Dealing with COBRA Claims

Written Procedures for COBRA Claims

Health plans are required to include written procedures for processing COBRA claims. Claims procedures must be described in your Summary Plan Description (SPD). Claims for COBRA coverage should be thoughtfully considered, and especially if the claim is denied, reviewed with your benefits consultant or an attorney well-versed in the federal COBRA and any applicable State "mini-COBRA" laws.

COBRA Notice of Unavailability of Continuation Coverage - 14 Days after Request

Group health plans may sometimes deny a request for continuation coverage when the plan determines the requester is not entitled to receive it. If you or your plan administrator decides to deny a request for continuation coverage from an individual, the plan must give the individual a Notice of Unavailability of Continuation Coverage. The notice must:

- Be provided within 14 days after the request is received, and
- The notice must explain the reason for denying the request.

Appeals - Notification of Decision

If an employer or plan administrator denies a claim for COBRA benefits, employees or others applying have at least 60 days to appeal the denial. At this time, you and/or your administrator should again carefully review the claim.

Regardless of the decision, employers are required to send a decision on the appeal generally within 60 days after the 60-day period for the appeal.

- COBRA Notice of Unavailability of Continuation Coverage

Additional COBRA Information

- An Employer's Guide to Group Health Continuation Coverage Under COBRA
- Fact Sheet: Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Continuation of Health Coverage- COBRA
- FAQs About COBRA Continuation Health Coverage