Mountaineer Flexible Benefits
Benefit Coordinator Reference Manual

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NOTICE: This Handbook is not intended to be all-inclusive. If conflicts exist between this handbook and the Internal Revenue Code or West Virginia Statutes or the Mountaineer Flexible Benefits Plan Summary Document, the Internal Revenue Code and the Statutes must be followed.

Mountaineer Flexible Benefits Plan

Special Note: This program is available to State Agencies, Universities & Colleges, participating Boards of Education, and participating Non-State Agencies.

1. Introduction

The Mountaineer Flexible Benefits Plan is sponsored by the West Virginia Public Employees Insurance Agency (PEIA) as a vehicle to provide additional benefits to eligible state employees and a tax savings to the participating employees and the state. The Plan qualifies as a Cafeteria Plan authorized by Section 125 of the Internal Revenue Code. FBMC Benefits Management, Inc. is the third party administrator of the Plan.

This manual is written by the staff at FBMC for Personnel Administrators, Benefit Coordinators and other state and county boards of education staff with responsibilities associated with the Mountaineer Flexible Benefits Plan. Its purpose is to communicate general information and procedures essential for implementation and ongoing administration of the Plan. It is important that staff at the state agencies, county boards of education, non-state agencies and their counterparts at FBMC have a clear understanding of the interface necessary to administer the Plan and the role each play to assure its accuracy and success.

In preparing this text our goal was to keep it simple and provide the reader with only the detail necessary to understand his/her role. Much of the text of this manual is written in a question and answer format. We hope you find it easy to use.

FBMC Contact Information:

Active Employee Correspondence:

FBMC Benefits Management, Inc.
P.O. Box 1878
Tallahassee, FL 32302
FBMC Service Center 1.844.559.8248

Retiree Correspondence:

FBMC Benefits Management, Inc.
P.O. Box 10789
Tallahassee, FL 32302
FBMC Service Center 1.844.559.8248

Note: When contacting the FBMC Service Center as a Benefit Coordinator, please understand that the service center representatives can not provide specific member information due to HIPPA regulations. However, they can still assist Benefit Coordinators with plan specifics, procedures and rules. For specific member information, please follow the procedures listed throughout the manual.

WV Mountaineer Flexible Benefits Office Staff:

1. Kayla Horton, FBMC Client Liaison @ 304.558.7850, Ext. 52627
   Email khorton@fbmc.com & Fax #1-850-425-6220
2. Emily Hoffman, FBMC Account Manager @ 304.558.7850, Ext. 52652
   Email ehoffman@fbmc.com & Fax #1-850-425-6220

Important Fax Information:

1. For **Active employees, new hires, transfers, open enrollment**: ATTN: Enrollment Processing Fax # 850.514.5803
2. For **Retirees:** ATTN: Direct Bill Fax # 866.836.9943
3. For **Change in Status**: ATTN: Change in Status Fax # 850.514.5803
4. For **Appeals**: ATTN: Appeals Fax #850.425.6220

2. Annual Enrollment

Developing and Distributing Material

Enrollment reference guides and enrollment forms are mailed by FBMC directly to employees' home addresses prior to the start of the enrollment. For Non-State Agencies, they are mailed to the agency for the agency to disperse.

In addition, FBMC maintains a limited inventory of material for use with new employee enrollment throughout the plan year. The Benefit Coordinator can call, reach out via email, or go to the onsite FBMC contact to request enrollment materials. Please provide them with the following information in your email to place your order:

Agency Name:
ATTN:
Address:
Phone number:
How many packets:
Specify Active or Retiree packets:

The contact information is:

1. Jodi Grady, FBMC @ 304.558.7850, Ext. 52605
   Email jgrady@fbmc.com & Fax #1-850-425-6220

Conducting the Enrollment

As soon as the material is distributed employees start asking questions. Who is available to assist with their questions?

PEIA coordinates a series of Benefit Fairs throughout the state during the open enrollment period. FBMC participates in the Fairs and Enrollment Counselors are available to answer questions. Check the Benefit Fairs schedule on the back cover of your Mountaineer Flexible Benefits reference guide for a location and time near you.

For immediate assistance, please encourage employees with questions to contact FBMC's Service Center at 1-844-559-8248. Our representatives are trained on all aspects of the Mountaineer Flexible Benefits Plan and can address all employee questions.

Must all employees complete an enrollment form?

This is referred to as a changes only enrollment.

For easier enrollment, during the annual open enrollment, please visit **www.myFBMC.com** and enroll online. Note: Online enrollment is only available during the Open Enrollment period. New Hires and Transfers throughout the year are to use the Mountaineer Flexible Benefits paper enrollment form and should be faxed to 1.850.514.5803 ATTN: Enrollment Processing. For Change in Status (CIS) throughout the year please use the Mountaineer Flexible Benefits paper enrollment form, mark the CIS box (top right corner of the form) and include the appropriate supporting documentation with the CIS request to prevent processing delays. This should be faxed to 1.850.514.5803 ATTN: CIS. Please remember when submitting a CIS to PEIA, if your employees have Mountaineer Flexible Benefits you must also submit the FBMC enrollment form to FBMC following the procedure above.

There are several ways to approach an enrollment. Under current practice, any eligible employee who already participates in the Plan does not need to complete a new form during open enrollment as long as he/she wants current benefits to continue. If changes are necessary during any open enrollment period, a new form must be completed indicating adds, cancels, changes, etc.

Collecting Enrollment Forms

During Open Enrollment employees must turn in completed forms to their Benefits Coordinator no later than the close of business the last day of Open Enrollment.

What does the Benefit Coordinator do with the forms?

The Benefit Coordinators should review the forms to ensure all information is complete and accurate before the forms are forwarded to Tallahassee. This process is very important for the accurate and timely creation of employee payroll deduction files and also the master files necessary for accounting and compliance reporting.

- The Benefit Coordinator reviews each form and first confirms that the employee is eligible for participation in the Mountaineer Flexible Benefits Plan. If not, the form should be rejected and the employee notified according to standard agency procedure.
- The Benefit Coordinator then completes the section in the bottom right corner designated "For Benefit Coordinator Use Only".
- The Benefit Coordinator then provides the employee a copy of their Open Enrollment Form for his/her records.
- The forms are then bundled and sent to FBMC twice weekly. At the end of Open Enrollment, all remaining forms should be sent to FBMC by the date specified on the enrollment form.

How does FBMC handle common enrollment form errors or discrepancies?

Enrollment form errors or discrepancies can be detected manually by the data entry specialists or automatically through the system-generated edit feature. They must be resolved quickly before the final enrollment data is generated for the various providers and the client.

Standard Procedure:

- Contact the Benefit Coordinator by phone to explain the discrepancy and resolve.
- If the Benefit Coordinator is unavailable, modify the form to meet plan requirements or to match coverage level with premium amount selected.
- Correct the form in red ink; initial the change.
- Document the Service Center Inquiry screen with the details of the situation.
- Forward a copy of the revised form with a letter of explanation to the Benefit Coordinator.

Each employee's Service Center inquiry screen is documented so that a history of events is detailed. Should the employee call FBMC, the Service Center representative has all pertinent information available to discuss the discrepancy and the solution with the employee and to assist the employee with any other needed adjustments.

How does FBMC handle forms if required information is missing?

If *employee-completed* information is missing, FBMC will make multiple attempts to contact the Benefit Coordinator. If we are unable to reach the Benefit Coordinator, the form remains in a pending status unless completed and return to FBMC by the first of June, so the elections are sent to the provider companies for the benefits to be effective the first day of the plan year.

NOTE: If a response is not received, the benefit selections will not be effective with the new plan year.

If *Benefit Coordinator-completed* information is missing, such as BC signature, agency work location number, annual salary, or number of pays, a call is placed to the

Benefit Coordinator. We first verify the employee's eligibility, because typically when this information is not completed, a Benefit Coordinator has not reviewed the form. If determined to be eligible, the information collected is written on the form in red ink, and the Service Center Inquiry screen is documented. If the employee is not eligible, the form is returned back to the Benefit Coordinator.

Supersede Forms - What are they and how are they handled?

An employee may change his/her mind about benefit selections during the open enrollment period after they have submitted an enrollment form. ***The Plan permits a change to be made as long as the employee submits a new enrollment form prior to the end of open enrollment.*** The second form is referred to as a **Supersede Form.**

In this case, the employee may submit a new form to his/her Benefit Coordinator. To avoid any confusion at FBMC, the Benefit Coordinator must write ***SUPERSEDE*** across the top of the enrollment form. The Benefit Coordinator reviews the form, all pertinent information is added as previously specified (see **Step 3 Collecting Enrollment Forms**), and the form is forwarded to FBMC.

Note: The number of supersede forms forwarded to FBMC should be clearly specified on the Transmittal Notice.

When a supersede enrollment form is received, FBMC replaces selections from the first form with selections indicated on the supersede form.

Confirmation Notices

Every employee who completes a **paper** enrollment form receives a Confirmation Notice from FBMC. Confirmation notices are printed and distributed by mail to their home address daily. The notice itemizes the benefits selected and the per pay amount to be deducted from the employee's paycheck.

The text of the Confirmation Notice instructs employees to carefully review the Notice and compare the information with their enrollment form; discrepancies are to be immediately brought to FBMC's attention by contacting Service Center at 1-844-559-8248.

Every employee who enrolls **online** during Open Enrollment will be prompted to print their own confirmation statement at the end of the sessions. After Open Enrollment, Benefit Coordinators will receive a secure email from FBMC with a copy of any of their employees' confirmation notice that enrolled online during open enrollment.

The insurance plan certificates and guides for all products can be located on www.myfbmc.com.

3. Plan Maintenance

Participating Boards Of Education & Non-State Agencies

Reconciliation of these payroll deductions is handled via the **Bill for the Month**. This monthly invoice is electronically remitted to each county board or non-state agency approximately 10 business days prior to the beginning of the month in which deductions will be taken.

What does the bill look like?

The bill consists of three parts:

- Part one is labeled the **Bill for the Month.** It identifies each participant's social security number; name and other critical plan benefit information.

The bill contains space to be used as a worksheet to identify by participant any changes needed.

- Section two is an **Adjustment Form for the Month** that is used to consolidate the changes from the worksheet and to communicate changes or adjustments to FBMC. Please utilize this document for communicating all changes in employment status, clearly specifying the employee name/ID, status (termination, retirement, deceased, etc. and date of event). A link to the digital copy of the form may be located under the Remittance Summary Form cover sheet.
- The final section is the **Remittance Summary Form.** When completed, the total remittance amount from this form should equal the actual deductions taken for the month, adding or subtracting any adjustments.

What are the specific steps to be taken for reconciliation?

Step one

After all payrolls have been generated for the month, total the actual deductions taken for all benefit categories and pay cycles.

Step two

Compare the employee totals to those on the **Total Bill** line on the Remittance Summary Form.

Step three

In most cases, the totals should agree. If the two totals are equal, your payroll system is balanced to the bill and the reconciliation is complete. You may complete the remittance and reporting process as shown in *step six.* If the two totals are not equal, proceed to *step four.*

Step four

Verify that all employees who have deductions for the month are listed within the main sections of the bill. Also verify that the amount actually deducted for Dependent Care Flexible Spending Accounts and other miscellaneous deductions match what is on the bill. *Note: The monthly amount listed on the bill should equal the total monthly deduction taken.*

When an individual discrepancy between the bill and the actual deduction is identified, the discrepancy must be documented on the FBMC adjustment form as described below. The adjustment form requires the following information for each employee with a deduction change:

SSA Number - the employee's Social Security number

Subscriber Name - the employee's last name followed by first name or first initial

Plan Date - the effective date of the change

CHG CD - any one of the change codes shown at the bottom of the adjustment form

PAY / YR - the number of payrolls during which Plan deductions are taken (10, 12, 18, 20, or 24 pay cycle)

Plan Code - The plan code for each type of deduction (e.g. DEPR for Dependent Care accounts, MISC for miscellaneous)

Comments - space provided for any additional explanation not covered by the change codes shown on the form

Employee Amount - the contribution from the employee to the Plan

Employer Amount - Not Applicable

If there are multiple entries for an employee, the Social Security number and name does not need to be repeated.

Step five

After all adjustments to the bill have been entered on the Adjustment Form(s), transfer the employee totals from the Adjustment Form(s) to the Remittance Summary Form (shown in the section 5). Calculate the total remittance amounts on the bill's Remittance Summary Form and verify that the amounts match the total employee deductions remitted. Make a copy of the payroll deposit (check) that will be forwarded to FBMC, keep for your records, and verify the deposit amount matches the total employee deductions remitted.

Step six

Please mail, no later than the 10th of the following month, all Adjustment Forms and the Remittance Summary Form to the address below. Check(s) should be made out to WV-Mountaineer Flexible Benefits.

FBMC
ATTN: Accounting-WV
P.O. Box 1878
Tallahassee, FL 32302-1878

4. Changes during the Plan Year

New Hire Enrollment

The Mountaineer Flexible Benefits Plan permits new hires to join the plan throughout the plan year. Employees complete and submit enrollment forms to their Benefit Coordinator.

The Benefit Coordinator confirms the employee's eligibility and completes the Benefit Coordinator section in the lower right comer of the form. The completed enrollment form is then forwarded to FBMC.

The effective date for all new hires is the first of the month following enrollment. When an employee terminates, retires or transfers; the effective date must be the last day of the current month. The employee is responsible for the full month's premium.

Employee Transfer

When an employee transfers, it is the New Benefits Coordinator responsibility to advise their **employee** to provide their current benefits to the new agency.

In the event that the new employee is unsure of his or her current benefits, the employee needs to contact the old agency to confirm coverage, call the FBMC Service Center, or log onto www.myfbmc.com.

Eligible Transfers include:

1. When an employee transfers from an agency that participates with the Mountaineer Flexible Benefits Plan to another agency that participates with the Mountaineer Flexible Benefits Plan, then the employee needs to complete the enrollment form and mark it "Transfer" (in the top right corner of the form).
2. When an employee transfers from an agency that does not participate with the Mountaineer Flexible Benefits Plan to another agency that participates with the Mountaineer Flexible Benefits Plan, then the employee needs to complete the enrollment form and mark it "New Hire" (in the top right corner of the form).

Note: The employee's new agency Benefit Coordinator needs to complete the "Benefit Coordinator Use Only" box (on the bottom right corner of the form) in order for the form to be processed.

Ineligible Transfers:

1. If an employee transfers from an agency that participates with the Mountaineer Flexible Benefits Plan to an agency that does not participate with the Mountaineer Flexible Benefits Plan, they will need to follow the procedure for terming employees' benefits.
2. If an employee transfers from an agency that does NOT participate with the Mountaineer Flexible Benefits Plan to an agency that does participate with the Mountaineer Flexible Benefits, they will be treated as a new hire.
3. If an employee transfers from one agency to another that both participate with the Mountaineer Flexible Benefits Plan, but did not have coverage they are not treated as a new hire and CANNOT pick up coverage.

Demographic Change Form

When an employee needs to update demographic information, such as:

- Change of Address
- Name change ONLY
- Phone number
- Email address

The demographic change form can be found on the myFBMC website. Please note: No changes to benefits will be made using this form.

Correcting Demographic Information

Any time a dependent's information is incorrect with FBMC, you will need to fax a copy of the enrollment form to 850.514.5803 Attn: Enrollment Processing. On your fax cover letter you will make a note advising the request you need to make. I.e., per the form, please update DOB.

If the participant made an error on the form, please make a note on your fax cover sheet requesting that the DOB be corrected to _____.

5. Change in Status (CIS) Events

Employees may change a benefit election upon the occurrence of a valid CIS event but only if the change is made on account of, and corresponds with, an event that affects their own, their spouse's or their dependent's coverage eligibility. Assuming that these general consistency requirements are satisfied, if the CIS event affects eligibility for a particular coverage, a corresponding change can be made to the same type of coverage. IRS regulations further clarify that a valid CIS event must result in the employee, spouse or dependent gaining or losing eligibility for coverage, or for a particular coverage option such as managed care or indemnity.

The employee must complete and submit an FBMC enrollment form, indicating "Change in Status" in the upper right corner. The form must be completed during the month of and two months following the qualifying event. FBMC will determine if the CIS meets IRS regulations. Employees should call FBMC Service Center at 1-844-559-8248 for more information if seeking to determine if their recent life or benefit change results in a valid CIS event. Employees may also contact Service Center at **FBMCServiceCenter@fbmc.com.** Upon approval, existing benefits will be stopped or modified (as appropriate) at the first of the month immediately following approval and completion of processing.

The following five events constitute valid changes in status:

- Change in your legal marital status, including marriage, death of spouse, divorce, legal separation (if recognized by state law) or annulment.
- Change in number of tax dependents, including marriage, birth, death, adoption or placement for adoption. Existing dependents can also be added whenever a dependent gains eligibility as a result of a valid CIS event.

- Change in employment status that affects coverage eligibility of employee, your spouse or your dependent, including: termination or commencement of employment, a switch between full-time and part-time status and vice versa, a strike or lockout, commencement or return from an unpaid leave of absence, change in work schedule such as an increase or decrease in the number of hours of employment, change from salaried to hourly status and vice versa, a change in work site.
- Change (the gain or loss) of spouse's or dependent's eligibility status, such as attainment of a specified age, student status, marital status, or any similar circumstances that satisfy or cease to satisfy the eligibility requirements under the plan providing the coverage.
- Change in place of residence of employee, spouse or dependent in which the carrier eligibility requirements are no longer met.

Life Events

Life Events is a post-tax product included as a companion to the plan and is not restricted by IRS rules; however, changes must be made in coordination with Trustmark, the underwriter of the benefit. All changes or inquiries after enrollment must be directed to Trustmark. In the event an employee is terminated, the employee has the option of contacting Trustmark to establish a direct billing process. *Note: Trustmark no longer offers new LifeEvents policies. Employees who currently have LifeEvents may continue their coverage.*

Trustmark Customer Service: 1-800-918-8877.

Benefit Coordinator's Role

If an employee has a qualifying event as indicated, how do they apply for a Change in Status? What role does the Benefit Coordinator play?

The Benefit Coordinator has the employee complete the FBMC paper enrollment form and mark it CIS in the top right corner. Then, they fax the completed CIS form and supporting documentation to FBMC @ 1.850.514.5803 ATTN: CIS. FBMC must receive the CIS form and supporting documentation within the new month of and two months following the qualifying event.

FBMC's Change In Status Specialist reviews the form, the documentation attached and either approves or denies the change based on the validity of the triggering event and the consistency of the event to the requested change. IRS regulations are strictly followed. If there is any doubt about the appropriate action, the Specialist seeks legal opinion. The IRS is contacted as necessary.Please allow up to 10 business days from receipt of form for completion of internal FBMC review.

An approved change is immediately processed and made effective the first of the following month (excluding birth/adoption or court order). A copy of the approved form is faxed to the Benefit Coordinator.

Finally, a copy of the CIS form is attached to the employee's original enrollment form at FBMC. The Benefit Coordinator makes any appropriate payroll adjustments

based on instructions from FBMC.

A denial change is formally documented in letter form, outlining the reason for the denial and any other pertinent information. The denial letter is mailed to the employee's home address, with a copy provided to the Benefits Coordinator.

Leave Of Absence

An employee who goes on leave of absence during any plan year may continue his/her Mountaineer Flexible Benefits plan benefits by paying the premiums directly, on an after-tax basis.

What benefits are eligible for continuation? How does an employee pay directly?

All benefits, including the two Flexible Spending Accounts, can be continued by the employee while on leave.

It is important to note that if an employee elects **not** to continue his/her benefits while on leave, the IRS forbids reentry into the plan until the next open enrollment period following the return from leave. The exception to this rule relates to benefits that must be reinstated following a return *from family medical leave.*

All personal payments by employees who are on leave should be sent to the Benefit Coordinator to keep track of the employees payments while on leave. Then, the Benefit Coordinator needs to complete a Mountaineer Flexible Benefits Personal Pay Summary form (Email the FBMC onsite contact if you need a copy of this form) and submit the check to:

FBMC
ATTN: Accounting-WV
P.O. Box 1878
Tallahassee, FL 32302

6. Filing an Appeal

Overview

If you have an enrollment change or request for a mid-plan year election change, you have the right to appeal the decision by sending a written request for a review within 30 days of the initial denial.

Your appeal must include:
- The name of your employer
- Your contact information, including an email address so that you may be contacted easily and timely
- Why you believe your request for a variance should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt and its supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review

may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

IMPORTANT NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

For appeals involving your enrollment elections or mid-year changes: FBMC Benefits Management Attn: Enrollment Appeal; Mail Slot 51 PO Box 1878 Tallahassee, FL 32302-1878

7. Compliance Services

COBRA & Retirement Notification

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

COBRA contains provisions giving certain former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available for specific *qualifying events.*

Can all benefits be continued?

The following Mountaineer Flexplan benefits can be continued under COBRA:

Benefit Description	Provider Company
Pre-tax Vision Care Plans	**MetLife**
Pre-tax Hearing Plan	**EPIC**
Pre-tax Indemnity Dental Care Plans	**Delta Dental of WV**
Pre-tax Health Care Flexible Spending Account	**PayFlex**

What are the *qualifying events* under COBRA?

Qualifying events are certain events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of qualifying event determines who is qualified and defines the required amount of time that a plan must offer the health coverage under COBRA. It is important to note that qualifying events differ for employees, spouses and dependents.

The types of qualifying events for **employees** are:

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

The types of qualifying events for **spouses** are:

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

The types of qualifying events for **dependent children** are the same as for the spouse with one addition: Loss of "dependent child" status under the plan rules.

Is there a simple chart to use to understand the various events and the periods of coverage?

Yes.

Qualifying Events	Who Qualifies For COBRA?	For How Many Months?
Termination	Employee, Spouse, Dependent Child	**18***
Reduced Hours	Employee, Spouse, Dependent Child	**18***
Employee entitled to Medicare	Spouse, Dependent Child	**36**
Divorce/legal separation	Spouse, Dependent Child	**36**
Death of covered employee	Spouse, Dependent Child	**36**
Loss of "dependent child" status	Dependent child	**36**

** Note: In the case of individuals who qualify for Social Security disability benefits, special rules apply to extend coverage an additional 11 months.*

What is the notification process regarding an employees termination or retirement?

In the event of termination of employment, the **employer** notifies FBMC via the normal billing process for County Board of Education and participating non-state agencies and via the payroll deduction / eligibility file for state employees.

When a Plan participant terminates his or her employment, all pre-tax benefits will cease on the last day of the month in which the employee is terminated. The Plan prohibits participants from making subsequent payments to the Plan unless they exercise their rights under COBRA.

Note: When an employee terms or retires, make sure when reporting to FBMC that you specify if the employee is terming or retiring. This is key information for

the continuation of benefits.

The **employer** is required to notify FBMC in the event of an employee's death, reduction in hours, or Medicare eligibility within 30 days of the qualifying event.

What is FBMC's process to continue the benefits?

When the employee or employer notifies FBMC of the qualifying event, PayFlex forwards by regular mail a COBRA Notification of Rights letter and an application form. The employee has sixty days to complete and return the application form to PayFlex.

Upon receipt of the application, PayFlex will send an initial bill to the employee that will be effective from the date coverage is lost. Premiums from the interim period are included on the bill and must be paid to keep the coverage in force under COBRA. The employee is given the option to make payments monthly, quarterly, semi-annually, or annually.

Benefits will remain in effect throughout the coverage period as long as premiums are paid. As a courtesy, PayFlex notifies each COBRA participant thirty days prior to the time that COBRA benefits are discontinued.

Once benefits are selected under COBRA can they be changed?

The initial application is the only opportunity that the employee will have to select benefits for continuation under COBRA. However, once selected, the employee can discontinue all or part of the benefits selected at any time during the *coverage period.*

What about rate changes?

If rate changes occur during the annual open enrollment period, employees who are continuing benefits under COBRA will be notified of the rate increase or decrease. Unless the employee chooses to drop the benefit(s), the change will become effective with the start of the new plan year and the employee's COBRA bill will be adjusted accordingly.

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