Who Qualifies for COBRA Continuation Coverage?

Qualifying events are those events which cause a member and/or his/her dependents to lose their Dental and Vision benefits with the Fund.

As a member of the Fund, you may purchase Continuation Coverage if:

- your employment terminates (either voluntarily or involuntarily) for any reason other than gross misconduct
- your hours are reduced to less than the minimum required for eligibility
- you are on an employer-approved leave

As the spouse of a member, you may purchase Continuation Coverage if the member loses coverage for any reason listed above, or if:

- the member dies while participating in the plan
- you become divorced or legally separated from the member and a judgment has been granted which terminates your eligibility
- as an ex-spouse either you or the member remarries within 36 months of your divorce, provided that you were eligible on the date of the remarriage

As a dependent child of a member, you may purchase Continuation Coverage if the member loses coverage for any reason listed under "As a member of the Fund..." above, or if:

- the member dies while participating in the plan
- you have reached the age of 19 and are not a full-time student
- as a full-time student dependent between the ages of 19 and 23 you have ceased to be a full-time student
- as a full-time student dependent you have reached the age of 23
- you have married and are no longer considered a dependent
- as an eligible stepchild you no longer reside with the member

Please note: The member, his/her spouse or a dependent child must notify the Fund in the event of a divorce, remarriage, or change in dependent status. The Fund must receive this notification within 60 days of the date on which coverage would terminate as a result of the qualifying event.

Length of Coverage

COBRA Continuation Coverage is a temporary extension of the Fund's Dental and Vision benefits. The length of coverage varies with the type of qualifying event responsible for the initial loss of benefits.

Eighteen Months: As either a member or a dependent of a member, you may continue coverage for a maximum of 18 months if your loss of coverage is due to:

- the member's termination (either voluntary or involuntary) from employment
- the reduction of the number of hours worked by the member
- the member's being on an employer-approved leave

Twenty-nine Months: Any beneficiary (either a member or a dependent of a member) who is determined under title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of Continuation Coverage shall be eligible for up to 29 months of Continuation Coverage. The qualified beneficiary must notify the Fund before the end of the initial 18 months of Continuation Coverage to be eligible for this 11 month extension.

Thirty-six Months: As a dependent of a member, you may continue coverage for a maximum of 36 months if your loss of coverage is due to:

- the death of the member
- the loss of dependent status as defined by the Fund
- the divorce of the member, provided that a judgment has been granted which terminates your eligibility
- the remarriage of either the member or his/her ex-spouse

Your Continuation Coverage may be terminated early for any of the following reasons:

- the Massachusetts Public Employees Fund no longer provides group coverage
- you are determined to be ineligible for Continuation Coverage benefits
- a monthly premium is not paid on time
- you become eligible for any other group plan which offers similar benefits (e.g., you transfer to a management position and are eligible with the GIC; you transfer to a position in another Bargaining Unit)
- in the case of the 29 months of Continuation Coverage, you cease to be disabled as defined under title II or XVI of the Social Security Act. If any individual so covered is determined to no longer be disabled, he/she must notify the Fund within 30 days of this determination.

Electing and Paying for COBRA Continuation Coverage

Once you, as either a member or a dependent of a member, have decided to continue your Dental and Vision benefits through the Fund's Continuation Coverage program, you must complete the enclosed COBRA Continuation Coverage Election Form. The Election Form is due at the Fund within 60 days of your termination from coverage or the due date printed on the Election Form, whichever is later. **Failure to submit the Election Form by the due date will be considered a waiver of your right to continue Vision and Dental Health coverage through the Fund's Continuation Coverage program.**

The premiums for family and/or single coverage are listed on the COBRA Continuation Coverage Election Form. These premiums are guaranteed until the end of the current plan year, which runs from July 1 to June 30. Once your COBRA Continuation Coverage Election Form has been processed at the Fund, you will be mailed payment coupons. The Fund does not bill you for your Continuation Coverage benefits. You are responsible for remitting your Continuation Coverage payments on time. Each Continuation Coverage premium you send in should be accompanied by the payment coupon(s) corresponding to the month(s) which that premium covers.

It is your responsibility to submit all required payments by the due date(s) even if you have not received or have misplaced your payment coupons. You must notify the Fund if you do not receive your payment coupons.

Your first Continuation Coverage payment is due within 45 days after the date of your election of COBRA Continuation Coverage. This premium must include the total number of payments due from your termination date through the current month. Subsequent premiums are due 30 days prior to the 1st day of the month for which you are remitting payment (e.g., payment for July is due June 1st). **No dental or vision benefits will be covered in any month until that month's premium has been received at the Fund.**

- All checks should be made payable to the Massachusetts Public Employees Fund. The COBRA Continuation Coverage Election Form and your monthly premiums should be mailed to the Fund at:

  PO Box 3319
  Peabody, MA 01961-3319

- You must allow five business days from receipt of your payment for your account to be updated.
- **Any payment not received after a 30 day grace period is considered to be late and is therefore not accepted by the Fund. Failure to submit a monthly premium on time results in the immediate cancellation of your coverage with no reinstatement allowed.**
- Please remember to notify the Fund of any change in your address.

The Fund provides COBRA continuation of coverage in accordance with the Public Health Service Act. This allows you and your dependents to temporarily receive benefits from the Fund under certain circumstances, known as "qualifying events", when plan coverage would otherwise terminate. You and/or your dependents must pay the full Continuation Coverage premium. You will be provided with monthly cost information if you become eligible for Continuation Coverage. The benefits which you and/or your dependents receive will be identical to those received by active Fund members. This pamphlet is an explanation of COBRA Continuation Coverage requirements, including who qualifies for coverage, the length of coverage, the procedure for electing Continuation Coverage, and the policies pertaining to COBRA Continuation Coverage payments.

This notice is being sent as a supplement to the information contained in the Massachusetts Public Employees Fund Vision & Dental Health Plans booklet.

This notice has important information about your right to continue your dental and vision benefits with the Massachusetts Public Employees Fund, as well as other options available to you, including coverage through the Massachusetts Health Connector at www.mahealthconnector.org. You may be able to get coverage through the MA Health Connector that costs less than COBRA continuation coverage. Please read the information in this notice carefully before you make your decision. If you choose to elect COBRA Continuation Coverage, you should use the enclosed Election From and return by the due date indicated.

If you have questions regarding your eligibility for COBRA Continuation Coverage, please call the Fund at 800-325-5214 or 617-426-4440.

COBRA Continuation Coverage is subject to your eligibility. The Fund reserves the right to terminate your coverage retroactively if you are determined to be ineligible.

MASSACHUSETTS PUBLIC EMPLOYEES FUND

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VISION & DENTAL HEALTH PLANS

NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE