What is Extended Coverage?

Extended Coverage is a term used by DHRM to describe the continuation of State Health Benefits Program coverage under the provisions of the Public Health Service Act when certain qualifying events cause a loss of that coverage. These provisions for state and local government employers are comparable to COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) coverage for private employers.

Reference to Benefits Administrators' responsibilities in this section assumes that the agency's Benefits Administrator is also the agency's Extended Coverage administrator. In agencies where other staff members handle Extended Coverage, please adjust this guidance to reflect your agency's process.

What plans require the offer of Extended Coverage?

Under the state program, the health plan and Medical Expense Flexible Spending Account (FSA) are subject to Extended Coverage provisions.

Are there any plans that do not require the offer of Extended Coverage?

There is no Extended Coverage opportunity for a Dependent Care Flexible Spending Account. Also, a participant who enrolls in Tricare supplemental coverage does not require the issuance of a COBRA General Notice, and when Tricare supplemental coverage ends, an Election Notice is not required. (Tricare supplemental coverage has its own continuation provisions, which are not administered by the state program.) However, if a Tricare supplement enrollee terminates that coverage and enrolls in one of the state program's health plans, a General Notice should be issued to advise of Extended Coverage rights under those plans.

When must Extended Coverage be offered?

Two things must happen to generate an offer of Extended Coverage:

- There must be an Extended Coverage qualifying event; and,
- The qualifying event must result in a loss of coverage.

An event that does not result in a loss of coverage does not require the offer of Extended Coverage. For example, while termination of employment is considered an Extended Coverage qualifying event, if the employee did not have State Health Plan coverage when the event occurred, no coverage is lost, and no offer is required.

Not all losses of coverage are qualifying events or require the offer of Extended Coverage. For example, coverage lost due to an Open Enrollment election

(terminating coverage or reducing membership) should not result in an Extended Coverage offer since Open Enrollment is not a qualifying event.

What is a Qualifying Event?

A qualifying event is a specific event, as described below, that results in the loss of group health plan coverage.

These events include:

- Termination of employment (voluntary or involuntary, except for termination due to gross misconduct*), including:
    - Retirement
- Reduction of hours, including:
    - Leaves without pay (not including FMLA—see additional information later in this section)
    - Long-term disability
    - Moving from full-time to part-time status
- Death of the employee
- Divorce
- Loss of child status

Also, a special rule applies to covered family members of employees who lose coverage due to the employee's termination of employment or reduction of hours when the employee was eligible for Medicare within the 18-month period prior to that qualifying event. In those cases, family members who are Qualified Beneficiaries are eligible for a total of 36 months of continuation coverage starting with the first qualifying event (the employee's Medicare eligibility based on this special rule). This means that they would actually be entitled to 36 months minus any period of continued/concurrent coverage after the employee's Medicare eligibility but prior to the termination or reduction event. As an example, if an active employee is eligible for Medicare effective March 1, 2011, terminates employment and loses coverage on May 31, 2011, covered family members would be entitled to Extended Coverage from June 1, 2011, through February 28, 2014 (33 months from the termination event and 36 months from the employee's Medicare eligibility event). The employee would only be entitled to 18 months of Extended Coverage (and would likely not elect coverage in favor of electing Medicare). Other than this special rule, Medicare eligibility is not a qualifying event for the state program since it does not result in a loss of coverage.

*Gross misconduct is not defined by regulation. Failure to offer Extended Coverage based on gross misconduct should be considered very carefully. Contact the Office of Health Benefits for assistance.

What is NOT a Qualifying Event?

Remember, in order for an Extended Coverage offer to be required, the event must be one of the specific qualifying events listed above, and it must result in a loss of coverage. This would not include:

- Coverage lost strictly due to an Open Enrollment change (no other simultaneous qualifying event)
- Loss of eligibility for other than a child (unless it was due to another qualifying event such as divorce)
- Coverage lost due to failure to pay a premium
- The start of FMLA
- Termination of employment (or any of the other listed events) when there is no coverage lost (e.g., employee had waived coverage)
- Reduction of hours to a leave with pay when there is no resulting loss of coverage

What is a loss of coverage?

For purposes of Extended Coverage, loss of coverage means a change in the terms and conditions of coverage. This often means simply that the coverage is terminated, but it could also mean that the employer premium contribution for coverage is lost (e.g., on certain leaves without pay or long-term disability) or any other change in the way that coverage is provided.

Who is Covered?

An employee, spouse or child who is **covered on the day before the qualifying event and loses coverage due to that event** should be offered the opportunity to elect Extended Coverage. These terminated health plan participants are called **Qualified Beneficiaries**.

Other Qualified Beneficiaries include:

- A child who is born to or placed for adoption with the covered employee during the Extended Coverage period
- A participant whose coverage is terminated in anticipation of a qualifying event (for example, a spouse who is terminated at open enrollment prior to a pending divorce)*

*Example: Employee covers his/her legal spouse. At open enrollment, the spouse is dropped from membership. Three months later, their divorce is finalized. The employee is allowed to drop the spouse at open enrollment, but under these circumstances, the spouse does not lose Extended Coverage rights. If the spouse provides a Qualifying Event Notice (see Notices) within 60 days of the date coverage would have been lost due to the qualifying event (the end of

the month in which the final divorce occurs), an Election Notice should be generated, and the spouse will be eligible for Extended Coverage for up to 36 months after the loss of coverage due to the qualifying event (divorce), but not for the period between the loss due to Open Enrollment and what would have been the loss due to the divorce. Sometimes the determination of "in anticipation of the qualifying event" is very clear, and sometimes it is not. Contact the Office of Health Benefits if assistance is needed in making this determination.

What are the rights of Qualified Beneficiaries?

- Each Qualified Beneficiary has the right to elect Extended Coverage independently. This means that a family group who is offered Extended Coverage may choose to enroll any or all Qualified Beneficiaries. (However, multiple family members may continue to be covered under dual or family memberships.)
- Qualified Beneficiaries have the same rights as similarly-situated non-Extended Coverage participants. This means that they can make plan and membership changes like any program participant.
- Qualified Beneficiaries may elect coverage that is identical to that which they had prior to the qualifying event. No plan change is allowed at the start of Extended Coverage.
- Qualified Beneficiaries have a 60-day election period starting with the later of the date that coverage is lost due to the qualifying event or the date that the election Notice is provided.

Can anyone other than Qualified Beneficiaries be covered through Extended Coverage?

Since Qualified Beneficiaries have the same rights as non-Extended Coverage plan participants, they can add eligible family members at open enrollment or with a qualifying mid-year event. However, other than those who meet the eligibility criteria to be Qualified Beneficiaries as described above, any other participants added to an Extended Coverage membership will not be Qualified Beneficiaries. This means that they do not have independent rights to coverage, and their continued participation is dependent on the enrollment of the Qualified Beneficiary through whom they gained eligibility. For example, an Extended Coverage/COBRA participant who lost coverage due to reaching the limiting age may add his/her own newborn to coverage, but since the newborn is not the child of the covered employee (but rather of the covered family member), the newborn would not be a Qualified Beneficiary and would lose coverage if the original Qualified Beneficiary terminated coverage (e.g., failed to pay the monthly premium within the payment grace period).

The Benefits Eligibility System designates qualified beneficiaries and non-qualified beneficiaries within the COBRA group.

How long does Extended Coverage last?

The duration of Extended Coverage/COBRA is based on the specific qualifying event that results in the loss of coverage.

Up to 18-month duration:

- Termination of employment
- Reduction of Hours

Up to 36-month duration:

- Divorce
- Child ceasing to be eligible for coverage as a child
- Death of employee/retiree

Up to 29-month duration:

- If any family member is determined to be disabled by the Social Security Administration during the first 60 days of continuation coverage and the disability lasts until the end of the initial 18-month Extended Coverage period, all covered family members may be entitled to an additional 11 months of continuation coverage if the Office of Health Benefits Extended Coverage/COBRA Administrator is notified within 60 days of either:
    - The date of the disability determination
    - The date of the qualifying event
    - The date on which coverage would be lost due to the qualifying event
    - The date on which the Qualified Beneficiary is informed of the obligation to provide the disability Notice

- Notification must be presented in writing and include the following information:
    - The name of the disabled Qualified Beneficiary
    - The date of the determination
    - Documentation from the Social Security Administration to support the determination
    - The written signature of the notifying party (Qualified Beneficiary or representative)
    - If the address of record is incorrect, a correct mailing address.

Can the duration of Extended Coverage be increased, and can it last more than 36 months?

Extended Coverage never lasts more than 36 months. However, an 18-month event can be extended to 29 months due to the disability extension described above, and it can be extended to 36 months if a second qualifying event occurs. Examples include:

- A divorce after a termination of employment or reduction of hours – spouse who loses coverage due to second qualifying event could get a total of 36 months measured from the original qualifying event
- Loss of child status after a termination of employment or reduction of hours – child losing eligibility due to age will be allowed to stay on the existing dual or family membership until the original 18 months of coverage are exhausted and then would be moved to individual coverage to complete the remainder of the 36 months from the original qualifying event under his/her own membership

  NOTE: A child who turns 26 during continuation of coverage under USERRA (e.g., Military LWOP) will be moved to his or her own COBRA continuation membership at the end of the year during which they turn age 26 since they are no longer entitled to the agency premium contribution. They may not remain on a family or dual membership with the agency contribution after eligibility is lost.

- Death of employee after a termination of employment or reduction of hours – remaining Qualified Beneficiaries would be eligible for 36 months from the original qualifying event

When is Extended Coverage offered when there is FMLA?

A special rule applies to individuals on a Family and Medical Leave Act (FMLA) leave of absence. Extended Coverage should not be offered at the start of the leave, but it should be offered if the employee does not return to work at the end of the FMLA leave period or at any time during the leave if the employee indicates that he or she will not return to work. Due to the special FMLA rule, an employee who has coverage during FMLA but fails to pay his or her premium, would be terminated due to non-payment, but the end of FMLA should still be treated as a qualifying event, and Extended Coverage should be offered, even if there is a break in coverage.

When does Extended Coverage run concurrently with other health plan eligibility?

Often, other continuation coverage is available simultaneously with Extended Coverage. Examples include:

- Retirement should be treated as a termination of employment. If the employee had coverage immediately prior to retirement, Extended Coverage must be offered, regardless of an offer of retiree coverage. Failure to offer Extended Coverage leaves the potential for coverage open until the offer is made and the election period is exhausted. If an eligible retiree does not elect retiree coverage or elects coverage and is then terminated within the 18-month Extended Coverage period (e.g., for non-payment) and Extended

Coverage was not offered, an offer is still available. This could result in significant liability to the program.

- Survivors of employees or retirees should also be offered Extended Coverage, regardless of any survivor benefit opportunities. Failure to do so could have consequences as noted above.

- Long-Term Disability (LTD) participants/Qualified Beneficiaries should be offered Extended Coverage based on the reduction of hours event and resulting loss of coverage/loss of employer contribution. Failure to do so under these circumstances could also result in the consequences discussed previously.

  LTD qualified beneficiaries who cease to be disabled or are otherwise terminated as LTD participants during the defined initial 18-month Extended Coverage period may exercise the remainder of the initial 18-month eligibility period by submitting their election form within 60 days of the loss of LTD coverage.

- Leaves of absence without pay during which the employer contribution to coverage continues but the employee pays his/her contribution on an after-tax basis (e.g., medical leaves without pay under the traditional sick leave plan) represent an Extended Coverage qualifying event (reduction of hours) and should run concurrently with Extended Coverage eligibility (except if the leave is due to WTA layoff—see more information at the end of this section). Upon the occurrence of the leave without pay, Extended Coverage should be offered starting the first of the full month of reduced hours and could last for 18 months. If the employee is eligible for and chooses to maintain the employer contribution (instead of electing Extended Coverage), he/she may wait until the employer contribution is lost to elect the remainder of the 18-month Extended Coverage period, at which time he/she will have 60 days to make the election. In no case should a Qualified Beneficiary have more than 18 months of Extended Coverage, including the period on leave without pay, from the original reduction-of-hours event. Termination of employment after a reduction of hours is not a separate qualifying event and will not result in a new Extended Coverage eligibility period.

  Example: Employee starts medical leave without pay on June 14 but maintains the employer contribution for 12 months due to being in the traditional leave program (instead of VSDP). Extended Coverage is offered starting July 1 for 18 months. The employer contribution continues through the following June 30 (12 months). At that time, if the employee does not return to work, he/she can elect to take the remaining six months (18 months minus 12 months running concurrently with the leave period) if he/she does so within 60 days of the loss of the employer contribution (in this example, the

employee would have through August 29 to exercise the remainder the of the Extended Coverage period.

Remember: offer of coverage based on other programs and policies (e.g., survivor coverage, retiree coverage, etc.) does not relieve the requirement to offer Extended Coverage. Failure to provide an Election Notice upon loss of coverage due to a qualifying event can result in an open liability to the program.

How much does Extended Coverage cost?

Qualified Beneficiaries pay the full cost of Extended Coverage. That includes the former employee and employer contribution plus a 2% administrative fee. If the 11-month disability extension is approved, the administrative fee increases to 50% for that extension period.

Notices

Five Notices are required to comply with Extended Coverage/COBRA regulations, as described below. The Notices are the real substance of Extended Coverage. Correct format and timing of the Notices are critical.

1. Initial General Notice

The purpose of this Notice (link to Notice format provided at the end of this section) is to advise Qualified Beneficiaries of their rights and responsibilities regarding Extended Coverage. Failure to provide this Notice relieves Qualified Beneficiaries of the responsibility to comply with any timing or format limitations, so if an Initial General Notice is not properly provided, a Qualified Beneficiary cannot be held responsible for knowing what he/she has not been told. (For example, if not notified by the Initial General Notice, a qualified beneficiary would not be required to notify his or her Benefits Administrator of certain qualifying events within 60 of losing coverage due to that event. This leaves the plan open for unlimited liability.)

The Initial General Notice must be provided within 90 days of the commencement of coverage. This would include:

- New employees if coverage is elected
- Qualifying mid-year events where an employee newly elects coverage and/or adds a spouse
- Open enrollment when an employee newly elects coverage and/or adds a spouse

Providing an Initial General Notice to an employee or spouse who is not enrolled does not fulfill the obligation to provide Notice if the enrollment occurs later.

The Notice should be sent by first class mail and addressed to the employee and, if applicable, the spouse. The address should include the name of the employee and, if applicable, either the name or relationship of the covered spouse (e.g., Jane Doe; Jane Doe and spouse; Jane Doe and John Doe). If the Notice is not properly addressed, it will not fulfill Notice requirements. Hand delivery of an Initial General Notice (e.g., during orientation) does not fulfill the requirements of notifying a covered spouse. Also, hand delivery of some Notices versus mailing of others eliminates the consistency of the process and, if challenged, creates doubt as to the proper provision of the Notice if the Qualified Beneficiary denies receipt. Currently, sending an Initial General Notice to a covered child, regardless of age, is not required.

In order to document mailing, agencies should develop and document a consistent process and follow that process. This could include keeping a copy of the Notice or maintaining a log of Notices sent. A log should include all pertinent information such as the specific address of the Notice, date sent, and reason for generating the Notice. The key to maintaining effective documentation is consistency of the process.

It is not necessary to send Notices by certified mail. Mailing by first class mail to the address of record is considered a reasonable, good-faith effort and assumes delivery. If a Notice is returned, Benefits Administrators should make an effort to update the address and send a new Notice. If unable to obtain a good address, document your efforts within your process.

2. Qualifying Event Notice

A Qualifying Event Notice is required upon the occurrence of Qualifying Events about which the Benefits Administrator would not automatically know. This would include:

- Divorce
- Loss of eligible child status (except due to age)*
- Any second qualifying event after initial Extended Coverage election**
- Request for disability extension**

*Loss of eligibility due to age is monitored by the Office of Health Benefits, and Benefits Administrators are provided with instructions for generating Election Notices each year. Due to limitations removed by the Patient Protection and Affordable Care Act effective July 1, 2011, under the state plan, loss of eligible child status for reasons other than age is less likely.

**These will generally be handled by the Office of Health Benefits Extended Coverage Administrator after the initial Extended Coverage election.

The Notice may be submitted by the Qualified Beneficiary/ies or a representative of the Qualified Beneficiary/ies. The format of the Notice is specifically described in the Initial General Notice and the Election Notice, and it must be given no later than 60 days from the date coverage was or should have been lost based on the Qualifying Event. To maintain consistency in the process, it is recommended that Benefits Administrators enforce the format of the Notice. Accepting Notices in other formats (via an enrollment form QME, verbally, etc.) ultimately removes any limitations as to how a Notice is given.

Some Qualifying Events do not require any Notice. Benefits Administrators are required to automatically generate an Election Notice upon the occurrence of the following Qualifying Events that result in a loss of coverage:

- Termination of employment
- Reduction of hours
- Death of employee

3. Notice of Unavailability

Upon receipt of a Qualifying Event Notice, if it is determined that an Election Notice is not appropriate, it is required that the requesting individual be provided a Notice of Unavailability within 14 days. This could be the result of a late Notice (given after the expiration of the 60-day window), loss of coverage due to a non-Qualifying Event (e.g., Open Enrollment), or any circumstances that are not specifically defined as Extended Coverage Qualifying Events and/or did not result in a loss of coverage due to that event.

There is no specific format for this Notice; it must simply explain the reason for unavailability of Extended Coverage. It should be sent by first-class to the individual/s who requested and is/are being denied the Extended Coverage opportunity.

4. Election Notice

However, if the Qualifying Event Notice is timely for an Extended Coverage Qualifying Event, an Election Notice should be generated within 14 days. Also, if the event is one that does not require a Qualifying Event Notice, an Election Notice should be generated within 14 days of the loss of coverage. Since the completed Election Form that is a part of the Election Notice starts the clock for premium payment periods, the Election Notice should not be generated prior to loss of coverage.

The Election Notice (link to this Notice is provided at the end of this section) serves as the offer of Extended Coverage, and it provides the rights and responsibilities of Qualified Beneficiaries, the election period, the election form, the duration of coverage, premium payment grace periods, and resources for additional information.

It should be addressed to all affected Qualified Beneficiaries, including children, and sent by first class mail. If all Qualified Beneficiaries live at the same address, a single Notice, properly addressed, is sufficient. An appropriate address could include the employee's or other Qualified Beneficiary's name, and the name or status of any covered family member/Qualified Beneficiary. If a Benefits Administrator has knowledge that a Qualified Beneficiary lives at a separate address, he/she must send the Election Notice to that address. The specified format of the Qualifying Event Notice includes an opportunity to provide a correct mailing address.

The Election Notice includes premium information for any membership level that could apply to the Qualified Beneficiaries since each Qualified Beneficiary has an independent right to coverage. For example, a family covering an employee, spouse and child at the time of the Qualifying Event that results in loss of coverage could elect Extended Coverage for a single, dual or family membership, so all membership levels should be included. Also, since Extended Coverage participants are eligible for premium rewards, different premiums would apply if premium rewards are in place at the start of the Extended Coverage period, so there could be premium differences based on whether one or both premium-reward-eligible Qualified Beneficiaries elect. For example, in the same family group, if both the employee and spouse are eligible for the premium reward at the time Extended Coverage begins, but only the employee and child elect coverage, only the employee's premium reward would reduce the Extended Coverage premium. If the employee and spouse both elected, they would both continue the premium reward.

Hand delivery of an Election Notice (e.g., during an exit interview) does not fulfill the requirements of notifying covered family members. Also, hand delivery of some Notices versus mailing of others eliminates the consistency of the process and, if challenged, creates doubt as to the proper provision of the Notice if the Qualified Beneficiary denies receipt.

Election Notices should be documented in a consistent manner. This might mean maintaining a copy of all Notices or maintaining an Election Notice log to include relevant information. Consistency of the process is the key to effective documentation.

The offer of COBRA should also generate a HIPAA Certificate of Creditable Coverage to document the end of coverage in the previous status.

Election Forms, which are a part of the Election Notice, must be submitted by the later of 60 days from the date that coverage is lost or from the date the Election Notice is mailed. This 60-day window must be defined on the Election Form. A spouse can elect on behalf of a spouse, and a parent can elect on behalf of a minor child. A spouse may not decline on behalf of a spouse. However, failure to respond within the 60-day window is equivalent to declining coverage.

If a declination of coverage (see Election Form) is received but rescinded prior to the end of the 60-day election period, the Qualified Beneficiary may still start coverage, but the effective date may be prospective to the election. Election Forms sent by Qualified Beneficiaries after the end of the 60-day election period will require the issuance of a Notice of Unavailability—see #3 above.

5. Notice of Early Termination

At any time Extended Coverage is elected and then terminated prior to the end of the maximum coverage period (e.g., due to failure to pay the premium within the grace period), the Qualified Beneficiary/ies must receive notification of the termination. There is no specific format for this Notice, but it must explain the reason for the termination. This would be the responsibility of the Extended Coverage Administrator in the Office of Health Benefits. In the case of termination for non-payment, it would be generated by the billing administrator.

Other Extended Coverage/COBRA Provisions

Medical Flexible Spending Accounts (FSA)

As reflected in the Election Notice, qualified beneficiaries who are enrolled in a Medical FSA and who have not used the full amount of their contributions at the time of the loss of coverage due to the qualifying event (account is underspent) must be offered the opportunity for continuation coverage by continuing to pay their monthly FSA contribution on an after-tax basis. If contributions have all been claimed (including claims in excess of the actual contribution amount) at the time of the qualifying event, no Extended Coverage is required. Benefits Administrators who receive Election Forms indicating a Medical FSA Extended Coverage election may contact the Office of Health Benefits to determine the status of the account and, if applicable, to establish continuing contributions. Access to the total annual election amount is available through the end of the plan year or until contributions cease, whichever is sooner.

Health Reimbursement Arrangement (HRA)

Qualified Beneficiaries enrolled in a plan that includes an HRA will have access to any balance remaining in the single or family group's HRA at the time of the loss of coverage if Extended Coverage is elected. For example, if a spouse loses coverage based on divorce from an employee, both the employee and the divorced spouse would have access to the existing family HRA balance at the time of the qualifying event. The Office of Health Benefits will monitor movement of HRA balances when a qualifying event occurs.

Initial Premium Payment

The first Extended Coverage/COBRA premium payment is due within 45 days of the election. The state program starts this 45-day payment period on the day that the Election is entered in BES. The amount due at the end of the 45-day period is the premium for any full months that fall between the Extended Coverage start date and the end of the 45-day grace period. For example, if a Qualified Beneficiary loses coverage effective January 31 and elects coverage on March 31 (also keyed on March 31), the initial premium will be due by May 15. At that time, at least the February, March and April premium must be paid. While the May premium is due by May 1, a 30-day grace period must be allowed for any single month. In this example, if the Qualified Beneficiary pays for only February and March by May 15, coverage may be opened for those months but terminated effective March 31 for failure to pay April's premium within the initial payment grace period (allowing for more than the single 30-day grace period for April).

Please note that Extended Coverage premiums are considered made when mailed, so a premium payment due on May 15, received on May 20 with a May 15 postmark is considered a timely payment.

Monthly Premium Payment Grace Periods

After the initial premium payment is made within the grace period, all future monthly premiums are due by the first of the coverage month with a 30-day grace period. Failure to pay by the end of the payment grace period will result in termination of coverage without the opportunity to return to the program based on this qualifying event.

Claim Payment During Payment Grace Periods

When premium payments are not made by the due date (taking into consideration mailing time), qualified beneficiaries are placed in a claims hold status (bill premium code 09 or 19) until the premium is received by the end of the grace period or coverage is terminated.

Partial Premium Payments

Premium payments made in less than the total amount due may result in termination of coverage back to the end of the month for which full premium payment is made if the payment is short by more than 10% or $50, whichever is greater. Premium shortfalls that are less than 10% or $50 (whichever is greater) will not result in termination of coverage. However, if a shortfall continues for a second month, the Qualified Beneficiary will be notified and given 30 days to remedy the underpayment.

What changes are allowed during Extended Coverage?

Extended Coverage participants have the same rights as similarly-situated non-Extended Coverage plan participants, including open enrollment, membership changes consistent with qualifying mid-year events, and premium rewards. Since Qualified Beneficiaries have individual rights, termination of one Qualified Beneficiary does not mean that all Qualified Beneficiaries in a dual or family contract will lose coverage. The Extended Coverage Change Request Form (available at the DHRM web site) allows a Qualified Beneficiary to notify the plan of allowable changes.

When does Extended Coverage End?

Extended Coverage will end for the following reasons:

- The end of the maximum available coverage period;
- The Qualified Beneficiary fails to pay the required premium by the end of the grace period;
- The Qualified Beneficiary becomes covered by another group health plan (without pre-existing condition limitations) or entitled to Medicare;
- The Qualified Beneficiary ceases to be disabled during the disability extension; or
- The Qualified Beneficiary is terminated for cause.

Under no circumstances will Extended Coverage last for more than 36 months.

As Benefits Administrator for Extended Coverage/COBRA, DHRM's Office of Health Benefits will generally handle termination of Extended Coverage.

Extended Coverage Initial Election and Ongoing Administration

Agencies are responsible for providing Initial General Notices, Notices of Unavailability and Election Notices to employees and family members based on this guidance. Upon timely receipt of the Election Form, agencies should key the election into BES. The BES Systems Guide provides keying assistance. Once the Qualified Beneficiary has been keyed for Extended Coverage, continuing administration will be handled by the Department of Human Resource

Management's Office of Health Benefits Extended Coverage/COBRA Administrator.

When is Extended Coverage offered to Workforce Transition Act (WTA) terminated employees?

Per the Code of Virginia, Extended Coverage/COBRA is offered to employees terminated under the provisions of the WTA at the end of the 12-month layoff/transitional leave period. Qualified Beneficiaries who fail to pay their contribution for coverage before the end of the layoff leave should be offered continuation coverage starting the first of the month after they are terminated for non-payment. In all cases, termination of employment provides up to18 months of eligibility for continuation coverage. Under these circumstances, Extended Coverage does not run concurrently with the "layoff leave" period.

Resources

The Initial General Notice and Election Notice provide an excellent summary of Extended Coverage provisions. Most questions regarding Extended Coverage can be answered based on information in these Notices which are available at www.dhrm.virginia.gov.

- Initial General Notice -
- Election Notice -
- Extended Coverage/COBRA Change Request