



ADMINISTRATION MADE EASY



COBRA Administration Guide



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COBRA Administration Introduction

Thank you for selecting UnitedHealthcare Benefit Services for your COBRA services.

The COBRA Administration Guidebook will help you navigate through the COBRA web portal at <https://www.uhcservices.com> for administration of services.



Employer and/or Broker engagement is required. This is an embedded self administered product.

What to Expect After Implementation

The user who was sent the initial Welcome Letter will receive notification via secure email within 7-10 business days after completing COBRA implementation on our containing the last step of activating COBRA services, as well as the COBRA Administration Guidebook and Contact Change form.

It is recommended that you have more than one contact with web portal access.

If you see the error 'Data Not Yet Available' on the **QEN** tab check to see if the Secure email has been received.

To help offset the rising cost of administration, effective January 1, 2023, UnitedHealthcare is making changes to the remittance and distribution of COBRA administration fees and premiums collected.

- A 2% COBRA member administrative fee will added to all COBRA rates and will be retained by UnitedHealthcare.
- All member premiums collected will be disbursed back to you to remit to carriers directly.



Employer/Broker Expectations

Expectations for Employer/Brokers

- Once the employee has been terminated off the group policy, the employer/broker is responsible for notifying UnitedHealthcare Benefit Services of the qualifying event by submitting a QEN at <https://www.uhcservices.com> within 30 days of termination.
- The employer/broker is responsible for sending out open enrollment information to COBRA participants at time of renewal.
- The employer/broker is responsible for entering the group's renewal information into the COBRA web portal every renewal period.
- For best practice, rate renewal should be received by UnitedHealthcare Benefit Services no later than 35 days prior to the renewal date in order to provide time for the participant to receive the renewal billing invoice.
- Once the plan elections have been received the employer/broker will then update the plan selections in the **Participant Review** under the **Plan Renewal** tab. If this option is not available, please submit your request to cobra@uhcservices.com.
- If your renewal rates are received after 90 days of the renewal date, Federal COBRA Regulations do not allow UnitedHealthcare Benefit Services to retro bill back to the effective date of the renewal. The employer will be responsible for the difference in premium.
- If the groups renewal rates are not finalized by 60 days after the renewal date, please contact the call center at 1-800-318-5311 or email cobra@uhcseivices.com for further instructions on how to complete the renewal process.
- It is then the employer's responsibility to visit <https://www.uhcservices.com> on a monthly basis to view Disbursement Reports by selecting Reports and then Scheduled Reports. You will find the monthly disbursement report that should be reconciled between the money deposited into the group's bank account along with what is being charged by the carrier(s). It is the responsibility of the employer to notify UnitedHealthcare Benefit Services of any discrepancies in a timely manner.
- If your group leaves UHC as their carrier or if you wish to terminate services with UnitedHealthcare Benefit Services COBRA, your group has the following options to request a COBRA Client Termination form:
 - ❖ call center at 1-800-318-5311
 - ❖ email cobra@uhcservices.com
 - ❖ web portal <https://www.uhcservices.com> under the **Resource** tab.



COBRA Administration – Landing Page

The web portal <https://www.uhcservices.com> is for implementation of COBRA, FSA and PTP services, it also serves as the web portal for COBRA administrative services after implementation. Please see the FSA Administration Guide for further guidance on the FSA administrative services or visit <https://employer.uhcbs.com>.

- Once you have logged into the web portal, there will be a landing page.
- Click either **Billing Services** on the top tabs or **Administer my Billing Services**



- On the left-hand side are the tabs to navigate the COBRA web portal.



COBRA Administration – Plan Details Tab

- There are two tabs as **Plan Details**.
 - The first **Plan Details** tab contains plans submitted during initial implementation. This tab is for informational purposes only.
 - The second Plan Details tab will show **active and terminated plans** for the group. This is the tab which will update each year when you complete your renewal.
- Filter the plans by entering a date in the Filter Plan Date and click **Find**.

Plan Name	Carrier Name	Division Name	Start Date	End Date	View
EMZ Secondary Health	Employee Benefit Services		09/01/2021 12:00:00 AM	09/31/2022 12:00:00 AM	
Guardian Dental	Guardian		09/01/2021 12:00:00 AM	09/31/2022 12:00:00 AM	
Guardian Vision	Guardian		09/01/2021 12:00:00 AM	09/31/2022 12:00:00 AM	
UHC BCTG (9452633) MEDICAL	UHC BCTG (9452633) MEDICAL		06/01/2021 12:00:00 AM	05/31/2022 12:00:00 AM	
VISION S178 (6482600)	UnitedHealthcare		06/01/2021 12:00:00 AM	05/31/2022 12:00:00 AM	

- By selecting the **View** column, you will be able to view plan details.
- Once you have clicked on the icon in the **View** column, this will open a new internet page.
- These are the current rates that are housed in the system for that specific plan.

Coverage	Rate Structure	Premium
Coverage:Employee + Child(ren)	Rate Structure:Fixed Amount	Premium:1,541.39
Coverage:Employee + Spouse	Rate Structure:Fixed Amount	Premium:1,151.86
Coverage:Employee Only	Rate Structure:Fixed Amount	Premium:473.38
Coverage:Family	Rate Structure:Fixed Amount	Premium:1,367.49

Carrier Address: P.O. Box 20964 Salt Lake City, UT, 84130
 Carrier Contact: Adm. Eligibility Phone: 866-642-4571 Fax: 243-733-6062
 Email: uhcgrms@lhasa.com
 Customer Service Phone:
 END OF PLAN



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- The 2% COBRA member administrative fee will be retained by UnitedHealthcare.
- All member premiums collected will be disbursed back to you to remit to carriers directly.



COBRA Administration – Take Over Tab

The Take Over tab will allow employers to enter participants who are already on COBRA so UnitedHealthcare Benefit Services can take over the administration of COBRA.



Please note that the take over tab is only available for 90 days after implementation.

➤ Click **NEXT** to begin.

The screenshot shows the UnitedHealthcare portal interface. The top navigation bar includes 'Account Overview', 'Billing Services', 'Reimbursement Services', and 'Pre-Paid Premium'. The left sidebar lists various options, with 'Take Over' selected. The main content area is titled 'Takeover Event' and contains introductory text. A blue button labeled 'NEXT' is highlighted with a red rectangular box.

➤ Enter information requested.

➤ Employee ID is optional.

The screenshot shows the UnitedHealthcare portal interface for the 'Add Beneficiary' screen. The top navigation bar includes 'Account Overview', 'Billing Services', 'Reimbursement Services', 'Pre-Paid Premium', and 'Beneficiary Administration'. The left sidebar lists various options, with 'Add Beneficiary' selected. The main content area is titled 'Add Beneficiary' and contains a form with the following fields: 'Social Security Number', 'Employee ID', 'First Name', 'Last Name', 'Address', 'City', 'State (Select a State)', 'Zip Code', 'Date of Birth', 'Gender' (with radio buttons for Male and Female), and 'Marital Status' (with radio buttons for Married and Single).



COBRA Administration – Take Over Tab

* Qualifying Event Code: (Select an Option) ▼

* Qualifying Event Date:

* Notification Date:

* Election Date:

* Election Received Date:

* Pay Through Date:

Billing Start Date:

Save **Cancel**

- The paid thru dates on the **Take Over** tab will determine when we start to invoice the COBRA participant(s).



Please make sure to notify all participants of changes in COBRA Administration so that participants do not pay the previous COBRA Third Party Administer (TPA) in error.

Please note that the next four dates must match the previous COBRA TPA dates.

- Qualifying Event Date = date of termination from employment
- Notification Date = date the participant was notified of their COBRA Continuation rights
- Election Date = date the participant elected COBRA
- Election Received Date = date the election notice was received from the participant
- Pay Through Date = the final date the participant has paid COBRA premium payment i.e., 09/30/20**
- Billing Start Date = date which participants billing should begin. i.e., Based on the example above, this date would be 10/01/20**
- Click **SAVE**

- Click **ADD DEP** to enter qualified dependents to the coverage. If no dependents, select **ADD COV.**

UnitedHealthcare

Account Overview | Billing Services | Reimbursement Services | Dep. Tax Options | Life Administration

Plan Details | Plan Details | Take Over | GEN | General Notice | Participants | Dependents | Documents | Ask the Expert

Take Over Notification Summary

Beneficiary Information

Sony Garcia
123 Garcia Lane
Summit, NJ 07995

Termination Date: 08/15/2023
Reason: Voluntary Termination
Election Date: 09/06/2023
Billing Start Date: 10/01/2023
Pay Through Date: 09/30/2023
Notification Date: 09/06/2023

ADD DEP **ADD COV** **SUBMIT**



COBRA Administration – Take Over Tab

- Enter all information that is required for Dependent
 - ✓ If there is no SSN for the dependent, please enter the member's SSN, changing the 4th and 5th digits to 02, 03, 04 etc.
- Click **SAVE**

- Click **ADD COV** to add coverage information

First Name	Last Name	Effective Date
Sample	Sample	06/15/2021

- Choose the Carrier ID, the Plan ID, and the Plan Tier.
- Enter the original coverage effective date
- Click on the Add beneficiary to the coverage box
- Click on the dependents which should be added to the coverage.
- Click **SAVE**

First Name	Last Name	Effective Date
Sample	Sample	06/15/2021



COBRA Administration – Take Over Tab

- Make sure all information is correct
- If there are additional coverages, select **ADD COV.**
- If a change needs to be made, please click on the edit button
- Click **SUBMIT**

UnitedHealthcare

Account Overview | **Enrollment Services** | Reimbursement Services | Pre-Tax Premiums | Site Administration

Take Over Notification Summary

Beneficiary Information

Class: Sample
EEO Number: Lane
Sample: K5 9999

Termination Date: 06/15/2021
Reason: Voluntary Termination
Enroll Date: 09/01/2021
Enroll Start Date: 10/01/2021
Enroll Through Date: 06/30/2021
Reenroll Date: 09/01/2021
Medical Renewal Code: 08/00/2021

List of Dependents

First Name	Last Name	Enroll Date
Sample	Sample	06/15/2021

List of Coverages

MEDICAL 0200 (020470) Employee + Children

ADD COV ADD COV

SUBMIT



COBRA Administration – QEN Tab

The QEN (Qualifying Event Notification) Tab is used by the employer/broker to enter a former employees, in order to offer COBRA. Any event which causes an employee and/or dependent to lose benefit coverages: Termination of Employment, Reduction of hours, Leave of Absence, Divorce/Legal Separation, Employees entitled to Medicare, Dependent reaching maximum age, or Employee's death.



The QEN Tab is not necessary if you have all UHC contracts. However, after 5 business days it is still the employer's responsibility to log into the web portal and verify that the employee has been sent the correct COBRA Notification.

- Enter the Social Security Number with the dashes.
- Click **NEXT STEP**

- Enter all information that is required.

Please remember that the Qualifying Event reason determines how long the participant receives COBRA. If you are unsure which event to choose, please call the UnitedHealthcare Benefit Services Customer Service Center at (800) 318-5311

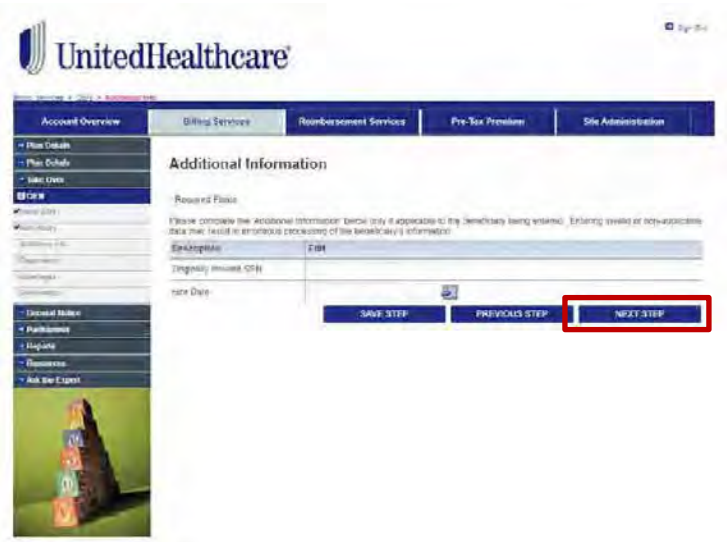
The Qualifying Event Date is the last day of employment for the participant.

- Click **NEXT STEP**



COBRA Administration – QEN Tab

- The Additional Information page is optional information for the participant being entered.
- Enter the Originally Insured Social Security Number. *This would be a require field in the case of a spousal/dependent loss of coverage.*
- Hire Date is an optional field.
- Click **NEXT STEP**



- If there are dependents that need to be entered (Spouse or Children), click **ADD NEW**
- If there are no dependents to add, click **NEXT STEP**

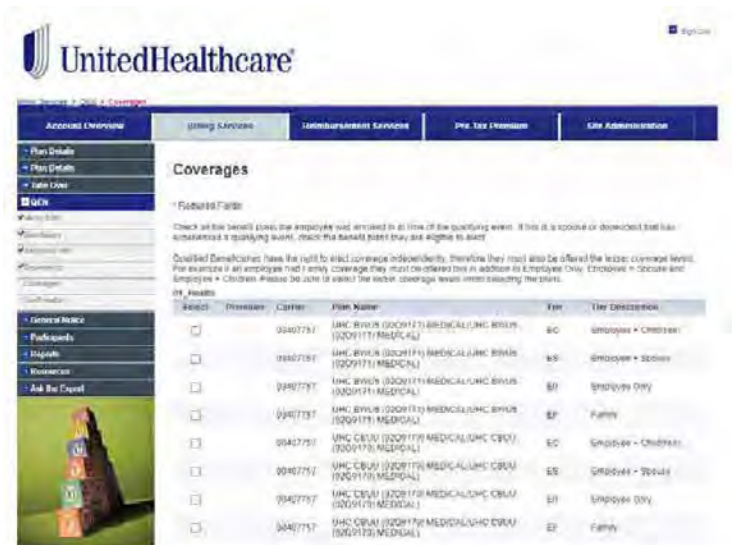


- If you're adding a dependent, enter all the required information.
- Click **Save**
- Click **ADD NEW** if additional dependents need to be added.
- Click **NEXT Step** once all dependents have been added.



COBRA Administration – QEN Tab

- You must choose the same coverage(s) the participant had during employment.
- If unsure, call your carrier for assistance.
- Click **NEXT STEP**



- Verify the COBRA Eligibility Start Date

This date is system calculated based on how your plans are set within UnitedHealthcare Benefit Services. If they are incorrect, please contact us via email at cobra@uhcervices.com or Ask The Expert tab on our web portal or call center at 1-800-318-5311.

- Click **CONTINUE**

Qualifying Event Date

Based on the selected Qualifying Event Date of 09/15/2021, the COBRA coverage for the selected plan(s) will begin on the following date(s). If this looks correct, click **CONTINUE** to proceed. If this is incorrect, please click **CANCEL** and update the Qualifying Event Date accordingly.

Cobra Eligibility Start Date	Plan Name
09/16/2021	UHC BWU5 (02Q9171) MEDICAL(UHC BWU5 (02Q9171) MEDICAL)
09/16/2021	UHC P5430 (02Q9170) DENTAL(UHC P5430 (02Q9170) DENTAL)
09/16/2021	UHC S1077 (02Q9170) VISION(UHC S1077 (02Q9170) VISION)



COBRA Administration – QEN Tab

- Verify all information on the confirmation page.
- Click **SUBMIT**
- Your QEN is now submitted, UnitedHealthcare Benefit Services will now send out the notification to the former employee.

The screenshot shows the UnitedHealthcare web portal interface. The top navigation bar includes 'Account Overview', 'Billing Services', 'Reimbursement Services', 'File Tax Forms', and 'Site Administration'. The main content area is titled 'Confirmation' and contains the following sections:

- Required Items:** A list of items that must be provided for COBRA enrollment, including Participant Name, Last 4 digits of the QEN, Payment amount, Payment period, and Your social insurance number.
- Participant Information:** A form with fields for Name (Sample), SSN (Sample Lane), Gender (M), and Marital Status (M).
- Coverages:** A table showing the selected coverage options.

Coverage	Plan Name	TRF	TRF Description
00437707	UHC PLUS (2021) MEDICAL (UHC PLUS (2021) MEDICAL)	ES	Employee Only

At the bottom right of the form, there are two buttons: 'BACK' and 'SUBMIT'. The 'SUBMIT' button is highlighted with a red rectangular box.



Once the QEN is entered, UnitedHealthcare Benefit Services will receive notification within 48 to 72 hours and a COBRA notification will be mail to the participant.



Once the QEN is submitted, you will not be able to go back and edit any information. Please contact us via email at cobra@uhcervices.com or Ask The Expert tab on our web portal or the call center at 1-800-318-5311.



Should the participant need urgent services, they can register at <https://www.uhcervices.com> and elect COBRA coverage. The participant can set up a payment method online or call the participant call center, 1-866-747-0048 to make a payment. **The call center can only take a check by phone.** Please see the **Resources** tab for a copy of the Participant COBRA Guide.



COBRA Administration – Dependent Events/Severance

QEN for Dependent Events

Spousal/Dependent Events:

- Death
- Divorce
- Medicare Entitlement



These are qualifying events in which the spouse and/or dependents are possibly entitled to COBRA coverage. These events need to be entered via the COBRA web portal by the employer/broker.

When entering the QEN onto the web portal enter the spouse's demographic information as the employee and Select EMPLOYEE ONLY coverage.



It is very important to include the original social security number of the employee when entering this type of event, via the QEN tab.

If the original coverage was Family coverage, select EMPLOYEE and CHILD(REN) coverage.

If the original coverage was Employee and Child(ren), enter the oldest child's demographic information as the employee and select EMPLOYEE and CHILD(REN) coverage.

Severance



We understand your former employee(s) might have a severance agreement with the employer. Please notify us of the severance agreement at cobra@uhcervices.com or via Ask The Expert on the web portal. Please indicate who the severance is for, how long the employer will be paying for the severance and what coverage(s) the severance will cover.

COBRA Administration – General Notice Tab

The General Notice describes general COBRA rights and employee obligations. This notice must be provided to each covered employee and each covered spouse of an employee who becomes covered under the plan. The notice must be provided within the first 90 days of coverage under the group health plan. The information is not saved in the web portal. Please keep a copy for your own records.

- Enter the covered employees name and address.
- Check the box next to ‘I understand’.
- Click **SUBMIT**



The screenshot shows the UnitedHealthcare web portal interface. At the top, there is a navigation bar with tabs for 'Account Overview', 'Billing Services', 'Reimbursement Services', 'Pay Your Premium', and 'COBRA Administration'. The 'COBRA Administration' tab is selected. Below the navigation bar, there is a sidebar menu with options like 'Plan Details', 'COBRA', 'General Notice', 'Rollovers', 'Roth IRAs', 'Investments', and 'Add the Export'. The main content area is titled 'General Notice' and contains a form for entering employee information. The form includes a dropdown for 'Employee Name' (Sample and Dependents), a text field for 'Direct Address' (123 Sample Lane), a dropdown for 'City' (Sample), a dropdown for 'State' (Kansas), and a text field for 'Zip' (55555). Below the form, there is a checkbox labeled 'I understand' and a 'SUBMIT' button.

- A PDF copy of the General Notice will appear.
- Please print this General Notice and send to the covered employee via mail.
- Mailing this certified will give you evidence that it was delivered to the employee.
- **Please see Appendix C – Samples section of this guide for a full sample copy of the General Notice.**

UnitedHealthcare
P.O. Box 740221
Atlanta, GA 30374
<http://uheservices.com>
Phone: (866) 747-0048

General Notice of COBRA Continuation Coverage ** Continuation Coverage Rights Under COBRA**

Sample Sample and Dependents,
123 Sample Lane
Sample, KS 55555

You are receiving this notice because you, your spouse, and/or dependents, if any, have recently become covered under the group health plan for the following employer:

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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



COBRA Administration – Participants Tab

The Participants Tab will allow you to look up participants in a COBRA Enrolled Status, Terminated, Notified or Notified Never Elected.

- There are several ways to look up the participant:
 - Last Name
 - Social Security Number
 - Last 4 of the SSN
 - Click **FIND** (this will pull all participants)



- When the participant has been found, you will have three options:
 - **Request Edit**
I.E.: Change Coverages, Correct Address, or Terminations
 - **Letters**
These are letters mailed from. UnitedHealthcare Benefit Services
I.E.: QEN, Billing and Payment Statements
 - **Report**
Summary of the specific COBRA participant



COBRA Administration – Participants Tab

- Click **Request Edit**

The screenshot shows the UnitedHealthcare COBRA Administration interface. The 'Participants' tab is active. The search criteria are set to 'All' for 'Employed Status'. The search results table has the following data:

Participant	LAN	Event Date	Event ID	Event Type	Request	Event C	Request
2005-02	2005-02-01	01			Request Edit		

- A popup will appear allowing you to send a message without emailing UnitedHealthcare Benefit Services COBRA team.
- This will allow the employer/broker to request changes such as address, birth dates, and/or coverages.
- You can also use this edit tool to ask questions about this specific participant.
- Click **SUBMIT**

Request Edit

Instructions: Please complete the information below.

1. Enter contact full name which corresponds to the email address entered.
2. Enter the email address that can be used for any questions.
3. Complete the description on what you need completed. Please include all information needed to complete the task.

If the email below is no longer valid, please send a request to have this email address updated on your user account.

* Contact Full Name:

* Email Address:

* Please type your request in the textbox below and click the Send button.

SUBMIT

CLOSE



COBRA Administration – Participants Tab

- Click on the icon under **Letters**

UnitedHealthcare

Participants

Search By:

Participant Status: All | GH# ID:

Last Name: | First Name: | SSN/SECURITY NUMBER: | Last 4 SSN:

RESULTS:

Participant	SSN	Event Date	Event ID	SP#ID	Proposed Date	Letters	Report
XXXXXX	XXXXXX	2024/01/01	01				

- There are several letters that you will be able to view and print for each participant.
- Please see Appendix C – Samples of guide for a sample of each type of letter.

UnitedHealthcare

Participant Letters

Some documents available on this page require Active Account Number (version 6.0 or higher). [Unactivated Account Number](#)

Participant:

Filter By: Letter | Table Sort: | View:

1112	Healthcare Plan	10/19/2021	
------	-----------------	------------	---

RESULTS

- Click on the icon under **Report**
- Report can be used to view demographics, coverages, payments, and dependent(s).
- Please see Appendix C – Samples of guide for a sample of the Report.

UnitedHealthcare

Participants

Search By:

Participant Status: All | GH# ID:

Last Name: | First Name: | SSN/SECURITY NUMBER: | Last 4 SSN:

RESULTS:

Participant	SSN	Event Date	Event ID	SP#ID	Proposed Date	Letters	Report
XXXXXX	XXXXXX	2024/01/01	01				



COBRA Administration – Reports Tab

The Reports tab is used to gain access to several different types of reports for the employers/brokers. One of the most important reports that can be found here is the employer disbursement reports.

- Once you have clicked on the **Reports** tab you will have several options:
 - On-Demand Reports
 - Scheduled Reports
 - Custom Reports




The screenshot shows the UnitedHealthcare web portal. The top navigation bar includes "Account Overview", "Billing Services", "Reimbursement Services", "Pre-Tax Premium", and "Site Administration". The "Reports" section is active, displaying a list of report options: "On-Demand", "Scheduled", and "Custom". Below the list, there are instructions for selecting a report type and a "View Report" button.



The screenshot shows the UnitedHealthcare web portal with the "Custom Reports" section active. It displays a "Report List" table with the following content:

Report List
No report existing matching the specified criteria

 Custom Reports at this time does not have any reporting capabilities.



COBRA Administration – Reports Tab

- Click on **On-Demand Reports**
 - **See list of reports on below**
- This allows you to generate different types of reports.
- Click **GENERATE REPORT** – the report will appear in PDF form.
- Click **GENERATE EXPORT** – the report will appear in excel spreadsheet form.



- This is a list of all the reports that can be found under the **On-Demand Reports** link
- **Please see Appendix C – Samples of guide for a sample of each report.**

Select a Report

Participant Extract
Participant Billing and Payments
Enrolled Participants
Notified Participants
Carrier/Coverage Counts
Terminated Participants
Plan Participation by Carrier
COBRA Plan Details
5500 Report
W-2 Report



COBRA Administration – Disbursements

Each month we deposit the COBRA premiums we have collected into the group's bank account via Electronic Funds Transfer around the 2nd week of the month. It is then the employer's responsibility to visit <https://www.uhcservices.com> monthly to view Disbursement Reports by selecting Reports and then Scheduled Reports. Review the monthly disbursement report that should be reconciled between the money deposited into the group's bank account along with what is being charged by the carrier(s). It is the responsibility of the employer to notify UnitedHealthcare Benefit Services of any discrepancies in a timely manner. Below are the steps to follow:

- Pull monthly disbursement report at <https://www.uhcservices.com>.
- Verify the total amount at the bottom of the report matches the amount that we deposited into the groups bank account via electronic funds transfer (EFT).
- Verify the amounts being billed on their carrier invoice matches the amount on the disbursement report.
- If these amounts do not match, should there be any other discrepancies or any questions regarding the COBRA disbursement please contact our COBRA Call Center at 800-318-5311, send an email to cobra@uhcservices.com or a request via Ask the Expert. In order to make any type of corrections we must be notified in a timely manner or you as the employer could be responsible for any shortages in premium.



If the discrepancy is due to a late submission of renewal rates, we will only retro bill if the rates were provided to us within 90 days of the renewal date.



Per Federal Regulations participants on COBRA must have a 30-day notice of any increase in rates therefore we will start billing with updated rates on the next bill statement. In this case the employer will be responsible for the shortage in premium between what was disbursed and what the participant was billed by the carrier invoice.

COBRA Administration – Reports Tab – Disbursement Reports

- Click **Scheduled Reports**
- Scheduled reports will allow you to view the monthly disbursement reports.
- Please see **Appendix C – Samples of guide for a sample of this report.**

UnitedHealthcare

Account Overview | Billing Services | **Disbursement Services** | Pre-Tax Premiums

Scheduled Reports

Report Type: All Reports

Date Range: Report To Date

From Date: 01/01/2021

To Date: 00/00/2001

FIND | CREATE NEW REPORTS

Fast Report List

Report	Download Data	View Report
Monthly Disbursement Report	2/2/2021	✓
Quarterly Disbursement Report	3/3/2021	✓
Monthly Disbursement Report	4/4/2021	✓
Monthly Disbursement Report	5/5/2021	✓
Monthly Disbursement Report	6/6/2021	✓
Monthly Disbursement Report	7/7/2021	✓
Monthly Disbursement Report	8/8/2021	✓
Monthly Disbursement Report	9/9/2021	✓
Monthly Disbursement Report	10/10/2021	✓
Monthly Disbursement Report	11/11/2021	✓
Monthly Disbursement Report	12/12/2021	✓

COBRA Administration – Resources Tab

The Resources Tab has several guides and forms which will be helpful with the administration of your groups COBRA services with UnitedHealthcare Benefit Services.

- Click on the Resources Tab
- Select Guide or Form you would like to view



UnitedHealthcare®

Sign Out

Billing Services > Resources

Account Overview Billing Services Reimbursement Services Pre-Tax Premium

Plan Details
Plan Details
QEN
General Notice
Participants
Reports
Resources
Ask the Expert

Resources

- COBRA Administration Guide
- COBRA Participant Enrollment Guide
- COBRA Participant Guide
- COBRA Renewal Guide
- ACH Form
- Important information about your right to COBRA
- COBRA, FSA and PTP Administration Brochure
- Secure Email Guide
- Implementation Guide
- UHCBS Change Form
- COVID-19 & COBRA
- American Rescue Plan Act (ARPA) & COBRA

Adobe Reader



COBRA Administration – Ask The Expert Tab

The Ask The Expert tab gives the employer the option to email our Customer Service Center.

- Click on the **Ask The Expert** Tab
- Fill out the information required.
- Ask the Expert your question
- Click **Submit**



The screenshot shows the UnitedHealthcare web portal interface. At the top, the UnitedHealthcare logo is on the left, and a 'Sign Out' link is on the right. Below the logo is a navigation menu with tabs for 'Account Overview', 'Billing Services', 'Reimbursement Services', and 'Pre-Tax Premium'. The 'Ask the Expert' tab is selected and highlighted in blue. The main content area is titled 'Ask the Expert' and contains a form with the following fields: 'Required Fields' (a text input), 'Group Name' (a dropdown menu), 'Contact First Name' (a text input), 'Contact Last Name' (a text input), 'Email' (a text input), 'Category' (a dropdown menu with 'Select One' selected), 'Subject' (a dropdown menu), and 'Question' (a large text area). A 'SUBMIT' button is located at the bottom right of the form. On the left side of the form, there is a small image of a stack of colorful blocks.



Your question/request will be answered by our COBRA Operations team via a secure email in 5-7 business days, to the email address you provided on the web portal when you submitted your request.

COBRA Definitions

What is COBRA?

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act, effective January 1, 1986.

Requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain events. Those events include:

- A covered employee's death,
- A covered employee's job loss or reduction in hours for reasons other than gross misconduct,
- A covered employee's becoming entitled to Medicare,
- A covered employee's divorce or legal separation, and
- A child's loss of dependent status (and therefore coverage) under the plan.

COBRA sets rules for how and when plan sponsors must offer and provide continuation coverage, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

Employers may require individuals to pay for COBRA continuation coverage. Premiums cannot exceed the full cost of the coverage, plus a 2 percent administration charge retained by UnitedHealthcare Benefit Services.

Qualifying Beneficiaries

- A qualified beneficiary is an employee who was covered by a group health plan on the day before a qualifying event occurred or that employee's spouse, former spouse, or dependent child.
- In certain cases, involving employer bankruptcy, a retired employee and their spouse, former spouse, or dependent children may be qualified beneficiaries.
- In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary.



COBRA Definitions

Duration of Continuation Coverage

If the qualified beneficiary is entitled to an 18-month maximum period of continuation coverage, qualified beneficiary may become eligible for an extension of the maximum time period in two circumstances. The first is when a qualified beneficiary is disabled; the second is when a second qualifying event occurs or lives in a state that offers a state continuation extension.

Disability - If any one of the qualified beneficiaries in the family are disabled and meets certain requirements, all the qualified beneficiaries in the family are entitled to an 11-month extension of the maximum period of continuation coverage (for a total maximum period of 29 months of continuation coverage). The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11- month disability extension.

The requirements are:

1. that the Social Security Administration (SSA) determines that the disabled qualified beneficiary is disabled before the 60th day of continuation coverage.
2. that the disability continues during the rest of the 18-month period of continuation coverage.

The disabled qualified beneficiary or another person on his or her behalf also must notify the plan of the SSA determination. The plan can set a time limit for providing this notice of disability, but the time limit cannot be shorter than 60 days, starting from the latest of: (1) the date on which SSA issues the disability determination; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (4) the date on which the qualified beneficiary is informed, through the furnishing of the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The plan can require qualified beneficiaries receiving the disability extension to notify it if the SSA makes such a determination, although the plan must give the qualified beneficiaries at least 30 days after the SSA determination to do so.

Second Qualifying Event – If qualified beneficiary is receiving an 18-month maximum period of continuation coverage, qualified beneficiary may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage) if experience a second qualifying event that is the death of a covered employee, the divorce or legal separation of a covered employee and spouse, a covered employee's becoming entitled to Medicare (in certain circumstances), or a loss of dependent child status under the plan. The second event can be a second qualifying event only if it would have caused a loss of coverage under the plan in the absence of the first qualifying event. If a second qualifying event occurs, qualified beneficiary will need to notify the plan.



COBRA Definitions

Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination for reasons other than gross misconduct or reduction in hours of employment	Employee Spouse Dependent Child	18 months
Employee enrollment into Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of 'dependent child' status under the plan	Dependent Child	36 months



COBRA Frequently Asked Questions

What is the log in process for uhcservices.com?

Please select the “login using OneHealth ID” and enter your login credentials for OneHealth ID (if you do not have a OneHealth ID, please select “Create a OneHealth ID”). In order to map your current login to your One Healthcare ID, please enter your current user account login credentials. Then, click “Add User”. Once successfully mapped the username will appear under “choose an account to login”. Please select “continue login”.

Is there a cost for UnitedHealthcare Benefit Services to administer services?

There are no additional costs for the administration of COBRA Billing, if the group has an eligible UHC plan and group has less than 100 eligible employees.

Will UnitedHealthcare Benefit Services administer COBRA for a groups Non UHC products?

UnitedHealthcare Benefit Services will administer plans for outside carriers if there is at least one active eligible UHC product. Eligible products would be Medical, Dental or Vision.

What accounts can I activate?

- Billing services- COBRA administration
- Reimbursement Services- FSA administration
- Pre-Tax Premium- Section 125 plan/Cafeteria plan

How does the COBRA billing process work?

- Once we have received the participant COBRA enrollment and a full month’s premium payment, UnitedHealthcare Benefit Services will notify the carrier(s) to reinstate coverage under COBRA.
- The participant will then show up on the groups invoice from the carrier. The group is responsible to pay the carrier as invoiced.
- Each month we deposit the participants COBRA premiums we have collected into the group's bank account via Electronic Funds Transfer around the 2nd week of the month via our month COBRA disbursement process.

For purposes of COBRA, who is an employee?

The term employee means any individual working for the employer, including part-time and full-time employees, regardless of whether the employee has enrolled in the health plan or is eligible for health insurance.

What is a health plan under COBRA?

Plans covering the following are generally considered health plans under COBRA:

- **Medical or surgical care**
- **Prescription drugs**
- **Dental care**
- **Vision care**
- **Hearing care**
- **Drug and mental health treatment**
- **Health flexible spending arrangements (FSAs)**
- **Health reimbursement arrangements (HRAs)**



COBRA Frequently Asked Questions

QUALIFYING EVENTS

What is a COBRA qualifying event?

A qualifying event is a specific event that occurs while a health plan is subject to COBRA and that results in a loss of coverage to a covered employee, covered spouse or a covered dependent child of the covered employee. The specific events are:

- Termination of employment or reduction of hours of the covered employee (other than by reason of gross misconduct).
- Death of a covered employee.
- Divorce or legal separation of a covered employee from the covered employee's spouse.
- A covered employee becoming entitled to Medicare benefits.
- A dependent child ceasing to be a dependent child under the terms of the health plan; An employer's filing of bankruptcy under Chapter 11 with respect to a retired covered employee, any spouse, surviving spouse or dependent child of such a covered employee, if on the day before the bankruptcy, the spouse, surviving spouse or dependent child were covered under the plan.

What is a second qualifying event under COBRA?

Where a qualified beneficiary elects COBRA following a termination of employment or reduction of hours and later experiences an event that would have been a qualifying event entitling the qualified beneficiary to 36 months of coverage, the qualified beneficiary is entitled to 36 months of coverage beginning from the date of the first qualifying event.

What qualifies as gross misconduct under COBRA?

While COBRA does not require an employer to extend COBRA continuation rights to an employee and his or her spouse and dependents where the employee's termination was due to gross misconduct, COBRA does not define gross misconduct. In addition, federal courts have not provided a clear standard for determining what constitutes gross misconduct. Court decisions have referred to gross misconduct as "intentional, willful, reckless, or deliberate." An employee's failure to follow an employer's policy is often not conduct that rises to the level of gross misconduct. An employer should consult with an attorney before refusing to offer an employee and his or her covered dependents COBRA continuation coverage based on the employer's determination that the employee was terminated because of gross misconduct. If an employer mistakenly determines that an employee's termination was a result of gross misconduct, the employer will be liable for failing to offer COBRA.

What is the election period for qualified beneficiary under COBRA?

Individuals that experience a qualifying event must be provided with an opportunity to elect COBRA continuation coverage at any time during the election period. An election period must be at least 60 days. The election period ends on the later of sixty days following:

- The date coverage under the plan terminates; or
- A qualifying event must: a) result in a loss of coverage; and b) be a result of one of the above specified events.
- The date on which the qualified beneficiary receives notice from the plan administrator.

A qualified beneficiary's election is deemed to be made on the date it is sent to the employer or plan administrator.

Once the election is made, the participant has 45 days from the date of the election to make their initial COBRA payment.



Reports - Participant Extract Sample Report

lhshdhealthcare
Participant Extract
Date: 10/04/2021

Date Range: 01/01/2021 - 10/04/2021

Including Terminators & including Dependents & including Nonfinal & including Enrolled & including Droppout & Terminated plans.

Selected Divisions: All

Client Name	Client Locid	Client Name	(W's) Park St	Family Suffix	Last Name	First Name	Middle Initial	Birthday	Street	State	City	State Address	Zip Code	Country Code	Phone	Email	Sex	Date of Birth	Marital Status	Enrolled Status	Dependent's Alternate ID	Dependent ID Code	Dependent Effective Date	Dependent Status	Dependent Status Date	Appl Qual Code
																	M		Single	Not final Never Enrolled						TE
																	M		Single	Not final Never Enrolled	CHILD		7/11/2011	Droppout	7/20/2011	DR
																	M		Single	Enrolled						DR
																	M		Single	Enrolled						DR
																	M		Single	Enrolled						DR
																	M		Single	Enrolled						DR

Code Description	Plan Sponsor Date	Appl Qual Date	Modification Date	Effective Date	Enroll Date	Withdraw Date	Will Term Code	Will Term Date	Termination Code	Termination Date	Date of Termination	Carrier ID	Carrier Name	Carrier Alias	Coverage Code	Coverage Description	Law of Coverage	Use of Coverage	Emp. Status Code	Coverage Qual Code	Coverage Description	Coverage Effective Date	Coverage End Date	Coverage Status	Coverage Valid Through Date
Termination of Supplemental Coverage	8/10/2011	1/11/2011	7/26/2011						Expense	7/26/2011	8/10/2011	70944011	Guardian	Quarterly	CC	Employee + Children	DC	DENTAL	DR		Termination of Employment	8/11/2011	1/11/2011		
Termination of Employment	8/10/2011	1/11/2011	7/26/2011						Expense	7/26/2011	8/10/2011	70944011	Guardian	Quarterly	CC	Employee + Children	DC	DENTAL	DR		Termination of Employment	8/11/2011	1/11/2011		
Secondary Termination	7/12/2011	1/11/2011	7/26/2011	8/10/2011	8/10/2011	8/11/2011	FA13					70944011	Guardian	Quarterly	CC	Child	DC	DENTAL	DR	Secondary Termination	8/11/2011	1/11/2011		10/11/2011	
Secondary Termination	7/12/2011	1/11/2011	7/26/2011	8/10/2011	8/10/2011	8/11/2011	FA13					70944011	Employee	Secondary	CC	Employee Only	DC	DENTAL	DR	Secondary Termination	8/11/2011	1/11/2011		10/11/2011	
Secondary Termination	7/12/2011	1/11/2011	7/26/2011	8/10/2011	8/10/2011	8/11/2011	FA13					70944011	Guardian	Quarterly	CC	Employee Only	DC	DENTAL	DR	Secondary Termination	8/11/2011	1/11/2011		10/11/2011	
Secondary Termination	7/12/2011	1/11/2011	7/26/2011	8/10/2011	8/10/2011	8/11/2011	FA13					70944011	Employee	Secondary	CC	Employee Only	DC	DENTAL	DR	Secondary Termination	8/11/2011	1/11/2011		10/11/2011	



Reports - Participant Billing and Payments Sample Report

Division: 6000000
 Fact: 0000 (Bill and Payment)
 Date: 12/01/2021
 Date Range: 01/01/2021 - 12/31/2021
 Include Terminations:

JobCode: Division: ALL

BillOff	Client Name	Division #	Envision Name	Plan	Event#	Last Name	First Name	Middle Initial	Employee#	Carrier ID	Carrier Name	Carrier Area	Coverage Code	Coverage Description	Bill Cvg. Start	Bill Begn	Bill End	Use Date	Start of Rate Period	Billend Amount	Coverage Rate	Bill Rate Code	Pynt Start	Pynt Bill Seq#	Payment Sequence	Sold Date	PAID Amount	Check Month	Posted Date	Source Code	Pymt Flow Code	Pymt Status	Com Disband
											Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	9/25/2021	521.98	521.98		8/1/2021	1	1	8/16/2021	571.76	705.51	08/2021	ED Lockbox Payment		Unapplied amount	
										000944311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	521.98	521.98		8/1/2021	1	1	8/16/2021	571.76	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										000944311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	521.98	521.98		8/1/2021	1	1	8/16/2021	571.76	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										001994311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	57.44	57.44		8/1/2021	1	1	8/16/2021	57.44	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										000920090	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	3479.89	3479.89		8/1/2021	1	1	8/16/2021	3479.89	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										000944311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	321.54	321.54		8/1/2021	1	1	8/16/2021	321.54	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										000944311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	321.54	321.54		8/1/2021	1	1	8/16/2021	321.54	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										001994311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	57.44	57.44		8/1/2021	1	1	8/16/2021	57.44	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										000910090	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	3479.89	3479.89		8/1/2021	1	1	8/16/2021	3479.89	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										000944311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	321.54	321.54		8/1/2021	1	1	8/16/2021	321.54	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										000944311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	321.54	321.54		8/1/2021	1	1	8/16/2021	321.54	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										001994311	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	57.44	57.44		8/1/2021	1	1	8/16/2021	57.44	705.51	08/2021	ED Lockbox Payment		Unapplied amount		
										000920090	Guardian Optima	0107		Employee Only	8/23/2021		8/11/2021	9/25/2021	3479.89	3479.89		8/1/2021	1	1	8/16/2021	3479.89	705.51	08/2021	ED Lockbox Payment		Unapplied amount		



Reports - Enrolled Participants Sample Report

UnitedHealthcare

Enrolled Participants Report

Date: 10/04/2021

Enrolled Dates: 01/01/2021 - 10/04/2021

Including Terminated Participants

Selected Divisions: ALL

SSN	Participant Name	Qualified Date	Qual. Code	Elig. End Date	Notified Date	Elected Date	Ele. Rc'd Date	Term. Date	Term. Reason
	Guardian	07/31/2021	AR	01/31/2023	07/26/2021	08/10/2021	08/10/2021		
	Employee Benefit Services	Employee Only		08/01/2021 - 01/31/2023					Paid Thru: 10/31/2021
	Guardian	Employee Only		08/01/2021 - 01/31/2023					Paid Thru: 10/31/2021
	UHC BZTQ (04S2633) MEDICAL	Employee Only		08/01/2021 - 01/31/2023					Paid Thru: 10/31/2021



Reports - Notified Participants Sample Report

UnitedHealthcare

Notified Participants Report

Date: 10/04/2021

Notified Dates: 01/01/2021 - 10/04/2021

Including Elected Participants

Selected Divisions: ALL

SSN	Participant Name	Qualified Date	Qual. Code	Elig. End Date	Elected Date	Notified Date	Last Enroll Date	Days To Enroll
		07/31/2021	TE	01/31/2023				
	UHC BZTQ (04S2633) MEDICAL	Employee Only			08/01/2021 - 01/31/2023	07/22/2021	09/29/2021	0
	Guardian	Employee Only			08/01/2021 - 01/31/2023	07/26/2021	09/29/2021	0
	Employee Benefit Services	Employee Only			08/01/2021 - 01/31/2023	07/26/2021	09/29/2021	0
	Guardian	Employee Only			08/01/2021 - 01/31/2023	07/26/2021	09/29/2021	0
	UHC BZTQ (04S2633) MEDICAL	Employee Only			08/01/2021 - 01/31/2023	07/26/2021	09/29/2021	0
		07/31/2021	TE	01/31/2023				
	Guardian	Employee + Child(ren)			08/01/2021 - 01/31/2023	07/30/2021	09/29/2021	0
	Employee Benefit Services	Employee + Child(ren)			08/01/2021 - 01/31/2023	07/30/2021	09/29/2021	0
	Guardian	Employee + Child(ren)			08/01/2021 - 01/31/2023	07/30/2021	09/29/2021	0
	UHC BZTQ (04S2633) MEDICAL	Employee + Child(ren)			08/01/2021 - 01/31/2023	07/30/2021	09/29/2021	0



Reports - Terminated Participants Sample Report

UnitedHealthcare

Terminated Participants Report

Date: 10/04/2021

Terminated Dates: 01/01/2021 - 10/04/2021

Selected Divisions: ALL

SSN	Participant Name	Qualified Date	Qual. Code	Elig. End Date	Notified Date	Elected Date	Ele. Rc'd Date	Term. Date	Term. Reason
	UHC BZTQ (04S2633) MEDICAL	07/31/2021	TE	01/31/2023	07/22/2021			07/30/2021	Expired
		Employee Only		08/01/2021 - 01/31/2023				Paid Thru:	
	Guardian	07/31/2021	TE	01/31/2023	07/30/2021			07/30/2021	Expired
	Employee Benefit Services	Employee + Child(ren)		08/01/2021 - 01/31/2023				Paid Thru:	
	Guardian	Employee + Child(ren)		08/01/2021 - 01/31/2023				Paid Thru:	
	UHC BZTQ (04S2633) MEDICAL	Employee + Child(ren)		08/01/2021 - 01/31/2023				Paid Thru:	



Reports - Plan Participation by Carrier Sample Report

UnitedHealthcare

Plan Participation by Carrier Report

Date: 10/04/2021

Enrolled Dates: 01/01/2021 - 10/04/2021

Including Terminated Participants & Excluding Dependents

Selected Divisions: ALL

Carrier Name: Employee Benefit Services									
SSN	Participant Name	Qualified Date	Qual. Code	Elig. End Date	Notified Date	Elected Date	Ele. Rc'd Date	Term. Date	Term. Reason
	Employee Only	07/31/2021	AR	01/31/2023	07/26/2021	08/10/2021	08/10/2021		
				08/01/2021 - 01/31/2023					Paid Thru: 10/31/2021
Carrier Name: Guardian									
SSN	Participant Name	Qualified Date	Qual. Code	Elig. End Date	Notified Date	Elected Date	Ele. Rc'd Date	Term. Date	Term. Reason
	Employee Only	07/31/2021	AR	01/31/2023	07/26/2021	08/10/2021	08/10/2021		
	Employee Only			08/01/2021 - 01/31/2023					Paid Thru: 10/31/2021
	Employee Only			08/01/2021 - 01/31/2023					Paid Thru: 10/31/2021
Carrier Name: UHC BZTQ (04S2633) MEDICAL									
SSN	Participant Name	Qualified Date	Qual. Code	Elig. End Date	Notified Date	Elected Date	Ele. Rc'd Date	Term. Date	Term. Reason
	Employee Only	07/31/2021	AR	01/31/2023	07/26/2021	08/10/2021	08/10/2021		
				08/01/2021 - 01/31/2023					Paid Thru: 10/31/2021



Reports - 5500 Report

UnitedHealthcare
5500 Report
Date: 10/04/2021

Enrolled Dates: (01/01/2021 - 10/04/2021)
Including Terminations & Excluding Dependents

Selected Divisions: ALL

Client#	Client name	Division#	Division Name	Ssn	Event#	Last Name	First Name	Qual Code	Code Description
					2			AR	Involuntary Termination
					2			AR	Involuntary Termination
					2			AR	Involuntary Termination
					2			AR	Involuntary Termination

Line ID	Line of Coverage	Carrier	Carrier Alias	Start Date	End Date	Paid Thru Date
DE	DENTAL	Guardian	Guardian Dental	6/1/2021	1/31/2023	10/31/2021
HE	HEALTH	Employee Benefit Services	EBS Secondary Health	6/1/2021	1/31/2023	10/31/2021
HE	HEALTH	UHC B2TQ (0452633) MEDICAL	UHC B2TQ (0452633) MEDICAL	6/1/2021	1/31/2023	10/31/2021
VI	VISION	Guardian	Guardian Vision	6/1/2021	1/31/2023	10/31/2021



Reports - W-2 Report

UnitedHealthcare

W-2 Report

Date: 10/04/2021

Enrolled Dates:(01/01/2021 - 10/04/2021)

Including Terminations

Selected Divisions: ALL

Client#	Client Name	Division#	Division Name	Ssn	Event#	Last Name	First Name	Qual Code	Code Description	Dental	Health	Vision	Grand Total
					2			AR	Involuntary Termination	\$65.82	\$1,576.50	\$22.32	\$1,664.64



Reports - Disbursement Report

UnitedHealthcare

Disbursement Report

All Disbursements

Date: 9/11/2021 11:33:57 AM

For Dates: 9/1/2021 - 9/30/2021

For Divisions: All Divisions

Paid To:		Account: Client-Direct Deposit									
Company No	Company Name	Division									
SSN	Participant Name	Carrier ID	Carrier	Coverage Code	Coverage	Coverage Date	Disbursement Date	Amount	Admin Fee	Total	
		00Q3345	UHC CA34 (00Q3345) MEDICAL	ED	Employee Only	9/1/2021	9/7/2021	\$391.31	\$7.83	\$399.14	
Total For: Carrier: UHC CA34 (00Q3345) MEDICAL								Total:	\$391.31	\$7.83	\$399.14
Total for all Carriers							Total:	\$391.31	\$7.83	\$399.14	
Adjustments:											
Total For:		Account: Client-Direct Deposit						Total:	\$399.14		





REQUEST EDIT

PRINT

Demographics

Important Information		Name/Address
Event Date:	07/31/2021	
Notified:	07/26/2021	
Elected:	08/10/2021	
Election Received:	08/10/2021	
Event Type:	Involuntary Termination	
Status:	Enrolled	Phone:
Sponsor Date:	07/23/2021	Email:
Other ID:		Birth Date: 11/07/1958
		Gender: M
		Marital: Single

Coverages/Elections

Coverage	Coverage Level	Premium	Effective	Eligibility Ends	Paid Thru Date
Guardian Dental	Employee Only	\$21.94	08/01/2021	01/31/2023	10/31/2021
EBS Secondary Health	Employee Only	\$52.14	08/01/2021	01/31/2023	10/31/2021
Guardian Vision	Employee Only	\$7.44	08/01/2021	01/31/2023	10/31/2021
UHC BZTQ (04S2633) MEDICAL	Employee Only	\$473.36	08/01/2021	01/31/2023	10/31/2021

Payments

EXPAND ALL

COLLAPSE ALL

Coverage	Coverage Level	Bill Amt.	Due Date	Grace Period Date	Balance
<input checked="" type="checkbox"/> EBS Secondary Health Starting: 10/01/2021		\$52.14	10/01/2021	10/31/2021	\$0.00
<input checked="" type="checkbox"/> Guardian Dental Starting: 10/01/2021		\$21.94	10/01/2021	10/31/2021	\$0.00



Participants - Participant Reports Sample

Participant Sample Report Page 2

<input type="checkbox"/>	Guardian Vision Starting: 10/01/2021	\$7.44	10/01/2021	10/31/2021	\$0.00
<input type="checkbox"/>	UHC BZTQ (04S2633) MEDICAL Starting: 10/01/2021	\$473.36	10/01/2021	10/31/2021	\$0.00
<input type="checkbox"/>	EBS Secondary Health Starting: 08/01/2021	\$52.14	09/24/2021	09/24/2021	\$0.00
<input type="checkbox"/>	Guardian Dental Starting: 08/01/2021	\$21.94	09/24/2021	09/24/2021	\$0.00
<input type="checkbox"/>	Guardian Vision Starting: 08/01/2021	\$7.44	09/24/2021	09/24/2021	\$0.00
<input type="checkbox"/>	UHC BZTQ (04S2633) MEDICAL Starting: 08/01/2021	\$473.36	09/24/2021	09/24/2021	\$0.00
<input type="checkbox"/>	Unapplied Payments				(\$50.00)
Total Balance: (\$50.00)					

Dependents

First Name	Last Name	Relationship	Birth Date	Effective
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Other Information

No Additional Information Available.



General Notice – General Notice Sample

General Notice of COBRA Continuation Coverage Sample

UnitedHealthcare
P.O. Box 740221
Atlanta, GA 30374
<http://uhcervices.com>
Phone: (866) 747-0048

Date Printed

General Notice of COBRA Continuation Coverage ** Continuation Coverage Rights Under COBRA**

Sample Sample and Dependents
123 Anywhere Street
Sample, GA 55555

You are receiving this notice because you, your spouse, and/or dependents, if any, have recently become covered under the group health plan for the following employer:

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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

This notice is intended to inform you of your rights and obligations under provisions of the COBRA law if you, your spouse and/or eligible dependents, if any, lose coverage due to a COBRA qualifying event in the future. Enclosed you will find a copy of your "Notice of Right to Elect COBRA Continuation Coverage". It is important that you, your spouse and/or eligible dependents, if any, are aware of and understand your rights under COBRA. Please share this information with any family members that are covered under the employer's group benefit plan(s).

We have also enclosed a copy of the "Health Insurance Portability and Accountability Act (HIPAA) Notice" so you are also aware of your rights and obligations under the HIPAA law.

Once again, this notice is for **informational purposes only**. Your benefits through your employer have not been terminated or affected in any way.

UnitedHealthcare
P.O. Box 740221
Atlanta, GA 33008
<http://uhcervices.com>

Phone: (866) 747-0048
Fax: (800) 324-3195
cobra@uhcervices.com

A-1100

UnitedHealthcare



General Notice of COBRA Continuation Coverage Sample

NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE

What is COBRA Continuation Coverage?

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. You, your spouse and dependent children, if any, should all take the time to read the entire notice carefully.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

*If a covered child of the employee is enrolled in the plan pursuant to a qualified medical child support order (QMCSO) during the employee's period of employment, he or she is entitled to the same rights under COBRA as if he or she were the employee's dependent.

How is COBRA Coverage Provided?



General Notice of COBRA Continuation Coverage Sample

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

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

Your Election Rights: When the Plan Administrator or designated Plan Service Provider is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage (because of one of the events described above) to inform the Plan Administrator or the designated Plan Service Provider that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end.

Coverage Rights: If you choose continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. Each covered person will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Maximum Period of Coverage: The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment (for reasons other than gross misconduct) or reduction in hours. In that case, the required continuation coverage period is 18 months. These 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Disability: The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of

General Notice of COBRA Continuation Coverage Sample

COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment.

To benefit from this extension, a qualified beneficiary must notify the Plan Administrator or designated Plan Service Provider of the disability determination on or before 60 days from the COBRA start date, and before the end of the original 18-month period. If you do not notify the Plan Administrator or the designated Plan Service Provider within the required period of time, you may lose your right to the extension.

The affected individual must also notify the Plan Administrator or designated Plan Service Provider within 30 days of any final disability determination that the individual is no longer disabled. Coverage will end on the first of the month, following at least 30 days after the date of the Social Security final disability determination letter.

California State Residence: Under California law, you may be eligible for a State mandated extension of benefits after your federally mandated COBRA period expires. California State laws allow an extension of COBRA benefits to a total of 36 months from the date of your qualifying event to Qualified Beneficiaries who begin COBRA coverage on or after January 1, 2003. You will be notified of this extension at the conclusion of your original COBRA coverage.

Flexible Spending Account or Medical Reimbursement Account: If you are participating in the company's Flexible Spending Account or Medical Reimbursement Account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

1. You will be allowed to continue coverage for the remainder of the current plan year if you have a balance remaining in your account at the time of your termination or reduction in hours;
2. You will not be able to receive reimbursements in excess of your original election amount in the account; and
3. You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

You Must Give Notice of Some Qualifying Events: Under the law, the employee or a family member has the obligation to inform the Plan Administrator or the designated Plan Service Provider, at the address on this form, of a divorce, legal separation, or a child losing dependent status within 60 days of the date of the event. The employer has the responsibility to notify the Plan Administrator or designated Plan Service Provider of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage. If you fail to notify the Plan Administrator or the designated Plan Service Provider within 60 days, you may lose your right to continuation coverage.

Adding Dependents to COBRA Coverage: A child who is born to or adopted by the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator or designated Plan Service Provider of the birth or adoption.

Expiration of COBRA Coverage: The law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The company no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;



General Notice of COBRA Continuation Coverage Sample

3. The qualified beneficiary becomes covered - after the date he or she elects COBRA coverage - under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

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

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

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Insurance Premiums: Under the law, you may have to pay all or part of the premium for your continuation coverage. You may also be required to pay a 2% administration fee above the cost of the premiums. If you are disabled, you may be required to pay 150% of the premium during the 11-month extension period.

Grace Period: There is a grace period of 30 days for payment of the regularly scheduled premium.

Conversion Coverage: At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided a conversion health plan is available to active employees. Please read your health plan benefits booklet or Summary Plan Description regarding any option for conversion coverage after the expiration of COBRA coverage. If there is an option for conversion to an individual policy, follow the instructions provided to apply for the coverage, as it would be separate coverage, and would not simply be an extension of COBRA coverage.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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



General Notice of COBRA Continuation Coverage Sample

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA) NOTICE

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of such an event.

Please note that the company group health plan may have a pre-existing condition exclusion period. If you are a late applicant, the pre-existing condition limitation period may be up to 18 months. Check your benefit booklet or Summary Plan Description for details.

The Plan will not treat pregnancy as a pre-existing condition. Additionally, the Plan will not impose any pre-existing condition exclusion or limitation with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, adoption, or placement for adoption, is covered under the Plan or has other creditable coverage.

Pre-Existing Conditions Limitations: Under HIPAA, the circumstances under which treatment for medical conditions may be excluded from health plan coverage are limited. Under the law, the length of a pre-existing condition or exclusion must be reduced by your prior health plan coverage. A "pre-existing condition" is defined as an illness, injury or condition which was diagnosed or for which medical advice, care or treatment was recommended or received within the six-month period prior to your enrollment date in the plan, or if the plan has a waiting period, prior to the first day of the waiting period.

Certificate of Creditable Coverage: You are entitled to a certificate from your employer, or former employer, that shows evidence of your prior health coverage. HIPAA requires an employer (who may designate a Plan Service Provider) to provide a certificate of creditable coverage to:

1. An individual who is entitled to elect COBRA continuation coverage;
2. An individual who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage; and
3. An individual who has elected COBRA continuation coverage and such coverage ends for any reason.

Plans must also provide a certificate of creditable coverage upon request by a plan participant any time within 24 months of a loss of coverage.

Applying for Reduction of a Pre-Existing Condition Limitation: The pre-existing condition limitation period will be reduced by creditable coverage you have had under other qualifying health plans, provided you have not experienced a period of more than 63 continuous days during which you were not covered by a health plan, excluding any waiting period for plan coverage.



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General Notice of COBRA Continuation Coverage Sample

Qualifying group health plans include: 1) a group health plan; 2) individual health insurance; 3) Medicare; 4) Medicaid; 5) a military-sponsored health care program; 6) a medical care program of the Indian Health Service or of a tribal organization; 7) state health benefits risk pool; 8) a Federal employee health benefit program; 9) a public health plan; or 10) any health plan under section 5(e) of the Peace Corps Act.

Following your submission of a certificate of creditable coverage from your prior group health plan(s), the plan administrator (or the designated Plan Service Provider) will notify you of your pre-existing condition limitation period under the health plan. If you feel that the Plan Administrator erred in determining your period of creditable coverage under another group health plan in arriving at your pre-existing condition limitation period under this plan, you may appeal the determination by making a written request for review to the Plan Administrator within thirty (30) days of notice of your applicable pre-existing condition limitation period under the health plan. Please include with

your appeal any evidence you feel should be considered by the Plan Administrator. The Plan Administrator will respond to your request for review within thirty (30) days of receipt of the appeal.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at (312) 353-0900.

If you have any questions about this notice or the law, please contact your Plan Administrator at the number or location provided in your benefits booklet or Summary Plan Description.

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

A-1100

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UnitedHealthcare



Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample



UnitedHealthcare®

P.O. Box 740221
Atlanta, GA 30374-0221

DPS\$\$\$PKG 202105061813130001COB

Eligible Dependents:
None

Date Printed: 05/07/2021

UnitedHealthcare
Division: Benefit Services
P.O. Box 740221
Atlanta, GA 30374-0221
Ph: (866) 747-0048

COBRA CONTINUATION COVERAGE ELECTION NOTICE
AND OTHER HEALTH COVERAGE ALTERNATIVES

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Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

Important Dates:

Qualification Date: 04/30/2021
Notification Date: 05/07/2021
NonCOBRA - Active Coverage End Date: 04/30/2021
Potential COBRA Coverage Start Date: 05/01/2021
Potential COBRA Coverage End Date: 10/31/2021
COBRA Election Period Expires: 07/05/2021
COBRA Eligibility will not be updated until the initial payment is received - refer to the Election Agreement

AYUDA ADICIONAL PARA LOS EMPLEADOS QUE HABLAN ESPAÑOL:

Este aviso contiene información importante acerca de su derecho a continuar con su cobertura de salud. Si necesita ayuda, por favor, póngase en contacto con UnitedHealthcare COBRA al teléfono 1-866-747-0048 y pida que le transfieran con un Representante del Servicio al Cliente que hable Español.

Please carefully read and review the information in this notice as it contains important information about your right to continue your group benefit coverage, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

You have had an event, Termination of Employment, that will result in loss of coverage under the (the "Plan") group benefit plan(s). If you do not elect to continue coverage, your coverage under the plan(s) will end on the "NonCOBRA Coverage End Date" noted above. Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, this is a qualifying event that will entitle you, your covered spouse and dependent child(ren), if any, to elect to continue coverage (known as "COBRA coverage") under the plan for up to 18 Months from the date of your qualifying event.

Each of the following individuals is entitled to elect to continue coverage he or she was enrolled in under the Plan. If a family member was covered the day before the qualifying event and is not listed below, please add that information to the Election Agreement.

Name (First Last)	Relationship
	Self

Please note: If your election contains coverage for your dependents, confirmation of the demographics and the social security number of the dependent(s) is required to complete your enrollment.

If you elect to continue your coverage under the Plan, your continuation coverage will begin on the start date shown below. The enclosed Election Agreement must be returned to UnitedHealthcare no later than the Election Expires date. If you do not return the completed Election Agreement by this date, you will lose your right to elect continuation coverage.

Carrier Name	Coverage	Amount Due	Net Due	Billing Period	Date	Election Expires
UHC CA34 (00Q3345) MEDICAL	Employee Only	\$ 399.14	\$ 399.14	1 Month	05/01/2021	07/05/2021

This notice provides important information concerning your rights and what you have to do to continue your coverage under the Plan. If you have any questions concerning the information in this notice or your rights to continue coverage, please contact UnitedHealthcare.

There may be other coverage options for you and your family. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days from when you lost coverage.

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Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

If you have any questions about your rights to COBRA continuation coverage, you should contact:

UnitedHealthcare Customer Care Center
P.O. Box 740221 Toll Free: 1-866-747-0048 TTY 711
Atlanta, GA 30374 Email: cobra_kyoperations@uhc.com
Web: <https://uhcservices.com>

Employer Name

ELECTION AGREEMENT Page 1 of 2

The primary qualified beneficiary may elect to continue coverage on behalf of all eligible dependents, which were covered the day before the qualifying event. If the primary qualified beneficiary has declined coverage, a dependent (or legal guardian) may elect independent coverage. Each eligible family member may elect coverage independently by completing a separate copy of this ELECTION AGREEMENT.

UnitedHealthcare offers you the ability to enroll online to save you time and money. To take advantage of this easy enrollment process, go to <https://uhcservices.com> and register as a user. If you enroll online, you do not need to return this form. You must enroll by the Election Expires date below or you and all eligible family members will lose your right to continuation coverage.

Ongoing invoices will be on a monthly basis; however, your first invoice may be for a partial month depending on your coverage start date. If your coverage start date is not the first of the month, then your initial invoice will contain a prorated premium amount for your first month of coverage.

I (we) elect the coverage(s) checked below for myself and my eligible dependents, if any:

Carrier Name	Coverage	Amount Due	Net Due	Billing Period	Date	Election Expires
<input checked="" type="checkbox"/> UHC CA34 (00Q3345) -MEDICAL	Employee Only	\$ 399.14	\$ 399.14	1 Month	05/01/2021	07/05/2021

DEPENDENT INFORMATION

Please check the members below who are electing to continue coverage. Should you decide to elect individual coverage for any of your dependents, for example spouse only or child only, the following information must be provided in order to complete the enrollment process. If any of the information is not provided, this could possibly delay your enrollment and eligibility. Please note, in order for you to enroll your dependents, the social security number for that dependent must be provided. If the child is less than six months of age, you will be required to provide the social security number on or before six months of age.

Name (First Last)	Birth Date	Sex	Relationship	Alt. SSN
<input checked="" type="checkbox"/>		Female	Self	

If a spouse and/or dependent was covered under the plan(s) prior to the qualifying event, but not listed, please provide their information. This information will be used to validate that the dependent was covered on the day prior to the event.

Please see reverse side to sign acknowledgement.

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Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

ELECTION AGREEMENT

Page 2 of 2

Important: By signing below, I acknowledge that I have read the **IMPORTANT INFORMATION ABOUT YOUR RIGHT TO COBRA CONTINUATION COVERAGE** and understand my election rights. I agree to notify UnitedHealthcare if 1) I or any of my covered dependents become covered by another group health plan or entitled to Medicare or 2) have a change of address.

If you elect continuation coverage, the initial premium payment must include full payment from the date you lost coverage under the Plan to the current month's premium payment. The actual amount of the premium required depends on the date coverage was lost and the date coverage is elected. **Insurance carriers will not reinstate your coverage until the initial premium is made, so you may send a check or money order for coverage elected with enclosed remittance slip or pay online.** However, you do have 45 days from the date you elect continuation coverage to send the initial premium payment. If you do not make your first payment within those 45 days, you will lose all continuation rights under the Plan.

An Election Agreement that does not elect COBRA coverage for all qualified beneficiaries or does not elect all available coverage is a waiver of COBRA coverage for those qualified beneficiaries and coverages. A qualified beneficiary who waived coverage (or for whom coverage is waived) may change a prior waiver of continuation coverage at any time before the election period expires by submitting a new Election Agreement before that expiration, but such coverage will be prospective from the date the updated election form is submitted. A failure to timely provide an election agreement is a waiver of COBRA coverage.

Signature _____
Date _____
Phone Number _____

Print Name _____
Email Address _____

UnitedHealthcare offers you the ability to enroll online to save you time and money. To take advantage of this easy enrollment process, go to <https://uhcservices.com> and register as a user.

Otherwise, please return this completed Election Agreement to:

UnitedHealthcare
P.O. Box 740221
Atlanta, GA 30374-0221

UnitedHealthcare offers you multiple options for making your payment:

1. UnitedHealthcare offers you the option to make a payment directly from your checking or savings account or from your credit or debit card (MasterCard, VISA, Discover, American Express). To take advantage of this easy payment process, login to <https://uhcservices.com> and click on the link to complete the information for your one-time payment. (Note: Credit or Debit Card payments cannot be taken over the phone)
2. If paying by check, your premium payment must be returned along with the remittance slip for the payment period(s) you are paying. The initial premium payment must include full payment from the date you lost coverage under the plan to the current month's premium payment. Please make your check payable to UnitedHealthcare and mail to the address on the remittance slip below.
3. UnitedHealthcare offers you the ability to make recurring premium payments through Electronic Funds Transfer (EFT) directly from your checking, savings, account, or credit/debit card account. If you decide to sign up for automatic withdrawals, they will continue as the premiums come due until either cancelled by submitting the request in writing, by canceling insurance coverage(s) or if using a credit/debit card, the expiration of the credit/debit card. To take advantage of this easy payment process, login to <https://uhcservices.com> and click on the link to complete the information for your automatic payment.

Checks or EFT's rejected for insufficient funds, credit/debit cards that are rejected, and/or checks that cannot be cashed (regardless of reason) do not constitute payment. Please note invoices will be mailed to you as a courtesy reminder even if you have signed up for Electronic Funds Transfer.

As not to delay the processing of your payment or request for changes, do not include correspondences with your payment. If you do not enroll online, please send all correspondences to:

UnitedHealthcare
P.O. Box 740221
Atlanta, GA 30374-0221

If you do not make your payment online, please mail your payment only to:

4/11



Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

UnitedHealthcare
P.O. Box 712796
Cincinnati, OH 45271-2796

Please cut the remittance slip below and return with your payment.

Please mail payment checks to:
UnitedHealthcare
P.O. Box 712796
Cincinnati, OH 45271-2796

IMPORTANT INFORMATION ABOUT YOUR RIGHT TO COBRA CONTINUATION COVERAGE

IMPORTANT - Other important information about your rights is provided to you on the following pages. Continuation coverage is offered subject to your eligibility. UnitedHealthcare may terminate your continuation coverage retroactively if you are determined to be ineligible for coverage.

What is continuation coverage?

Federal Law requires that most group plans (including this plan) give employees and their families the opportunity to continue their benefit 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 event, Qualified Beneficiaries can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. The covered employee, spouse, and dependent children who were covered the day before the qualifying event are considered Qualified Beneficiaries under the Plan.

Continuation coverage is the same coverage that is offered to other participants under the Plan who are not receiving continuation coverage. You will be able to continue with the same benefits you had the day before your qualifying event. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants covered under the Plan; this includes open enrollment and special enrollment rights. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained by contacting the "Plan" owner.

What Plans am I eligible to continue?

You and any eligible family members are allowed to continue the Plan(s) you were covered by the day before your qualifying event.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For

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Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

How long will continuation coverage last?

In the case of a loss of coverage due to termination of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of loss of coverage due to an employee's death, divorce or legal separation from the employee, 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.

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

- ? For any reason the Plan would terminate coverage of a participant not receiving continuation coverage (such as fraud) or;
- ? Any required premium is not paid in full on time or;
- ? A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan or;
- ? A qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation of coverage or;
- ? The employer ceases to provide any group health plan for its employees or;
- ? You wish to voluntarily terminate your continuation coverage; the request must be submitted in writing to UnitedHealthcare.

If you or a qualified beneficiary becomes covered under another group health plan, entitled to Medicare, or recover from a disability, you must immediately (or within 30 days when you or the qualified beneficiary becomes entitled to Medicare) notify UnitedHealthcare at 1-866-747-0048.

How can I extend the length of continuation coverage?

If you elect continuation coverage, an extension of the 18-month coverage period may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify UnitedHealthcare 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, but such a revocation will result in prospective coverage that is effective as of the date the new or revised election is submitted.

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 us of the 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 who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. During the 11-month extension, you may be required to pay 150% of the premium. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify us of the 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 coverage if a second qualifying event occurs during the first 18 months of 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 legal separation from the covered employee, the covered employee's Medicare entitlement (if it results in a loss of coverage), or a dependent child ceasing to be eligible for coverage as a dependent under the Plan. You must notify us within 60 days after any second qualifying event which may occur.

For more information about extending the length of COBRA continuation coverage visit <http://www.dol.gov/ebsa/publications/cobraemployee.html>.

How can I elect continuation coverage?

You must decide to elect continuation coverage within 60 days from the later of the loss of coverage date, or the notification date of your rights. Each qualified beneficiary 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 Agreement. 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 at any time during the 60-day election period.

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. 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.

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Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

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% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant who is not receiving continuation coverage. In the case of an extension of continuation coverage due to a disability, each qualified beneficiary may be required to pay up to 150% of the entire premium.

Monthly rates are renewed once a year and are based on your previous employer's renewal period. At that time, your rates could be adjusted if the active rates are adjusted.

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to sign up, beginning on the earlier of

- The month after your employment ends, or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on

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Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

More Information about individuals who may be qualified beneficiaries

Special enrollment rights under the Medical Plan - There may be situations in which you can enroll your eligible dependents in COBRA continuation coverage, which are considered special enrollment events. These events include your marriage, the birth or adoption of a child, and, under some circumstances, your or your eligible dependent's loss of other health coverage. When a special enrollment event occurs, Federal law requires that eligible employees be permitted to elect coverage for themselves and their eligible dependents under the Medical Plan. This opportunity applies only to the Medical Plan and not to other benefit plans.

Alternate recipients under QMCSOs - A child of the covered employee who is receiving benefits under the Health Plan pursuant to a qualified medical child support order (QMCSO) received by your employer during the covered employee's period of employment is entitled to the same rights to elect COBRA continuation coverage as an eligible dependent child of the covered employee.

Electing COBRA after Leave under the Family and Medical Leave Act (FMLA)

Special COBRA rules apply if you take an FMLA leave and do not return to work. If you are covered under the Health Plan on the day before your FMLA begins, you and any covered eligible dependents are eligible for COBRA continuation coverage even if you do not continue coverage during your FMLA leave. Further, your COBRA continuation coverage period begins on the earlier of the last day of the month in which your FMLA leave ends or the last day of the month you unequivocally advise your employer that you do not intend to return to work.

Coverage under USERRA

If you lose coverage because you take a qualified military leave of absence, you and/or your dependents will be entitled to protection under either COBRA or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). When the requirements of COBRA and USERRA differ, you will receive protection under the law that gives you the greater benefit. Coverage under COBRA and USERRA run concurrently. For example, you cannot elect COBRA continuation coverage after receiving USERRA continuation coverage for the maximum coverage period. USERRA currently provides a maximum coverage period of 24 months. If you believe USERRA may apply to you, you may contact UnitedHealthcare at 1-866-747-0048 using the information in this notice.

Medicare

If you or your spouse are not age 65 and you do elect COBRA continuation coverage, upon Medicare entitlement, your COBRA will automatically be terminated. Those currently covered that have not reached 65 are allowed to continue on the COBRA until the end of their COBRA eligibility or they reach age 65.

If you or your spouse are age 65 or over and elect COBRA continuation coverage, Medicare is the primary payer. If you or a family member has Medicare based on a disability and COBRA continuation coverage, Medicare is the primary payer. However, if you or a family member has Medicare based on End Stage Renal Disease (ESRD), COBRA continuation coverage is the primary payer for a 30-month period and Medicare is the secondary payer.

Be advised, if an individual does not enroll in Medicare Part B and that individual incurs claims for outpatient services, the group medical plan will process these claims on a secondary basis (regardless of the fact there is no Medicare Part B primary coverage), the carrier will estimate the benefits Medicare "would have" paid if the individual had been enrolled in Medicare Part B. The result is the individual's out of pocket expense may be much higher than what is expected.

When considering your options for health coverage, you may want to think about:

Premiums. Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Provider Networks. If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

Drug Formularies. If you're currently taking medication, a change in your health coverage may affect your costs for medication - and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

Severance payments. If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

Service Areas. Some plans limit their benefits to specific service or coverage areas - so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

Other Cost-Sharing. In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

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Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

When and how must payment for continuation coverage be made?

First payment for continuation coverage (Initial Premium Payment)

If you elect continuation coverage, the initial premium payment must include full payment from the date you lost coverage under the Plan to the current month's premium payment. The actual amount of the premium required depends on the date coverage was lost and the date coverage is elected. Some insurance carriers will not reinstate your coverage until the initial premium is made, so you may send a check or money order for coverage elected with enclosed remittance slip or pay online. However, you do have 45 days from the date you elect continuation coverage to send the initial premium payment. If you do not make your first payment within those 45 days, you will lose all continuation rights under the Plan.

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. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month for which coverage is provided. We will send payment invoices indicating the premium amount and due date. If you do not receive the invoice, the premium is still due on the 1st of the month as indicated. You can see a copy of your invoice at <https://uhc.services.com>.

Grace period for periodic payments

Although periodic payments are due on the first of the month, you will be given a grace period of 30 days 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. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated 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.

Note: To assure continued and uninterrupted coverage, you are responsible for making timely premium payments even if you do not receive monthly premium reminders. The past due amount can cause a suspension or termination of coverage until the payment is received.

In order to maintain eligibility under the group benefit plan(s), your payment must be received and postmarked no later than the coverage due date noted on each remittance coupon. Failure to remit payment prior to the coverage due date may result in a loss of coverage without the possibility of reinstatement. Your premium payment must be returned along with the remittance coupon for the payment period(s) you are paying. Please make your check payable to UnitedHealthcare. 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.

Your payments for continuation coverage should be made payable to UnitedHealthcare and sent to:

UnitedHealthcare
P.O. Box 712796
Cincinnati, OH 45271-2796

UnitedHealthcare offers you the ability to make premium payments through Electronic Funds Transfer (EFT) directly from your checking or savings account. If you decide to sign up for automatic withdrawals, they will continue as the premium comes due until either cancelled by submitting the request in writing or by canceling insurance coverage(s). To take advantage of this easy payment process, go to <https://uhc.services.com> to fill out the form and mail it to the address on the form.

UnitedHealthcare also offers you the option to make a one-time payment directly from your checking or savings account or your credit or debit card. To take advantage of this easy non-recurring payment process, go to <https://uhc.services.com> and click on the link to complete the banking information for your payment.

Keep your Plan Informed of Address Changes

In order to protect your family's rights, you should keep UnitedHealthcare and 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.

UnitedHealthcare Customer Care Center
P.O. Box 740221 Toll Free: 1-866-747-0048 TTY: 711
Atlanta, GA 30374 Email: cobra_kyoperations@uhc.com
Web: <https://uhc.services.com>

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact:

UnitedHealthcare Customer Care Center
P.O. Box 740221 Toll Free: 1-866-747-0048 TTY: 711
Atlanta, GA 30374 Email: cobra_kyoperations@uhc.com
Web: <https://uhc.services.com>

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Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

o **Online:** UHC_Civil_Rights@uhc.com

o **Mail:** Civil Rights Coordinator, UnitedHealthcare Civil Rights Overage, P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 90 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services:

o **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/files/index.html>.

o **Phone:** Toll-free 1-800-868-1019, 1-800-537-1857 (TDD)

o **Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 209F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

備註: 如蒙您說中文 (Chinese), 我們免費為您提供語言協助服務。請撥打會員卡所列的免費語言電話號碼。

XIN LỜI Y: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ nhận diện của quý vị.

알림: 한국어 (Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 지원 전화번호로 문의하십시오.

PAALALA: Kung nagpasasala ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulungan sa wika. Pakitawagin ang toll-free na numero ng telepono na nasa likang identification card.

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете получить бесплатные услуги по переводу с русского языка на русский язык (RUSSIAN). Для этого вы можете позвонить по бесплатному номеру на обратной стороне вашей идентификационной карты.



Participant – Letter Samples

COBRA Continuation Coverage Election Notice Sample

هذه الخدمة متوفرة باللغات العربية (Arabic)، الإسبانية (Spanish)، الفرنسية (French)، الإيطالية (Italian)، البرتغالية (Portuguese)، البولندية (Polish)، الألمانية (German)، اليابانية (Japanese)، الهندية (Hindi)، الصينية (Chinese)، الفارسية (Farsi)، الكورية (Korean)، الهنديكستانية (Hindustani)، والناجاوي (Navajo).

ATANSYON: Si w'apale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye servis ki gratis pou ede w' nan ling pa w. Tanpri ree nimewo gratis ki sou ka idantifikasyon w.

ATTENTION: Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), dostępne są darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na kartce identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: In caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG! Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項: 日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

هذه الخدمة متوفرة باللغات العربية (Arabic)، الإسبانية (Spanish)، الفرنسية (French)، الإيطالية (Italian)، البرتغالية (Portuguese)، البولندية (Polish)، الألمانية (German)، اليابانية (Japanese)، الهندية (Hindi)، الصينية (Chinese)، الفارسية (Farsi)، الكورية (Korean)، الهنديكستانية (Hindustani)، والناجاوي (Navajo).

આવક, માટે સહ્ય દિવિ (Hindi) सहायता के, आपको अपना सहायता सहाय, कि गुना उपनाय से। गुणा अना उपनाय से से सुवीचक बात-की, सहा सहा, का बात-की।

DEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov lii rau tus xov tooj hu deb dawb (as leev muaj nyob rau ntawm koj daim yug) cim chis lus kheej.

සාධක හඳුනාගැනීමේ සහ ආයතන සේවාවන් (Sinhala) වාචික සහකාර සේවාවක් සපයයි. සාධක හඳුනාගැනීමේ සහ ආයතන සේවාවන් සඳහා අදාළ අංකයට නොමිලට කථනාතුරු කළ හැකිය.

DARKAAR: Nu sarfkaan fi Ilocano (Ilocano), fi serbiyo para fi baddang fi lengguage nga awanan bayanan, ket sidacaan para kanyam. Maicawat nga awagan ti tol-free a numero ti telepono nga nakalista ayan ti identification card mo.

DIL BAAKONNIZIN: Diné (Navajo) bizaad bee yaniltigo, saad bee aks emdaawoigni, taa jik'eh, bee narahooti. Taa she'ehi nimaatsosoo niltizi bee neehozingii dine-dee' taa jik'ehgo beehi bee haneh bik'ehi bee hodilinih.

UGOW: Haddi aad ku hadasho Soomaali (Somali), adeegyada laageerada (uqadda) oo bilaash ah ayaa heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaala kaarkaaga aqoontaaga.

Z-111E

Benefit Services

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Participant – Letter Samples

COBRA Continuation Coverage Invoice Sample



UnitedHealthcare®

P.O. Box 740221
Atlanta, GA 30374-0221

DPS\$\$\$PKG 202105270002230002COB

Eligible Dependents:
None

COBRA NOTICE - IMPORTANT INFORMATION

Due to the COVID-19 National Emergency, payment timelines used by group health plans for continuation of health care coverage (COBRA) have been extended from March 1, 2020, until thirty (30) days after the end of the COVID-19 National Emergency (the "Outbreak Period").

If your account terminates for non-payment during the Outbreak Period, you can contact us by phone or email to make payment and reinstate coverage until the earlier of (1) year from the end of your premium grace period, or 60 days after the announced end of the National Emergency (the end of the Outbreak Period).

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Participant – Letter Samples

COBRA Continuation Coverage Invoice Sample

If you do not make the full premium payment, your coverage will not be activated and claims will not be paid, until the required payment is made.

Date Printed: 05/27/2021

UnitedHealthcare
Division: Benefit Services
P.O. Box 740221
Atlanta, GA 30374-0221
Ph: (866) 747-0048

CONTINUATION COVERAGE INITIAL BILLING

This confirms the receipt of your COBRA election form requesting continuation of your coverage for you and your eligible dependents, if any.

Your initial premium is as follows:

Carrier Name	Coverage	Coverage Dates	Amount
UHC CA34 (00Q3345) MEDICAL	Employee Only	05/01/2021 - 05/31/2021	\$ 399.14
Paid:05/25/2021 Ref.#CCPMT	Credit Card Payment	Payment Recvd:05/26/2021	\$ -399.14
			<hr/>
			Total \$ 399.14
			<hr/>
			Prev.Cred. \$-399.14
			<hr/> <hr/>
			Total \$ 0.00

The coverage elected will be effective on the Coverage Dates above. If the initial premium has not been paid, your coverage may remain cancelled until the initial premium is paid. Your payment must include full payment from the date you lost coverage to the current premium payment. The initial premium payment can be sent anytime prior to 07/09/2021, but no extension can be made to the due date.

UnitedHealthcare is providing billing services for you under the Staff Care 24/7 LLC group benefit plan(s). Enclosed is your remittance slip which reflects the premium due and payable for your coverage. Detailed account information, payment information and electronic copies of mailings sent to you can be found on your account at <https://uhcservices.com>.

For further information, please contact:

UnitedHealthcare Customer Care Center
P.O. Box 740221 Ph: 1-866-747-0048
Atlanta, GA 30374 Email: cobra_kyoperations@uhc.com
Web: <https://uhcservices.com>

UnitedHealthcare offers you multiple options for making your payment:

1. UnitedHealthcare offers you the option to make a payment directly from your checking or savings account or from your credit or debit card (MasterCard, VISA, Discover, American Express). To take advantage of this easy payment process,

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Participant – Letter Samples

COBRA Continuation Coverage Invoice Sample

login to <https://uhcservices.com> and click on the link to complete the information for your one-time payment. (Note: Credit or Debit Card payments cannot be taken over the phone)

2. If paying by check, your premium payment must be returned along with the remittance slip for the payment period(s) you are paying. Please make your check payable to UnitedHealthcare and mail to the address on the remittance slip below.

3. UnitedHealthcare offers you the ability to make reoccurring payments through Electronic Funds Transfer (EFT) directly from your checking or savings account or from your credit or debit card (MasterCard, VISA, Discover, American Express). If you decide to sign up for automatic withdrawals, they will **continue as the premiums come due** until either cancelled by submitting the request in writing, canceling insurance coverage(s) or if using a credit/debit card, the expiration of the credit/debit card. To take advantage of this easy payment process, login to <https://uhcservices.com> and click on the link to complete the information for your automatic payment.

Checks or EFT's rejected for insufficient funds, credit/debit cards that are rejected, and/or checks that cannot be cashed (regardless of reason) do not constitute payment.

IMPORTANT INFORMATION

As not to delay processing of your payment or request for changes, do not include correspondence with your payment.

Keep your plan informed of address changes

In order to protect you and your family's rights, you should keep UnitedHealthcare informed of any change in your address and the address of your family members by sending updated information to:

UnitedHealthcare
P.O. Box 740221
Atlanta, GA 30374-0221

You may also email cobra_kyoperations@uhc.com or visit our secure website, <https://uhcservices.com> and use the Request Edit function from the left-hand menu.

Contact UnitedHealthcare at 1-866-747-0048 for:

- ? Premium and/or invoice questions
- ? Coverage effective date questions

Contact the customer service number on the back of your ID card for:

- ? Detailed plan questions
- ? Claims questions

Please cut the remittance slip below and return it with your payment.

Due Date: 07/09/2021 Amount Due: 0.00

Mail and Make Checks Payable to:
UnitedHealthcare
P.O. Box 712796
Cincinnati, OH 45271-2796

IMPORTANT REMINDERS TO COBRA PARTICIPANTS

Please read this information carefully and save it with your important records for future reference as it pertains to your continued participation in the employer's benefit plan(s).

1. Please keep in mind UnitedHealthcare Benefit Services is not the insurance carrier. UnitedHealthcare Benefit Services has been hired by the Employer to handle the administrative requirements that pertain to COBRA. If you have any questions on new cards, claims, provider information, etc., you need to contact the insurance carrier directly.
2. Insurance premiums must be paid in full within the required period of time, or your coverage will be cancelled.

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Participant – Letter Samples

COBRA Continuation Coverage Invoice Sample

3. Payment will be considered made on the date postmarked by the post office, which must fall within the required period of time or your benefit coverage will be cancelled.
4. When a COBRA participant sends in the initial payment, it will be retroactively applied to the date regular coverage was lost from the employer.
5. If payment is made with a "Non-Sufficient Funds" (NSF) check, you must reissue the payment within the required time period, or coverage will be cancelled.
6. Claims may be "pending" each month with the insurance carrier until they receive notice from the Employer or UnitedHealthcare Benefit Services that the monthly premium payment has been made. Please bear in mind that each insurance carrier's schedule for releasing pending claims may be different. If you have questions about the status of your insurance claims, contact the insurance carrier directly, as UnitedHealthcare Benefit Services will not have this information.
7. A Qualified Beneficiary (defined as any individual covered under the benefit plan(s) with the employee the day before a COBRA event takes place, when benefit coverage was lost) has 60 days to notify the employer or UnitedHealthcare Benefit Services of a subsequent COBRA event to which an additional period of COBRA coverage will be allowed, such as death of the covered (former) employee, a dependent aging off of the benefit plan, divorce, or the covered (former) employee's entitlement (covered by) Medicare. In these situations, the maximum length of coverage that can be extended is a total of 36 months between the 2 events.
8. If coverage is elected for a dependent under the maximum age of the plan's requirements, coverage will be cancelled once the dependent reaches the maximum age if you do not notify the carrier or UnitedHealthcare Benefit Services that the dependent is a full-time college student and request separate COBRA coverage for the student.
9. If a COBRA participant becomes covered under any other group health plan that does not limit or exclude coverage for pre-existing conditions, COBRA coverage will be dropped by the employer. It is the COBRA participant's responsibility to immediately notify UnitedHealthcare Benefit Services if they become covered under another group health insurance plan.
10. The Qualified Beneficiary must notify UnitedHealthcare Benefit Services immediately if there is an address change of any of the COBRA participants. The exception to this is for a student who has temporarily relocated to attend school.
11. If the COBRA event notification and election forms arrive at the last known address and one of the Qualified Beneficiaries no longer resides there (such as a spouse), it is the obligation of the recipient (by law) to forward a copy of the information to the intended parties addressed in the letters.
12. If a Qualified Beneficiary has a break of more than 63 days of coverage, a future health care plan may consider a waiting period before covering any pre-existing conditions. A waiting period imposed by a new employer for entry into the group plan is not counted toward the 63-day break in service.
13. If a Qualified Beneficiary is disabled on or before the date that COBRA coverage begins, or within the first 60 days of COBRA coverage, he or she may be entitled to an extension of COBRA coverage. The extension may be up to an additional 11 months, beyond the initial 18 month coverage period. To be eligible for the extension, the Qualified Beneficiary must be determined disabled by the Social Security Administration and must notify the Plan Administrator or Plan Service Provider within 60 days of the disability determination and before the 18 month period expires. If disability ends during the extension period, the COBRA participant MUST notify the Employer or UnitedHealthcare Benefit Services, and provide a copy of the Social Security final determination. After a disability ends, the participant may retain coverage until the first of the month after 30 days following the final Social Security determination letter.
14. If a COBRA participant fails to notify UnitedHealthcare Benefit Services or the Employer of coverage gained after they elect COBRA, fails to advise of disability ending, or in any other way defrauds the employer, please be advised that legal action can be taken to recoup claims paid during the time period when COBRA coverage would have been terminated.

B-1210

Benefit Services

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Participant – Letter Samples

End of Eligibility Conversion Notice Sample



UnitedHealthcare®

P.O. Box 740221
Atlanta, GA 30374-0221

DPS\$\$\$PKG 202012021840030001COB

Eligible Dependents:
None

Date Printed: 12/03/2020

UnitedHealthcare
END OF ELIGIBILITY CONVERSION NOTICE

You are approaching the end of eligibility for the following continuation coverage(s) under COBRA. The eligibility end date is listed below.

Client:

Carrier Name	Coverage	Coverage Ends
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1/2



Participant – Letter Samples

End of Eligibility Conversion Notice Sample

GUARDIAN DENTAL	Employee Only	05/31/2021
GUARDIAN DENTAL	Family	05/31/2021
GUARDIAN VISION	Employee Only	05/31/2021

You may be entitled to convert some or all of the plans to an individual plan. If a conversion option is available, the details of your conversion opportunities can be requested through the insurance carrier shown above with a *C*. A timely response is required so we encourage you to contact the insurance carrier 60 days prior to the expiration of your continuation coverage(s) under COBRA.

The benefits provided under an individual conversion policy may not be identical to those provided under your current plan. To find out more information regarding an individual policy you will need to contact the insurance carrier directly.

UnitedHealthcareCustomer Care Center
P.O. Box 740221Ph: 1-866-747-0048
Atlanta, GA 30374Email: cobra_kyoperations@uhc.com
Web: <https://uhcservices.com>

Z-1380

Benefit Services

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Participant – Letter Samples

Notice of End of Eligibility Sample

10/5/21, 8:24 AM

View Letter Z-1328



UnitedHealthcare®

P.O. Box 740221
Atlanta, GA 30374-0221

DPS\$\$\$PKG 202105300703470001COB

Eligible Dependents:

First Name

Last Name

Date Printed: 06/01/2021

UnitedHealthcare
Division: Benefit Services
P.O. Box 740221
Atlanta, GA 30374-0221
Ph: (866) 747-0048

NOTICE OF END OF ELIGIBILITY

We want to let you know that your COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage will end on the dates shown below:

Client:

Coverage

1/2



Participant – Letter Samples

Notice of End of Eligibility Sample

Name	Coverage	Ends
GUARDIAN DENTAL	Employee Only	05/31/2021
UHC AHKI (05F5627) MEDICAL	Employee Only	05/12/2021

If you have questions about this letter or you think there has been an error please call us toll free at:

UnitedHealthcareCustomer Care Center
P.O. Box 740221Ph: 1-866-747-0048
Atlanta, GA 30374Email: cobra_kyoperations@uhc.com
Web: <https://uhcservices.com>

Z-1328

Benefit Services



Contact Us

If you have any additional questions, please contact us

Employers and Brokers: Client Advocate Center



1-800-318-5311



cobra@uhcservices.com

Participant: Participant Call Center



1-877-797-7475



cobra_kyoperations@uhc.com

- Call centers are open Monday thru Friday 7AM to 7PM Central Standard time.

Thank You!

