

FAQs for Employees about COBRA Continuation Health Coverage



U.S. Department of Labor
Employee Benefits Security Administration
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Q1: What is COBRA continuation health coverage?

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

Q2: What does COBRA do?

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

Q3: Who is entitled to benefits under COBRA?

There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plans, qualified beneficiaries, and qualifying events:

Plan Coverage - Group health plans for employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year are subject to COBRA. Both full and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

Qualified Beneficiaries - A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is either an employee, the employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

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

Qualifying Events for Employees:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in the number of hours of employment

Qualifying Events for Spouses:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

Qualifying Events for Dependent Children:

- Loss of dependent child status under the plan rules
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered employee's becoming entitled to Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

Q4: How does a person become eligible for COBRA continuation coverage?

To be eligible for COBRA coverage, you must have been enrolled in your employer's health plan when you worked and the health plan must continue to be in effect for active employees. COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.

Q5: What group health plans are subject to COBRA?

The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments.

Q6: What process must individuals follow to elect COBRA continuation coverage?

Employers must notify plan administrators of a qualifying event within 30 days after an employee's death, termination, reduced hours of employment or entitlement to Medicare.

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

Plan participants and beneficiaries generally must be sent an election notice not later than 14 days after the plan administrator receives notice that a qualifying event has occurred. The individual then has 60 days to decide whether to elect COBRA continuation coverage. The person has 45 days after electing coverage to pay the initial premium.

Q7: How long after a qualifying event do I have to elect COBRA coverage?

Qualified beneficiaries must be given an election period during which each qualified beneficiary may choose whether to elect COBRA coverage. Each qualified beneficiary may independently elect COBRA coverage. A covered employee or the covered employee's spouse may elect COBRA coverage on behalf of all other qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child. Qualified beneficiaries must be given at least 60 days for the election. This period is measured from the later of the coverage loss date or the date the COBRA election notice is provided by the employer or plan administrator. The election notice must be provided in person or by first class mail within 14 days after the plan administrator receives notice that a qualifying event has occurred.

Q8: How do I file a COBRA claim for benefits?

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures must be described in the Summary Plan Description.

You should submit a claim for benefits in accordance with the plan's rules for filing claims. If the claim is denied, you must be given notice of the denial in writing generally within 90 days after the claim is filed. The notice should state the reasons for the denial, any additional information needed to support the claim, and procedures for appealing the denial.

You will have at least 60 days to appeal a denial and you must receive a decision on the appeal generally within 60 days after that.

Contact the plan administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices. There can be charges up to 25 cents a page for copies of plan rules.

Q9: Can individuals qualify for longer periods of COBRA continuation coverage?

Yes, disability can extend the 18 month period of continuation coverage for a qualifying event that is a termination of employment or reduction of hours. To qualify for additional months of COBRA continuation coverage, the qualified beneficiary must:

- Have a ruling from the Social Security Administration that he or she became disabled within the first 60 days of COBRA continuation coverage
- Send the plan a copy of the Social Security ruling letter within 60 days of receipt, but prior to expiration of the 18-month period of coverage

If these requirements are met, the entire family qualifies for an additional 11 months of COBRA continuation coverage. Plans can charge 150% of the premium cost for the extended period of coverage.

Q10: Is a divorced spouse entitled to COBRA coverage from their former spouses' group health plan?

Under COBRA, participants, covered spouses and dependent children may continue their plan coverage for a limited time when they would otherwise lose coverage due to a particular event, such as divorce (or legal separation). A covered employee's spouse who would lose coverage due to a divorce may elect continuation coverage under the plan for a maximum of 36 months. A qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation. After being notified of a divorce, the plan administrator must give notice, generally within 14 days, to the qualified beneficiary of the right to elect COBRA continuation coverage.

Divorced spouses may call their plan administrator or the EBSA Toll-Free number, 1-866-444-EBSA (3272) if they have questions about COBRA continuation coverage or their rights under ERISA

Q11: If I waive COBRA coverage during the election period, can I still get coverage at a later date?

If a qualified beneficiary waives COBRA coverage during the election period, he or she may revoke the waiver of coverage before the end of the election period. A beneficiary may then elect COBRA coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

Q12: Under COBRA, what benefits must be covered?

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage). A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

Q13: When does COBRA coverage begin?

COBRA coverage begins on the date that health care coverage would otherwise have been lost by reason of a qualifying event.

Q14: How long does COBRA coverage last?

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

Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and will end at the end of the maximum period. It may end earlier if:

- Premiums are not paid on a timely basis
- The employer ceases to maintain any group health plan
- After the COBRA election, coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election,

COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

- After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

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

Some plans allow participants and beneficiaries to convert group health coverage to an individual policy. If this option is generally available from the plan, a qualified beneficiary who pays for COBRA coverage must be given the option of converting to an individual policy at the end of the COBRA continuation coverage period. The option must be given to enroll in a conversion health plan within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. The conversion option, however, is not available if the beneficiary ends COBRA coverage before reaching the end of the maximum period of COBRA coverage.

Q15: Who pays for COBRA coverage?

Beneficiaries may be required to pay for COBRA coverage. The premium cannot exceed 102 percent of the cost to the plan for similarly situated individuals who have not incurred a qualifying event, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus 2 percent for administrative costs.

For qualified beneficiaries receiving the 11 month disability extension of coverage, the premium for those additional months may be increased to 150 percent of the plan's total cost of coverage.

COBRA premiums may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay premiums on a monthly basis if you ask to do so, and the plan may allow you to make payments at other intervals (weekly or quarterly).

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

If premiums are not paid by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate coverage retroactively to the beginning of the period of coverage.

If the amount of the payment made to the plan is made in error but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices.

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

Q16: If I elect COBRA, how much do I pay?

When you were an active employee, your employer may have paid all or part of your group health premiums. Under COBRA, as a former employee no longer receiving benefits, you will usually pay the entire premium amount, that is, the portion of the premium that you paid as an active employee and the amount of the contribution made by your employer. In addition, there may be a 2 percent administrative fee.

While COBRA rates may seem high, you will be paying group premium rates, which are usually lower than individual rates.

Since it is likely that there will be a lapse of a month or more between the date of layoff and the time you make the COBRA election decision, you may have to pay health premiums retroactively—from the time of separation from the company. The first premium, for instance, will cover the entire time since your last day of employment with your former employer.

You should also be aware that it is your responsibility to pay for COBRA coverage even if you do not receive a monthly statement.

Although they are not required to do so, some employers may subsidize COBRA coverage.

Q17: Is the COBRA Premium Reduction (Subsidy) still available to individuals who have lost their jobs?

The American Recovery and Reinvestment Act (ARRA) provided a COBRA premium reduction for eligible individuals who were involuntarily terminated from employment through the end of May 2010. Due to the statutory sunset, the COBRA premium reduction under ARRA is not available for individuals who experience involuntary terminations after May 31, 2010. However, individuals who qualified on or before May 31, 2010 may continue to pay reduced premiums for up to 15 months, as long as they are not eligible for another group health plan or Medicare.

Individuals who believe they have been incorrectly denied the subsidy may request the Employee Benefits Security Administration to review their denial and issue a determination within 15 business days. The [application](#) to request a review is available on this Web site.

Q18: What can I do if I believe I am eligible for the premium reduction but my plan sponsor has denied my request for treatment as an “assistance eligible individual”?

If the plan determines that you are not eligible for the premium reduction, you can request an expedited review of the denial. The Department of Labor will handle requests related to private sector employer plans subject to ERISA’s COBRA provisions. Applicants may either be the former employee or a member of the former employee's family who is eligible for COBRA continuation coverage or the COBRA premium assistance through an employment-based health plan. The Department of Health and Human Services will handle requests for Federal, State, and local governmental employees including public schools, public colleges and universities, or a police or fire department, as well as requests related to group health insurance coverage provided pursuant to state continuation coverage laws. The Departments are required to make a determination regarding your request within 15 business days after receiving your completed application for review. The Secretary of Labor may assess a penalty against a plan sponsor (and similarly, the Secretary of HHS against a health insurance issuer) of not more than \$110 per day for a failure to comply with a determination within 10 days after the date of the receipt of the determination.

Note: Appeals to the Department of Labor must be submitted on the U.S. Department of Labor application form. The form is available at <http://www.dol.gov/COBRA/main.html> and can be completed online or submitted by mail or fax as indicated in the instructions. If you believe you have been inappropriately denied eligibility for the premium reduction, you may wish to speak with an Employee Benefits Security Administration Benefits Advisor at 1-866-444-3272 before filing this form. Appeals to the Department of Health and Human Services must be submitted on the Centers for Medicare & Medicaid Services application form. The form is available at www.continuationcoverage.net and can be submitted by mail or fax as indicated in the instructions. For more information about the review of denials, individuals can also contact Maximus, a CMS-sponsored contractor, at 1-866-400-6689.

Q19: I have been on COBRA with the 65% premium subsidy for almost 15 months, what should I do?

Those individuals who qualified for the premium reduction were only required to pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will need to pay the full amount to continue your COBRA continuation coverage. If you are unsure when your 15 months of premium assistance ends or how much the new premium is, contact your plan right away so that you can make sure you pay the correct amount for the correct time period. If you do not make the full payment within the correct time period, your COBRA coverage can be canceled.

Q20: What if I can not afford to pay the full premium for the remaining 3 months?

It is very important to pay the remaining 3 months if at all possible, as you lose some health coverage rights or options if your COBRA is terminated for non-payment. Individuals who exhaust their COBRA are eligible to obtain coverage through state high risk pools and also qualify for special enrollment in a spouse's plan. These rights are lost if an individual's COBRA is terminated for non-payment. (**Note:** If a person becomes eligible for coverage in a new employer's plan or spouse's plan, they lose eligibility for the subsidy and are required to notify their COBRA provider of their eligibility for the other coverage.)

If you have limited income and resources (assets), you may want to contact your state to determine if you are eligible for Medicaid or other programs that may assist you in obtaining assistance with health coverage.

Q21: If I did not make the premium payment on time and my coverage was canceled what can I do?

You may want to contact your plan and ask if they will reinstate your coverage; however, if your coverage was terminated for not making the payment within the grace period, the plan is not required to reinstate your coverage. If you believe your coverage was canceled inappropriately, please contact an EBSA Benefits Advisor at 1-866-444-3272 for assistance.

If you have lost coverage, and are not eligible to enroll in a new employer's plan or a spouse's plan, you may want to contact your state department of insurance to get information about obtaining an individual policy. You may be able to cover your children under your state's Children's Health Insurance Program- call 1-877 KIDS NOW (1-877-543-7669) or go to www.insurekidsnow.gov to find out about eligibility and enrollment.

Additionally, the Affordable Care Act provides that plans or issuers that make available coverage to dependent children must make such coverage available for children up to age 26. Because this provision has a varying applicability date, contact the plan to see if such coverage is available. The

Affordable Care Act also established Pre-existing Condition Insurance Plans (PCIP) for those with pre-existing conditions. For information about how these plans work, go to www.healthcare.gov.

If you have limited income and resources (assets), you may want to contact your state to determine if you are eligible for Medicaid or other programs that may assist you in obtaining assistance with health coverage.

Q22: Can I receive COBRA benefits while on FMLA leave?

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

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

Q23: What changes did the Trade Act of 2002 and the TAA Health Coverage Improvement Act of 2009 make with regard to COBRA continuation coverage?

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the 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. The TAA Health Coverage Improvement Act of 2009 section of ARRA made several amendments to these provisions which expire on December 31, 2010 unless Congress extends the legislation. For updates and information on the affect of the expiration on the ARRA changes, go to <http://www.irs.gov/individuals/article/0,,id=217420,00.html>.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at <http://www.doleta.gov/tradeact/>.

Q24: What is the Federal Government's role in COBRA?

COBRA continuation coverage laws are administered by several agencies. The Departments of Labor and Treasury have jurisdiction over private-sector health group health plans. The Department of Health and Human Services administers the continuation coverage law as it affects public-sector health plans.

The Labor Department's interpretive and regulatory responsibility is limited to the disclosure and notification requirements of COBRA. If you need further information on your disclosure or notification rights under a private-sector plan, or about ERISA generally, telephone EBSA's Toll-Free number at: 1-866-444-3272.

The Internal Revenue Service, Department of the Treasury, has issued regulations on COBRA provisions relating to eligibility, coverage and premiums in 26 CFR Part 54, Continuation Coverage Requirements Applicable to Group Health Plans. Both the Departments of Labor and Treasury share jurisdiction for enforcement of these provisions.

The Center for Medicare and Medicaid Services offers information about COBRA provisions for public-sector employees. You can write them at this address:

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C1-22-06
Baltimore, MD 21244-1850
Tel 1-877-267-2323 x61565

Q25: I am a federal employee. Can I receive benefits under COBRA?

Federal employees are covered by a law similar to COBRA. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

Q26: Am I eligible for COBRA if my company closed or went bankrupt and there is no health plan?

If there is no longer a health plan, there is no COBRA coverage available. If, however, there is another plan offered by the company, you may be covered under that plan. Union members who are covered by a collective bargaining agreement that provides for a medical plan also may be entitled to continued coverage.

Q27: How do I find out about COBRA coverage and how do I elect to take it?

Employers or health plan administrators must provide an initial general notice if you are entitled to COBRA benefits. You probably received the initial notice about COBRA coverage when you were hired.

When you are no longer eligible for health coverage, your employer has to provide you with a specific notice regarding your rights to COBRA continuation benefits.

Employers must notify their plan administrators within 30 days after an employee's termination or after a reduction in hours that causes an employee to lose health benefits.

The plan administrator must provide notice to individual employees of their right to elect COBRA coverage within 14 days after the administrator has received notice from the employer.

You must respond to this notice and elect COBRA coverage by the 60th day after the written notice is sent or the day health care coverage ceased, whichever is later. Otherwise, you will lose all rights to COBRA benefits.

Spouses and dependent children covered under your health plan have an independent right to elect COBRA coverage upon your termination or reduction in hours. If, for instance, you have a family member with an illness at the time you are laid off, that person alone can elect coverage.