proposal pertain to the review and revision of existing forms and procedures and the development of the new early termination notices. The cost of distribution of the termination notices will be an ongoing operating cost.

Ongoing operating costs arise from completing the forms upon the occurrence of each event that gives rise to a notice obligation with information specific to the dates, plan, employee, spouse, or dependent children, and from distributing the completed forms. No completion or distribution cost is attributed to the general notice, except where dependents reside at separate addresses, as the required information is expected to be included in the Summary Plan Description. No burden is included for completing the employer's notices because they involve adding information that the employer has at hand in its customary personnel practices. Similarly, no completion burden is calculated for the qualified beneficiaries' notices because this information is limited, readily accessible, and would be provided as a usual practice by only the qualified beneficiary who wished to continue coverage. Otherwise, the cost of completion of notices is expected to be incurred at a rate of $34 per hour for 5 minutes for election notices and 1 minute for termination notices.

Postage and materials for distribution are estimated at $0.38 per notice. No assumption has been made as to the number of these notices that will be

[20] Wage rates are based on National Occupational Employment and Wage Estimates from the Occupational Employment of the Bureau of Labor Statistics for 2000, adjusted for compensation rate growth, additional compensation costs, and overhead.

distributed electronically. Plan administrators are not precluded from using electronic disclosure methods that comply with regulations at 29 CFR.104b–1(b) and (c). However, the Department believes that due to the nature of the rights and obligations involved in COBRA notice requirements, most plan administrators tend not to choose electronic distribution methods for COBRA notices. The Department requests comments on the use of electronic technology in COBRA notice administration. The application of these assumptions results in estimates of the distribution of 2,809,000 employer notices, 651,000 employee notices, 4,699,000 plan administrator election notices, and 1,000,000 early termination notices each year.

The preparation and distribution of these notices is accounted for as cost rather than hours because most COBRA administration is accomplished through the purchase of services for which fees are paid. The Department welcomes comments on its assumptions and methodology for arriving at these estimates. The number of notices of unavailability of continuation coverage cannot be reasonably estimated.

Type of Review: New collection.

Agency: Employee Benefits Security Administration, Department of Labor.

Title: Notice Requirements of the Health Care Continuation Coverage Provisions.

OMB Number: 1210–0NEW.

Affected Public: Individuals or households; business or other for-profit; not-for-profit institutions.

Respondents: 415,000.

Frequency of Response: On occasion.

Responses: 9,159,000.

Estimated Total Burden Hours: None.

Total Annualized Capital/Startup Costs: $1,452,500.

Total Burden Cost (Operating and Maintenance): $17,386,200.

Total Annualized Cost: $18,838,700.

Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of analysis under the RFA, EBSA proposes to continue to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis of this definition is found in section 104(a)(2) of the Act which permits the Secretary to prescribe simplified annual reports for pension plans, which cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for exemptions or simplified annual reporting and disclosure requirements for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants that satisfy certain other requirements.

Further, while some large employers may have small plans, in general most small plans are maintained by small employers. Thus, EBSA believes that assessing the impact of this proposed rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business which is based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 *et seq.*). EBSA therefore requests comments on the appropriateness of the size standard used in evaluating the impact of this proposed rule on small entities. On this basis, EBSA has determined that the proposed regulation will not have a significant impact on a substantial number of small entities. In support of this conclusion, the Department has conducted an initial regulatory flexibility analysis, which is summarized below.

EBSA is proposing the regulation to provide plans and qualified beneficiaries with greater certainty as to how the notice obligations of COBRA can be met. The Department is considering this action because inquiries to the Department as well as public comment in response to the 1997 RFI indicated that service providers and plan administrators would welcome guidance that would provide greater administrative efficiency and reduce exposure to risk resulting from procedural or substantive failures to meet notification requirements. At the same time, improvements in the quality of information provided to participants and beneficiaries is expected to help them understand their rights and limit their risk of losing the opportunity to elect the COBRA coverage that is required to be offered.

The COBRA provisions of title I of ERISA require a group health plan to offer qualified beneficiaries the opportunity to elect continuation coverage when they would otherwise lose group health coverage as a result of certain events described in the statute as ''qualifying events.'' Under section 608, the Secretary has the authority to carry out the provisions of Part 6 of title I of ERISA. Further, the Conference Report that accompanied COBRA provided that the Secretary has the authority to issue regulations implementing the notice and disclosure provisions of section 606 of ERISA. The Department's objective in issuing the proposed regulations is to provide guidelines that will assure plan administrators that they are in compliance with the notification provisions of COBRA and that participants and beneficiaries have sufficient information to exercise their COBRA rights. Small plans will benefit from clarifications about the content and timing of notices and from the likelihood that fewer determinations about COBRA coverage will be delayed, disputed, or appealed. In addition, an increased number of qualified beneficiaries in small health plans will be able to obtain group health plan continuation coverage.

The Department believes that, because of the expertise required, small plans will use service providers to review notices and to modify or adapt Department models for use by the plan administrator. Generally, COBRA service providers offer plans on-going administrative services such as notifying employees about their group health plan continuation coverage, distributing and processing election forms, collecting and applying premium payments, and monitoring COBRA compliance. Small plans, in particular, are less likely to have in-house capabilities to handle these administrative tasks. For a service provider, reviewing and adopting or modifying forms for plans will result in some direct cost. Service providers may choose to absorb some of the cost in order to maintain competitive products; others may charge the cost to their client

plans. Where these costs are charged to plans, the cost will most likely be minimized because of the economies of scale inherent in the use of standardized forms and procedures. At the same time, costs to small plans are further reduced because of the large number of small plans that share the cost burden; there are approximately seven times as many small plans as large plans. Finally, to further reduce costs, the Department has provided two model notices that can be adapted by service providers for use by individual plans.

The cost estimates for small plan compliance recognize only the cost of changes to existing practices associated with the proposed regulation; they exclude the impact of the statute itself. Costs result first from the likelihood that service providers will develop or modify two notices currently required to be sent to a plan administrator, and the requirement to develop and implement the new early termination notice described in the proposed regulation. No cost is attributable to the new notice of unavailability of continuation coverage. Finally, small plans will incur transfer costs as a result of an increase in the number of elections of continuation coverage by qualified beneficiaries who would have lost the opportunity to elect COBRA coverage absent improved notices and procedures.

The Department estimates that there are approximately 2.5 million plans with fewer than 100 participants that are considered small group health plans under the Department's definition. Among these, COBRA applies to only those plans with 20 or more employees or 365,000 plans, with approximately 12.3 million participants. While the majority of group health plans subject to COBRA are small plans, participation in those plans represents only about 22% of participation in all plans covered by COBRA. Based on the analysis below, the cost to small group health plans to review and adapt or modify existing notices is estimated at $275,900. The cost to develop the new early notice of termination is estimated at $254,300. The total cost to small plans for a service provider's assistance in reviewing, modifying, or developing notices is estimated to be $530,200, or $1.45 per small plan. The comparable average cost to large plans is $37.38 per plan.

Employers with small plans will also incur transfer costs as a result of increased numbers of qualified beneficiaries who will elect continuation coverage. A portion of the cost of health care coverage previously borne by individuals will be transferred from those new COBRA enrollees to plan sponsors under the proposed regulations. For small plans, the per-plan transfer costs are considerably less than for large plans due to there being fewer participants. The potential transfer cost to small plans is estimated to range between $2.6 million and $5.2 million, depending on the number of qualified beneficiaries who will elect COBRA coverage. The rate of potential losses of opportunity to elect COBRA coverage is estimated to fall between .5% and 1%. This represents an average of $7–$14 per small plan. The comparable cost to large plans ranges from $9.4 million to $18.7 million, an average of $185–$370 per plan. At the upper bound, the cost of the proposed regulation for 365,000 small plans is estimated to be $5.7 million, or $15.45 per plan.

Although the basis for the proposed regulation lies in the notice and disclosure provisions of section 606 of title I of ERISA, the proposed regulation does not duplicate, overlap, or conflict with other relevant federal rules. COBRA notification provisions have been in effect for many years. As such, most plan administrators and service providers have developed procedures to comply with their statutory obligations. The proposed regulation merely seeks to provide additional, detailed guidance that will clarify a plan's administrative obligations while assuring plan administrators and service providers that, in complying with the proposed regulation, they have satisfied their statutory obligations. A discussion of alternatives to the proposed regulation that the Department considered appears above in the discussion under Executive Order 12866.

The Department has attempted to minimize the burden of the review and potential revision of existing notices that will be undertaken in response to this guidance by including model notices that can be adapted to plans' specific circumstances. This should lessen the use of resources for small and large plans alike.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), as well as Executive Order 12875, this proposed rule does not include any federal mandate that may result in expenditures by state, local, or tribal governments in the aggregate of more than $100 million, or increased expenditures by the private sector of more than $100 million.

Small Business Regulatory Enforcement Fairness Act

The rule being issued here is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and, if finalized, will be transmitted to Congress and the Comptroller General for review. The rule is not a ''major rule'' as that term is defined in 5 U.S.C. 804, because it is not likely to result in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or federal, state, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Federalism Statement

Executive Order 13132 (August 4, 1999) outlines fundamental principles of federalism and requires the adherence to specific criteria by federal agencies in the process of their formulation and implementation of policies that have substantial direct effects on the States, the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. This proposed rule would not have federalism implications because it has no substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Section 514 of ERISA provides, with certain exceptions specifically enumerated, that the provisions of Titles I and IV of ERISA supersede any and all laws of the States as they relate to any employee benefit plan covered under ERISA. The requirements implemented in this proposed rule do not alter the fundamental provisions of the statute with respect to employee benefit plans, and as such would have no implications for the States or the relationship or distribution of power between the national government and the States.

List of Subjects in 29 CFR Part 2590

Employee benefit plans, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department proposes to

amend Subchapter L, Part 2590 of Title 29 of the Code of Federal Regulations as follows:

SUBCHAPTER L—GROUP HEALTH PLANS

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

1. The heading of subchapter L is revised to read as shown above.

2. The heading of part 2590 is revised to read as shown above.

3. The authority citation for part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 401(b), Pub. L. 105–00, 112 Stat. 645; and Secretary of Labor's Order No. 1–2003, 68 FR 5374 (Feb. 3, 2003).

4. The following new sections are added to subpart A of part 2590:

Subpart A—Continuation Coverage, Qualified Medical Child Support Orders, Coverage for Adopted Children

Sec.
2590.606–1 General notice of continuation coverage.
Appendix to § 2590.606–1.
2590.606–2 Notice requirement for employers.
2590.606–3 Notice requirements for covered employees and qualified beneficiaries.
2590.606–4 Notice requirements for plan administrators.
Appendix to § 2590.606–4.

§ 2590.606–1. General notice of continuation coverage.

(a) *General.* Pursuant to section 606(a)(1) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a group health plan subject to the continuation coverage requirements of Part 6 of title I of the Act shall provide, in accordance with this section, written notice to each covered employee and spouse of the covered employee (if any) of the right to continuation coverage provided under the plan.

(b) *Timing of notice.* The notice required by paragraph (a) of this section shall be furnished to each employee and each employee's spouse, not later than the earlier of:

(1) The date that is 90 days after the date on which such individual's coverage under the plan commences, or, if later, the date that is 90 days after the date on which the plan first becomes subject to the continuation coverage requirements; or

(2) The first date after commencement of coverage of either the covered employee or the spouse on which the administrator is required, pursuant to § 2590.606–4(b), to furnish the covered employee, spouse, or dependent child of such employee notice of a qualified beneficiary's right to elect continuation coverage.

(c) *Content of notice.* The notice required by paragraph (a) of this section shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(1) The name of the plan under which continuation coverage is available, and the name, address and telephone number of the party responsible under the plan for the administration of continuation coverage benefits;

(2) A general description of the continuation coverage under the plan, including identification of the classes of individuals who may become qualified beneficiaries, the types of qualifying events that may give rise to the right to continuation coverage, the obligation of the employer to notify the plan administrator of the occurrence of certain qualifying events, the maximum period for which continuation coverage may be available, when and under what circumstances continuation coverage may be extended beyond the applicable maximum period, and the plan's requirements applicable to the payment of premiums for continuation coverage;

(3) An explanation of the plan's requirements regarding the responsibility of a qualified beneficiary to notify the administrator of a qualifying event that is a divorce, legal separation, or a child's ceasing to be a dependent under the terms of the plan, and a description of the plan's procedures for providing such notice;

(4) An explanation of the plan's requirements regarding the responsibility of qualified beneficiaries who are receiving continuation coverage to provide notice to the administrator of a second qualifying event (such as divorce or legal separation, death of covered employee, covered employee's becoming enrolled in Medicare, and child's loss of dependent child status) or a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 *et seq.* or 1381 *et seq.*), that a qualified beneficiary is disabled, and a description of the plan's procedures for providing such notices;

(5) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(6) A statement that the notice does not fully describe continuation coverage or other rights under the plan and that more complete information regarding such rights is available from the plan administrator and in the plan's summary plan description.

(d) *Single notice rule.* A plan administrator may satisfy the requirement to provide notice in accordance with this section to a covered employee and the covered employee's spouse by furnishing a single notice addressed to both the covered employee and the covered employee's spouse, if, on the basis of the most recent information available to the plan, the covered employee's spouse resides at the same location as the covered employee. The prior sentence shall not apply if a spouse's coverage under the plan commences after the date on which the covered employee's coverage commences, unless the spouse's coverage commences before the date on which the notice required by this section is required to be provided to the covered employee.

(e) *Notice in summary plan description.* A plan administrator may satisfy the requirement to provide notice in accordance with this section by including the information described in paragraphs (c)(1), (2), (3), (4), and (5) of this section in a summary plan description meeting the requirements of § 2520.102–3 of this title furnished in accordance with paragraph (b) of this section.

(f) *Delivery of notice.* The notice required by this section shall be furnished in a manner consistent with the requirements of § 2520.104b–1 of this title, including paragraph (c) of that section relating to the use of electronic media.

(g) *Model notice.* The appendix to this section contains a model notice that is intended to assist administrators in discharging the notice obligations of this section. Use of the model notice is not mandatory. The model reflects the requirements of this section as they would apply to single-employer group health plans and must be modified if used to provide notice with respect to other types of group health plans, such as multiemployer plans or plans established and maintained by employee organizations for their members. In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language, and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content

requirements of paragraph (c) of this section.

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APPENDIX TO § 2590.606-1
MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(For use by single-employer group health plans)

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You are receiving this notice because you have recently become covered under [*enter name of group health plan*] (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is [*enter name, address and telephone number of Plan Administrator*]. [*If the Plan Administrator administers COBRA continuation coverage, add the following:* The Plan Administrator is responsible for administering COBRA continuation coverage.] [*If the Plan Administrator does not administer COBRA continuation coverage, add the following:* COBRA continuation coverage for the Plan is administered by [*enter name, address and telephone number of party responsible for administering COBRA continuation coverage*].

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* are not required to pay] for COBRA continuation coverage.

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

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

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

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

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

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the plan as a "dependent child."

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

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

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

applicable to this Plan: (1) within 30 days of any of these events *or (2)* within 30 days following the date coverage ends.]

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must send this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin [*Enter the option applicable to this Plan: (1)* on the date of the qualifying event *or (2)* on the date that Plan coverage would otherwise have been lost].

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. [*insert and modify to reflect actual plan provisions on this notice:* You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.] This notice should be sent to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these**

cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event [or *enter longer period if permitted under the terms of the Plan*]. This notice must be sent to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact [*enter name of appropriate party*] or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

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

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§ 2590.606–2. Notice requirement for employers.

(a) *General.* Pursuant to section 606(a)(2) of the Employee Retirement Income Security Act of 1974, as amended (the Act), except as otherwise provided in this section, the employer of a covered employee under a group health plan subject to the continuation coverage requirements of Part 6 of title I of the Act shall provide, in accordance with this section, notice to the administrator of the plan of the occurrence of a qualifying event that is the covered employee's death, termination of employment (other than by reason of gross misconduct), reduction in hours of employment, Medicare entitlement, or a proceeding in a case under title 11, United States Code, with respect to the employer from whose employment the covered employee retired at any time.

(b) *Timing of notice.* The notice required by this section shall be furnished to the administrator of the plan—

(1) In the case of a plan that provides, pursuant to section 607(5) of the Act, that continuation coverage and the applicable period for providing notice under section 606(a)(2) of the Act shall commence with the date of loss of coverage, not later than 30 days after the date on which a qualified beneficiary loses coverage under the plan due to the qualifying event;

(2) In the case of a multiemployer plan that provides, pursuant to section 606(a)(2) of the Act, for a longer period of time within which employers may provide notice of a qualifying event, not later than the end of the period provided pursuant to the plan's terms for such notice; and

(3) In all other cases, not later than 30 days after the date on which the qualifying event occurred.

(c) *Content of notice.* The notice required by this section shall include sufficient information to enable the administrator to determine the plan, the covered employee, the qualifying event, and the date of the qualifying event.

(d) *Multiemployer plan special rules.* This section shall not apply to any employer that maintains a multiemployer plan, with respect to qualifying events affecting coverage under such plan, if the plan provides, pursuant to section 606(b) of the Act, that the administrator shall determine whether such a qualifying event has occurred.

§ 2590.606–3. Notice requirements for covered employees and qualified beneficiaries.

(a) *General.* In accordance with the authority of sections 505 and 606(a)(3) of the Employee Retirement Income Security Act of 1974, as amended (the Act), this section sets forth requirements for group health plans subject to the continuation coverage requirements of Part 6 of title I of the Act with respect to the responsibility of covered employees and qualified beneficiaries to provide the following notices to administrators:

(1) Notice of the occurrence of a qualifying event that is a divorce or legal separation of a covered employee from his or her spouse;

(2) Notice of the occurrence of a qualifying event that is a beneficiary's ceasing to be covered under a plan as a dependent child of a participant;

(3) Notice of the occurrence of a second qualifying event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a qualified beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 *et seq.* or 1381 *et seq.*) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(5) Notice that a qualified beneficiary, with respect to whom a notice described in paragraph (a)(4) of this section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled.

(b) *Reasonable procedures.* (1) A plan subject to the continuation coverage requirements shall establish reasonable procedures for the furnishing of the notices described in paragraph (a) of this section.

(2) For purposes of this section, a plan's notice procedures shall be deemed reasonable only if such procedures:

(i) Are described in the plan's summary plan description required by § 2520.102–3 of this title;

(ii) Specify the individual or entity designated to receive such notices;

(iii) Specify the means by which notice may be given;

(iv) Describe the information concerning the qualifying event or determination of disability that the plan deems necessary in order to provide continuation coverage rights consistent with the requirements of the Act; and

(v) Comply with the requirements of paragraphs (c), (d), and (e) of this section.

(3) A plan's procedures will not fail to be reasonable, pursuant to this section, solely because the procedures require a covered employee or qualified beneficiary to utilize a specific form to provide notice to the administrator, provided that any such form is easily available, without cost, to covered employees and qualified beneficiaries.

(4) If a plan has not established reasonable procedures for providing a notice required by this section, such notice shall be deemed to have been provided when a written or oral communication identifying a specific qualifying event is made in a manner reasonably calculated to bring the information to the attention of any of the following:

(i) In the case of a single-employer plan, either the organizational unit that has customarily handled employee benefits matters of the employer, or any officer of the employer;

(ii) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee, or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred; or

(iii) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization subject to regulation under the insurance laws of one or more States, the person or organizational unit that handles claims for benefits under the plan or any officer of the insurance company, insurance service, or other similar organization.

(c) *Periods of time for providing notice.* A plan may establish a reasonable period of time for furnishing any of the notices described in paragraph (a) of this section, provided that any time limit imposed by the plan with respect to a particular notice may not be shorter than the time limit described in this paragraph (c) with respect to that notice.

(1) *Time limits for notices of qualifying events.* The period of time for furnishing a notice described in paragraph (a)(1), (2), or (3) of this section may not end before the date that is 60 days after the later of:

(i) In the case of a plan that provides, pursuant to section 607(5) of the Act, that continuation coverage and the applicable period for providing notice under section 606(a)(2) of the Act shall commence with the date of loss of coverage, the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event;

(ii) In the case of any plan other than a plan described in paragraph (c)(1)(i) of this section, the date on which the relevant qualifying event occurs; or

(iii) The date on which the qualified beneficiary is informed, through the furnishing of the plan's summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

(2) *Time limits for notice of disability determination.* (i) Subject to paragraph (c)(2)(ii) of this section, the period of time for furnishing the notice described in paragraph (a)(4) of this section may not end before the date that is 60 days after the later of:

(A) The date of the disability determination by the Social Security Administration; or

(B) The date on which the qualified beneficiary is informed, through the furnishing of the summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

(ii) Notwithstanding paragraph (c)(2)(i) of this section, a plan may require the notice described in paragraph (a)(4) of this section to be furnished before the end of the first 18 months of continuation coverage.

(3) *Time limits for notice of change in disability status.* The period of time for furnishing the notice described in paragraph (a)(5) of this section may not end before the date that is 30 days after the later of:

(i) The date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the qualified beneficiary is no longer disabled; or

(ii) The date on which the qualified beneficiary is informed, through the furnishing of the plan's summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator.

(d) *Required contents of notice.* (1) A plan may establish reasonable requirements for the content of any notice described in this section, provided that a plan may not deem a notice to have been provided untimely if such notice, although not containing all of the information required by the plan, is provided within the time limit established under the plan in conformity with paragraph (c) of this section and the administrator is able to determine from such notice the plan, the covered employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event (if any) occurred.

(2) An administrator may require a notice that does not contain all of the information required by the plan to be supplemented with the additional information necessary to meet the plan's reasonable content requirements for such notice before the notice is deemed to have been provided in accordance with this section.

(e) *Who may provide notice.* With respect to each of the notice requirements of this section, any individual who is either the covered employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

(f) *Plan provisions.* To the extent that a plan provides a covered employee or qualified beneficiary a period of time longer than that specified in this section to provide notice to the administrator, the terms of the plan shall govern the time frame for such notice.

(g) *Additional rights to continuation coverage.* Nothing in this section shall be construed to preclude a plan from providing, in accordance with its terms, continuation coverage to a qualified beneficiary although a notice requirement of this section was not satisfied.

§ 2590.606–4. Notice requirements for plan administrators.

(a) *General.* Pursuant to section 606(a)(4) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a group health plan subject to the

continuation coverage requirements of Part 6 of title I of the Act shall provide, in accordance with this section, notice to each qualified beneficiary of the qualified beneficiary's rights to continuation coverage under the plan.

(b) *Notice of right to elect continuation coverage.* (1) Except as provided in paragraph (b)(2) or (3) of this section, upon receipt of a notice of qualifying event furnished in accordance with § 2590.606–2 or § 2590.606–3, the administrator shall furnish to each qualified beneficiary, not later than 14 days after receipt of the notice of qualifying event, a notice meeting the requirements of paragraph (b)(4) of this section.

(2) In the case of a plan with respect to which an employer of a covered employee is also the administrator of the plan, except as provided in paragraph (b)(3) of this section, a notice meeting the requirements of paragraph (b)(4) of this section shall be furnished not later than 44 days after:

(i) In the case of a plan that provides, pursuant to section 607(5) of the Act, that continuation coverage and the applicable period for providing notice under section 606(a)(2) of the Act shall commence with the date of loss of coverage, the date on which a qualified beneficiary loses coverage under the plan due to the qualifying event; or

(ii) In all other cases, the date on which the qualifying event occurred.

(3) In the case of a plan that is a multiemployer plan, a notice meeting the requirements of paragraph (b)(4) of this section shall be furnished not later than the later of:

(i) The end of the time period provided in paragraph (b)(1) of this section; or

(ii) The end of the time period provided in the terms of the plan for such purpose.

(4) The notice required by this paragraph (b) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The name of the plan under which continuation coverage is available; and the name, address and telephone number of the party responsible under the plan for the administration of continuation coverage benefits;

(ii) Identification of the qualifying event;

(iii) Identification of each qualified beneficiary who is recognized by the plan as being entitled to elect continuation coverage with respect to the qualifying event, and the date on which coverage under the plan will terminate (or has terminated) unless continuation coverage is elected;

(iv) A statement that each individual who is a qualified beneficiary with respect to the qualifying event has an independent right to elect continuation coverage, that a covered employee or a qualified beneficiary who is the spouse of the covered employee (or was the spouse of the covered employee on the day before the qualifying event occurred) may elect continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event, and that a parent or legal guardian may elect continuation coverage on behalf of a minor child;

(v) An explanation of the plan's procedures for electing continuation coverage, including an explanation of the time period during which the election must be made, and the date by which the election must be made;

(vi) An explanation of the consequences of failing to elect or waiving continuation coverage, including an explanation that a qualified beneficiary's decision whether to elect continuation coverage will affect the future rights of qualified beneficiaries to portability of group health coverage, guaranteed access to individual health coverage, and special enrollment under Part 7 of title I of the Act, with a reference to where a qualified beneficiary may obtain additional information about such rights; and a description of the plan's procedures for revoking a waiver of the right to continuation coverage before the date by which the election must be made;

(vii) A description of the continuation coverage that will be made available under the plan, if elected, including the date on which such coverage will commence, either by providing a description of the coverage or by reference to the plan's summary plan description;

(viii) An explanation of the maximum period for which continuation coverage will be available under the plan, if elected; an explanation of the continuation coverage termination date; and an explanation of any events that might cause continuation coverage to be terminated earlier than the end of the maximum period;

(ix) A description of the circumstances (if any) under which the maximum period of continuation coverage may be extended due either to the occurrence of a second qualifying event or a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 *et seq.* or 1381 *et seq.*) (SSA), that the qualified beneficiary is disabled, and the length of any such extension;

(x) In the case of a notice that offers continuation coverage with a maximum duration of less than 36 months, a description of the plan's requirements regarding the responsibility of qualified beneficiaries to provide notice of a second qualifying event and notice of a disability determination under the SSA, along with a description of the plan's procedures for providing such notices, including the times within which such notices must be provided and the consequences of failing to provide such notices. The notice shall also explain the responsibility of qualified beneficiaries to provide notice that a disabled qualified beneficiary has subsequently been determined to no longer be disabled;

(xi) A description of the amount, if any, that each qualified beneficiary will be required to pay for continuation coverage;

(xii) A description of the due dates for payments, the qualified beneficiaries' right to pay on a monthly basis, the grace periods for payment, the address to which payments should be sent, and the consequences of delayed payment and non-payment;

(xiii) A description of any opportunity provided under the plan for other health coverage for which the covered employee or qualified beneficiary may be eligible, either as an alternative to continuation coverage or in addition to continuation coverage (*e.g.*, alternative coverage on a group basis under the plan, an option to enroll under an individual conversion health plan after exhaustion of continuation coverage, retiree health coverage), an explanation of how election of such other coverage would affect the qualified beneficiaries' continuation coverage rights under the plan and rights to guaranteed access to individual health coverage;

(xiv) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(xv) A statement that the notice does not fully describe continuation coverage or other rights under the plan, and that more complete information regarding such rights is available in the plan's summary plan description or from the plan administrator.

(c) *Notice of unavailability of continuation coverage.* (1) In the event that an administrator who receives a notice of qualifying event furnished in accordance with § 2590.606–3 determines that an individual is not entitled to continuation coverage under Part 6 of title I of the Act, the administrator shall provide to such

individual an explanation as to why the individual is not entitled to elect continuation coverage.

(2) The notice required by this paragraph (c) shall be furnished by the administrator in accordance with the time frame set out in paragraph (b) of this section that would apply if the administrator had determined that the individual was entitled to elect continuation coverage.

(d) *Notice of termination of continuation coverage.* (1) The administrator of a plan that is providing continuation coverage to one or more qualified beneficiaries with respect to a qualifying event shall provide, in accordance with this paragraph (d), notice to each such qualified beneficiary of any termination of continuation coverage that takes effect earlier than the end of the maximum period of continuation coverage applicable to such qualifying event.

(2) The notice required by this paragraph (d) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The reason that continuation coverage has terminated earlier than the end of the maximum period of continuation coverage applicable to such qualifying event;

(ii) The date of termination of continuation coverage; and

(iii) Any rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

(3) The notice required by this paragraph (d) shall be furnished by the administrator as soon as practicable following the administrator's determination that continuation coverage shall terminate.

(e) *Special notice rules.* The notices required by paragraphs (b), (c), and (d) of this section shall be furnished to each qualified beneficiary or individual, except that—

(1) An administrator may provide notice to a covered employee and the covered employee's spouse by furnishing a single notice addressed to both the covered employee and the covered employee's spouse, if, on the basis of the most recent information available to the plan, the covered employee's spouse resides at the same location as the covered employee; and

(2) An administrator may provide notice to each qualified beneficiary who is the dependent child of a covered employee by furnishing a single notice to the covered employee or the covered employee's spouse, if, on the basis of the most recent information available to the plan, the dependent child resides at the same location as the individual to whom such notice is provided.

(f) *Delivery of notice.* The notices required by this section shall be furnished in any manner consistent with the requirements of § 2520.104b–1 of this title, including paragraph (c) of that section relating to the use of electronic media.

(g) *Model notice.* The appendix to this section contains a model notice that is intended to assist administrators in discharging the notice obligations of this section. Use of the model notice is not mandatory. The model reflects the requirements of this section as they would apply to single-employer group health plans and must be modified if used to provide notice with respect to other types of group health plans, such as multiemployer plans or plans established and maintained by employee organizations for their members. In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements of paragraph (b)(4) of this section.

BILLING CODE 4510–29–P

APPENDIX TO § 2590.606-4
MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE
(For use by single-employer group health plans)

[*Enter date of notice*]

Dear: [*Enter Name of Employee,*
Spouse, Dependent Children, as appropriate]

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

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this notice or your rights to coverage, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

If you do not elect to continue your health care coverage by completing the enclosed "Election Form" and returning it to us, your coverage under the Plan will end on [*enter date*] due to:

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

Each of the following persons is entitled to elect to continue health care coverage under the Plan:

☐ Employee – [*enter name*]
☐ Spouse (or former spouse of employee) [*enter name*]
☐ Dependent children [*enter name(s)*]

Because of the event (checked above) that will end your coverage under the Plan, you [*and/or, as appropriate,* your spouse, and dependent children] are entitled to continue your health care coverage for up to _____ months [*enter 18 or 36 months as appropriate*]. If you elect to continue your coverage under the Plan, your continuation coverage will begin on [*enter date*] and can last until [*enter date*].

Your continuation coverage will cost: [*enter amount each qualified beneficiary would be required to pay for each option per month of coverage and any other permitted coverage periods.]*

IMPORTANT - To elect continuation coverage you MUST complete the enclosed "Election Form" and return it to us. You may mail it to the address shown on the Election Form [*or describe other acceptable means of submission*]. The completed Election Form must be post-marked by [*enter date*] [*or received by [enter date] if submitted by other means*]. If you do not submit a completed Election Form by this date, you will lose your right to elect

continuation coverage. Important information about your rights is provided to you on the pages after the Election Form.

COBRA CONTINUATION COVERAGE ELECTION FORM

[*Name of Employee / Spouse / Dependent Children (as appropriate)*]

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

[*Enter Name and Address*]

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

	Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a.				
b.				
c.				
d.				

Type of coverage elected (check only one):

☐ [*enter description of option*]

☐ [*enter description of option*]

☐ [*enter description of option*]

Signature _____ Date _____

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

_____

_____

Print Address _____ Telephone number _____

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

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

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [*add if applicable:* open enrollment and] special enrollment rights. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from [*enter name, address and telephone number of appropriate party (Plan Administrator or other party)*].

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[If the maximum period of coverage of this notice is 18 months, add the following three paragraphs:]

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event

occurs. You must notify [*enter name of COBRA administrator*] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify [*enter name of COBRA administrator*] of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify [*enter name of COBRA administrator*] of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify [*enter name of COBRA administrator*] within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal

law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

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

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

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated [*if Plan permits, add:* unless you request that your continuation coverage begin only with the date of your Election Notice] up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact [*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

[*enter appropriate payment address*]

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. [*Enter additional information on other due dates for payments if Plan permits other periodic payment schedules.*] Under the Plan, these periodic payments for continuation coverage are due on the [*enter due day for each month of coverage*]. [*If Plan offers other payment schedules, enter with appropriate dates:* You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan [*select one:* will *or* will not] send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

[*enter appropriate payment address*]

Grace periods for periodic payments

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

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

[If Plan provides any election of other health coverage besides continuation coverage (such as alternative coverage in lieu of continuation coverage, individual conversion rights, etc.), enter description of all such coverages and explain how election of such other coverages would affect continuation coverage rights under the Plan. The following are two separate examples of such a description:]

Can you elect other health coverage besides continuation coverage?

Under the Plan, you have the right to elect alternative group health coverage for a period of six months at no cost to you instead of the continuation coverage described in this Notice. If you elect this six-month alternative coverage, you will lose all rights to the continuation coverage described in this Notice. You should also note that if you enroll in the alternative group health coverage you lose your right under federal law to purchase individual health insurance that does

not impose any pre-existing condition limitations when your alternative group health coverage ends. You must contact [*add appropriate contact information*] if you wish to elect alternative coverage.

-- OR –

Under the Plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from: [*Enter name, address and telephone number of appropriate party (plan administrator or other party)*].

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

Keep Your Plan Informed of Address Changes

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

Signed at Washington, DC, this 20th day of May, 2003.

Ann L. Combs,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

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