

***SAMPLE FORM OF NOTICE OF CONTINUATION RIGHTS FOR
MASSACHUSETTS GROUPS WITH 2-19 ELIGIBLE EMPLOYEES
(TO BE DISTRIBUTED WHEN COVERAGE BEGINS)***

**NOTICE OF CONTINUATION RIGHTS FOR
QUALIFIED BENEFICIARIES OF
CERTAIN SMALL EMPLOYERS**

If you have group health coverage through an employer which employs between 2-19 employees eligible for coverage, you are eligible for continuation of group coverage under Massachusetts law upon the occurrence of certain “Qualifying Events” which would otherwise result in the termination of your group coverage. Persons who are eligible for this continuation coverage are called “Qualified Beneficiaries.” If you are a Qualified Beneficiary, you must make a written election for continued coverage within the election period in order to receive it. The election period will begin on the date group coverage would otherwise terminate and will end 60 days after that date, or 60 days after the date of any notice of the right to elect continuation coverage, whichever is later. If different types of coverage are available under the employer’s plan, each Qualified Beneficiary shall be entitled to make a separate selection among such types of coverage. A Qualified Beneficiary is a person who has group health coverage through a Massachusetts employer with 2-19 employees eligible for coverage on the day before a Qualifying Event which would otherwise result in the loss of the group coverage occurs.

The continuation coverage provided will be the same as the group coverage provided to similarly situated active employees who have not experienced a qualifying event. If the group coverage is modified for such active employees, the same modifications will apply to the continuation coverage. Evidence of insurability will not be required for the continuation coverage.

The following events are Qualifying Events when they result in the loss of a Qualified Beneficiary’s eligibility for active employee group coverage:

1. the death of the eligible employee;
2. the termination or reduction in hours of the eligible employee’s employment for reasons other than gross misconduct;
3. the divorce or legal separation of the eligible employee from his or her spouse;
4. the eligible employee’s becoming entitled to benefits under Medicare;
5. a dependent child’s ceasing to be an eligible dependent under the terms of the plan;
6. for retirees only, the commencement of a bankruptcy proceeding by or against the employer which results in a substantial loss of coverage within one year before or after the commencement of the proceeding.

You must notify your employer within 60 days of the date of any divorce, legal separation, or child's loss of dependent status to be eligible for continuation coverage.

The maximum period for which continuation coverage shall be available with respect to each Qualifying Event listed above will be:

1. 36 months after the death of the eligible employee.
2. 18 months after the termination of employment or reduction in hours; UNLESS a second Qualifying Event (other than bankruptcy of the employer) occurs within 18 months after the first Qualifying Event, in which case the maximum continuation period shall be 36 months from the date of the first Qualifying Event. ALSO, if a Qualified Beneficiary is determined to be disabled at the time of termination of employment or reduction in hours under Title II or Title XVI of the Social Security Act, then the maximum continuation coverage period shall be 29 months, but only if the Qualified Beneficiary provides notice of the determination within 60 days after the date of such determination, and only if such determination is made by the Social Security Administration within the first 18 months of the continuation coverage.
3. 36 months after the date of the divorce or legal separation which resulted in the loss of coverage.
4. 36 months after the eligible employee's entitlement to benefits under Medicare.
5. 36 months after the dependent child's loss of dependent status.
6. When the employer commences a bankruptcy action, the retiree may be covered until his or her death; but for covered dependents of the retiree, the maximum coverage period will be 36 months after the retiree's death.

HOWEVER, the continuation coverage will end before the maximum coverage period is completed when any of the following occurs:

- a) As to coverage with any carrier, the date on which that carrier ceases to provide a health benefit plan to other similarly situated eligible employees of the employer;
- b) Any premium required to cover a Qualified Beneficiary is not paid in a timely manner. Premium payment is timely if it is made within 30 days after it is due;
- c) The Qualified Beneficiary becomes covered under any other health benefit plan which does not exclude or limit coverage for any preexisting condition of the Qualified Beneficiary. Such other health coverage shall include Medicare, unless the continuation coverage is provided to a retiree of a bankrupt company;
- d) A Qualified Beneficiary who was determined disabled under the Social Security Act is no longer disabled. In this event, continuation coverage shall cease on the month that begins more than 30 days after the date of the final determination under the Social Security Act that the Qualified Beneficiary is no longer disabled. Qualified Beneficiaries must notify the employer within 30 days after such a final determination that the Qualified Beneficiary is no longer disabled.

Continuation coverage requires the payment of premium, which may not be more than 102% of the applicable group premium. You may elect to pay premiums monthly. Premium payments

and other communications must be made to the employer. The initial premium must be paid within 45 days of the date continuation coverage is elected. For Qualified Beneficiaries whose continuation coverage is extended beyond 18 months because of a disability determination, the premium shall be 150% of the applicable group premium after the 18th month of coverage.

When a Qualified Beneficiary has completed his or her maximum period of continuation coverage, he or she will be eligible for any individual plan of conversion coverage which the carrier providing continuation coverage at the end of the coverage period generally offers to similarly situated beneficiaries at the time the continuation coverage ceases.

**SAMPLE FORM OF NOTICE OF CONTINUATION ELECTION RIGHTS
FOR MASSACHUSETTS GROUPS WITH 2-19 ELIGIBLE EMPLOYEES
(TO BE SENT TO QUALIFIED BENEFICIARIES
UPON KNOWLEDGE OR NOTICE OF A QUALIFYING EVENT)**

CONTINUATION NOTICE AND ELECTION FORM

(Company Letterhead)

[[[Date

Qualified Beneficiary's Name

Social Security Number: _____

Street Address

City, State, Zip Code]]]

This is to inform you that even though you can no longer be covered under our group health plan as of *[[[date that coverage terminates]]]*, you may continue your benefits under the plan beyond this date. If any dependents of yours were covered under the plan, their benefits may also be continued.

You have 60 days from *[[[the later of the date coverage terminates or the date of this notice]]]* to notify us of your election.

If continuation coverage is elected for you or your dependents, coverage will be continued for each of you until the earliest of the following occurs for each of you:

- ⇒ 18 months after the Qualifying Event which caused the loss of your coverage; however, if you (or your dependent) were disabled as of the date of the termination of a covered employee's employment or reduction in hours which resulted in the loss of coverage, as determined by the Social Security Administration under Title II or Title XVI of the Social Security Act, then the continuation coverage period is 29 months, PROVIDED THAT the Social Security determination is made within the 18-month period after the employee's termination of employment or reduction in hours. To preserve your right to additional coverage by reason of disability, you must inform *[[[Employer Name]]]* of the determination of disability within 60 days of the date it was made;
- ⇒ You (or your dependent) become covered under a health plan that has no limitations or exclusions with respect to any preexisting conditions that you (or your dependent) may have;
- ⇒ You (or your dependent) become entitled to Medicare. If the former employee becomes entitled to Medicare, the maximum continuation coverage period for his or dependents is 36 months;

- ⇒ 36 months if a second Qualifying Event (other than the employer's bankruptcy) occurs during the initial 18-month continuation period after the employee's termination of employment or reduction in hours which resulted in the loss of group coverage;
- ⇒ Premium payments are not made on a timely basis;
- ⇒ Our group health plan is no longer in force.

The monthly premium to continue coverage is \$_____ for you and \$_____ for your dependents. The first premium due will cover the period beginning *[[[date coverage terminates]]]* and ending on *[[[date]]]*. Accordingly, you must pay a total initial premium of \$_____ if you wish to keep all of your current coverage in force.

We must receive your initial payment within 45 days of the date you sign this election form, or you will lose your right to continue coverage. After the first payment, all other premium payments must be made within 30 days after the date on which they are due. You have the right to pay premiums monthly.

If any payment is not received on time, you will lose your option to continue coverage.

Please complete the bottom portion of both copies of this notice. Keep one copy for your records and return one copy to: *[[[Employer Name, Title, Company, Street Address, City, State, Zip Code]]]*

* * * * *

I wish to continue coverage under your group health plan Yes _____ No _____

Coverage is elected for the following persons (list all names of those whose coverage will be continued):

My first payment is enclosed Yes _____ No _____

-or-

I will make my first payment within 45 days Yes _____

Signature _____ Date _____
Print Name:

IMPORTANT:

In order that your coverage may continue, we must receive:

- 1) **A completed copy of this notice by *[[[date that is 60 days after the later of the date of this notice or the date of coverage termination]]]*, and**
- 2) **Your first payment within 45 days after the date you sign this form.**

***SAMPLE LETTER TO NOTIFY MASSACHUSETTS EMPLOYERS WITH
2 - 19 ELIGIBLE EMPLOYEES OF THEIR OBLIGATION TO
ADMINISTER CONTINUATION BENEFITS***

[Date]

Employer's Benefits Administrator

Address

City, State, Zip

Re: Massachusetts Continuation Requirements

Dear Employer:

Massachusetts law requires that group health plan coverage for employers with between 2 - 19 employees who are eligible for coverage must offer continuation benefits. The continuation benefits required are similar to federal COBRA requirements, with a few substantive differences:

- A carrier may cease to provide continuation coverage when it no longer provides group coverage to any "similarly situated" active employees of the employer. (COBRA coverage continues until the carrier no longer coverage any employees of the employer.)
- In order to qualify for the 29-month continuation period because of disability, a Qualified Beneficiary may be required to show that a disability determination was made by the Social Security Administration at the time of the qualifying event. (COBRA allows the determination to be anytime during the first 60 days of coverage.)
- Massachusetts law does not specifically apply the 29-month continuation extension period to dependents of Qualified Beneficiaries, whereas COBRA does.
- Massachusetts law is silent on the issue of whether children born to or placed for adoption with the covered employee during continuation period are Qualified Beneficiaries in their own right, whereas COBRA now specifically states that they are Qualified Beneficiaries.

Our records indicate that you may have between 2 - 19 employees eligible for health coverage under your group plan. This letter is to notify you that ConnectiCare of Massachusetts requires that you administer the continuation benefits mandated by Massachusetts law. Administration responsibilities include the following:

- Distributing a notice of continuation rights to all employees at the time they become covered under your plan.
- Sending a continuation notice and election form to all Qualified Beneficiaries at the time of a Qualifying Event.
- Collecting continuation premiums and forwarding them to ConnectiCare of Massachusetts.

- Notifying ConnectiCare of Massachusetts of any persons who elect or discontinue continuation coverage.

There are two format notices attached to this letter. The first, entitled *Notice of Continuation Rights for Qualified Beneficiaries of Certain Small Employers*, should be given to all employees who enroll for coverage. The second, entitled *Continuation Notice and Election Form*, should be sent to all Qualified Beneficiaries (including spouses) at the time a qualifying event occurs. You may want to also include another copy of the first notice at the time of the qualifying event, so that Qualified Beneficiaries may easily review their rights under the Massachusetts continuation law.

Please note that under some circumstances, you may be subject to both federal COBRA and Massachusetts continuation requirements. COBRA applies to employers with 20 or more employees, whereas the Massachusetts continuation law applies to employers with 2 - 19 employees eligible for coverage. As a result, if an employer has 25 employees, only 15 of whom are eligible for coverage, both state and federal laws could be held to apply. In these circumstances, the Massachusetts law provides that affected employees be allowed the benefit of the more liberal mandate. You should consult with your attorney when deciding what continuation rights you should offer employees and dependents.

When administering continuation benefits, you should contact _____ at [[[phone number]]] to make premium payments and to answer questions and resolve issues you may have concerning continuation coverage.

Sincerely,