



Harvard Pilgrim
HealthCare

REASONS FOR SUBMISSION (PLEASE CHECK ONE) ☐ NEW ENROLLMENT/CONTRACT ☐ CHANGE TO CONTRACT ☐ TERMINATE CONTRACT	QUALIFYING EVENT DATE: _____ ☐ OPEN ENROLLMENT ☐ NEW HIRE ☐ COBRA ☐ LOSS OF INSURANCE ☐ COURT ORDER ☐ BIRTH/ADOPTION ☐ P/T TO F/T ☐ MARRIAGE/DIVORCE ☐ MOVED IN/OUT OF SERVICE AREA ☐ DEATH ☐ VOLUNTARY CANCELLATION
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REASON FOR CHANGES (CHECK ALL THAT APPLY) ☐ CHANGE COVERAGE TYPE ☐ ADD DEPENDENT LISTED ☐ TERMINATE DEPENDENT LISTED ☐ TRANSFER/RE-ENROLL TO COBRA ☐ OTHER: _____

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	GROUP #DIVISION	DATE OF HIRE	EFFECTIVE DATE OF COVERAGE
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SUBSCRIBER INFORMATION

HP ID	PRODUCT: ☐ HMO ☐ PPO ☐ POS ☐ ACCESS AMERICA	PLAN NAME
SUBSCRIBER FIRST NAME	MI	LAST NAME
SSN	HOME PHONE	WORK PHONE
STREET ADDRESS (NO PO BOX)	APT #	CITY
PRIMARY LANGUAGE (OPTIONAL)	PCP FULL NAME	PCP TOWN
CELL PHONE	EMAIL	DOB
STATE	ZIP	GENDER ☐ M ☐ F
CURRENT PATIENT ☐ YES ☐ NO	PCP ID #	

SPOUSE INFORMATION

SPOUSE FIRST NAME	MI	LAST NAME	DOB
SSN	MAILING ADDRESS (IF DIFFERENT)		RELATION CODE
PCP FULL NAME	PCP TOWN	CURRENT PATIENT ☐ YES ☐ NO	PCP ID #

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB
MAILING ADDRESS (IF DIFFERENT)	SSN		RELATION CODE
PCP FULL NAME	PCP TOWN	CURRENT PATIENT ☐ YES ☐ NO	PCP ID#

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB
MAILING ADDRESS (IF DIFFERENT)	SSN		RELATION CODE
PCP FULL NAME	PCP TOWN	CURRENT PATIENT ☐ YES ☐ NO	PCP ID#

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB
MAILING ADDRESS (IF DIFFERENT)	SSN		RELATION CODE
PCP FULL NAME	PCP TOWN	CURRENT PATIENT ☐ YES ☐ NO	PCP ID#

☐ PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS

OTHER INSURANCE – IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER HEALTH INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? ☐ YES, PLEASE COMPLETE ☐ NO			
NAME OF HEALTH PLAN	HEALTH PLAN ID NUMBER	EFFECTIVE DATE	NAMES OF SUBSCRIBER

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY HARVARD PILGRIM. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINISTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDES A SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

EMPLOYEE SIGNATURE

DATE

EMPLOYER SIGNATURE

DATE

Thank you for choosing Harvard Pilgrim Health Care.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	Contract change	Termination
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	Moved from Area
Employment Status Change	Loss of Employer Premium contributions	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- ❖ **Product/Plan Name:** Please be sure to fill in the correct product code for the plan you have selected. Your options are HMO, POS, PPO and Access America. If your employer offers multiple Harvard Pilgrim Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing. If you know the Plan MD # (MD0000016670) the number to identify the plan/product please include the information.
- ❖ **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. **IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.**
- ❖ **Primary Care Provider:** If your plan is an HMO or POS, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away. Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section.
- ❖ **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
 - 02 Spouse/Civil Union
 - 03 Child up to age 26
 - 06 Disabled (verification required)
 - 07 Ex-spouse
 - DP Domestic Partner
 - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Harvard Pilgrim Health Care for processing. If you need additional assistance completing this form or selecting a PCP, please call a member services coordinator at 1-888-333-4742.

Coverage underwritten or administered by Harvard Pilgrim Health Care. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

MEDICAL INSURANCE

	HPHC AA PPO PLAN	
	In-Network	Out-of-Network *
Plan Year Deductible	\$300 per member \$600 family	\$600 per member \$1,200 family
Plan Year Out-of-Pocket Max. (Includes Member cost share)	\$3,000 per member \$6,000 Family	
Preventive Care		
Routine & Preventive Servicing & Testing	No Charge	Ded., then 20% coinsurance
Other Services		
Office Visit - Primary Care	\$35 Copay	Ded., then 20% coinsurance
Office Visit – Specialist Care	Level 1: \$35 Copay Level 2: \$40 Copay	Ded., then 20% coinsurance
Chiropractic Visits	\$35 Copay	Ded., then 20% coinsurance
Diagnostic Lab & X-ray	Ded., then no charge	Ded., then 20% coinsurance
CT, MRI, & PET Scan	Ded., then \$100 copay	Ded., then 20% coinsurance
Outpatient Surgery	Ded., then \$150 copay per visit up to a max of \$600 per plan year	Ded., then 20% coinsurance
Inpatient Hospital	Ded., then \$150 copay per visit up to a max of \$600 per plan year	Ded., then 20% coinsurance
Behavior Health Inpatient	Ded., then \$150 copay per visit up to a max of \$600 per plan year	Ded., then 20% coinsurance
Occupational & Physical Therapy (100 visit combined limit per plan year)	\$35 Copay	Ded., then 20% coinsurance
Ambulance	Ded., then no charge	
Emergency Room (copay waived if admitted)	Ded., then \$150 copay per visit up to a max of \$600 per plan year	
Urgent Care	\$35 Copay	Ded., then 20% coinsurance
Pharmacy Benefits- Express Scripts	Deductible applies first then:	
Retail Pharmacy (30-day supply) Generic / Preferred / Non-Preferred	\$15 / \$30/ \$65	
Mail (90-day supply) Generic / Preferred / Non-Preferred	\$30 / \$60 / \$130	

MEDICAL INSURANCE

	HPHC – AA Value EPO \$300 Plan
	In-Network Only
Plan Year Deductible	\$300 Individual / \$600 Family
Plan Year Out-of-Pocket Max. (Includes Member cost share)	\$3,000 Individual / \$6,000 Family
Plan Year Rx Deductible	Medical Deductible
Preventive Care	
Routine & Preventive Servicing & Testing	No Charge
Other Services	
Office Visit - Primary Care	\$30 copay per visit
Office Visit – Specialist Care	\$35 copay per visit
Chiropractic Visits	\$35 copay per visit
Diagnostic Lab & X-ray	Ded., then no charge
CT, MRI, & PET Scan	Ded., then \$100 copay per procedure
Out- Patient Surgery	Ded., then \$150 copay per admission up to a max. of \$600 per plan year
Inpatient Hospital	Ded., then \$150 copay per admission up to a max. of \$600 per plan year
Behavior Health Inpatient	\$150 copay per admission up to a max. of \$600 per plan year
Occupational & Physical Therapy (100 visits combined)	\$35 copay per visit
Ambulance	No Charge
Emergency Room (copay waived if admitted)	\$150 copay
Urgent Care	\$30 copay per visit
Pharmacy Benefits- Express Scripts	
Retail Pharmacy (30-day supply) <i>Generic / Preferred / Non-Preferred</i>	Ded., then: \$10 / \$30 / \$65
Mail (90-day supply) <i>Generic / Preferred / Non-Preferred</i>	Ded., then: \$20 / \$60 / 130

MEDICAL INSURANCE



Point32Health companies

	HPHC – AA Value EPO \$1,000 Plan
	In-Network Only
Plan Year Deductible	\$1,000 Individual / \$2,000 Family
Plan Year Out-of-Pocket Max. (Includes Member cost share)	\$5,000 Individual / \$10,000 Family
Plan Year Rx Deductible	Medical Deductible
Preventive Care	
Routine & Preventive Servicing & Testing	No Charge
Other Services	
Office Visit - Primary Care	\$25 copay per visit
Office Visit – Specialist Care	\$35 copay per visit
Chiropractic Visits	\$35 copay per visit
Diagnostic Lab & X-ray	Ded., then no charge
CT, MRI, & PET Scan	Ded., then \$100 copay per procedure
Out- Patient Surgery	Ded., then \$150 copay per admission up to a max. of \$600 per plan year
Inpatient Hospital	Ded., then \$150 copay per admission up to a max. of \$600 per plan year
Behavior Health Inpatient	Ded., then \$150 copay per admission up to a max. of \$600 per plan year
Occupational & Physical Therapy (100 visits combined)	\$35 copay per visit
Ambulance	No Charge
Emergency Room (copay waived if admitted)	\$150 copay
Urgent Care	\$25 copay per visit
Pharmacy Benefits- Express Scripts	
Retail Pharmacy (30-day supply) <i>Generic / Preferred / Non-Preferred</i>	Ded., then: \$15 / \$30 / \$50
Mail (90-day supply) <i>Generic / Preferred / Non-Preferred</i>	Ded., then: \$30 / \$60 / \$150

Dudley-Charlton Regional School District
Insurance Rates 60/40 PPO, 70/30 split (unless otherwise noted)
Effective 7/1/26 - 6/30/27

Individual		Family
Individual	HPHC PPO \$300/\$600 Deductible 60/40 split Access America (AA 300) Group # 180371	Family
\$ 1,515.80	Full Monthly Premium	\$ 3,838.02
\$ 909.48	Monthly Employer/DCRSD Share	\$ 2,302.81
\$ 727.58	Monthly Employee Share (20 Pays)	\$ 1,842.25
\$ 606.32	Monthly Employee Share (24 Pays)	\$ 1,535.21
\$ 363.79	Bi-Weekly (20 Pays)	\$ 921.12
\$ 303.16	Bi-Weekly (24 Pays)	\$ 767.60
\$ 757.90	Monthly Retiree Rate 50/50	\$ 1,919.01
\$ 1,546.12	Monthly COBRA Rate	\$ 3,914.78

Individual	HPHC EPO \$300/\$600 Deductible Access America Value (AAV 300) Group # 180372	Family
\$ 1,128.30	Full Monthly Premium	\$ 2,871.88
\$ 789.81	Monthly Employer/DCRSD Share	\$ 2,010.32
\$ 406.19	Monthly Employee Share (20 Pays)	\$ 1,033.88
\$ 338.49	Monthly Employee Share (24 Pays)	\$ 861.56
\$ 203.09	Bi-Weekly (20 Pays)	\$ 516.94
\$ 169.25	Bi-Weekly (24 Pays)	\$ 430.78
\$ 564.15	Monthly Retiree Rate 50/50	\$ 1,435.94
\$ 1,150.87	Monthly COBRA Rate	\$ 2,929.32

Individual	HPHC EPO \$1000/\$2000 Deductible Access America Value (AAV 1000) Group # 180373	Family
\$ 1,009.54	Full Monthly Premium	\$ 2,574.23
\$ 706.68	Monthly Employer/DCRSD Share	\$ 1,801.96
\$ 363.43	Monthly Employee Share (20 Pays)	\$ 926.72
\$ 302.86	Monthly Employee Share (24 Pays)	\$ 772.27
\$ 181.72	Bi-Weekly (20 Pays)	\$ 463.36
\$ 151.43	Bi-Weekly (24 Pays)	\$ 386.13
\$ 504.77	Monthly Retiree Rate 50/50	\$ 1,287.12
\$ 1,029.73	Monthly COBRA Rate	\$ 2,625.71

Individual	Altus Dental Low Plan Group # 2895-0001	Family
\$ 44.64	Full Monthly Premium	\$ 122.74
\$ 31.25	Monthly Employer/DCRSD Share	\$ 85.92
\$ 16.07	Monthly Employee Share (20 Pays)	\$ 44.19
\$ 13.39	Monthly Employee Share (24 Pays)	\$ 36.82
\$ 8.04	Bi-Weekly (20 Pays)	\$ 22.09
\$ 6.70	Bi-Weekly (24 Pays)	\$ 18.41
\$ 22.32	Monthly Retiree Rate 50/50	\$ 61.37
\$ 45.53	Monthly COBRA Rate	\$ 125.19

Retiree Dental Low Plan Group # 2896-0001

Individual	Altus Dental High Plan Group #2895-0002	Family
\$ 57.04	Full Monthly Premium	\$ 160.19
\$ 31.25	Monthly Employer/DCRSD Share Low plan	\$ 85.92
\$ 30.95	Monthly Employee Share (20 Pays)	\$ 89.12
\$ 25.79	Monthly Employee Share (24 Pays)	\$ 74.27
\$ 15.47	Bi-Weekly (20 Pays)	\$ 44.56
\$ 12.90	Bi-Weekly (24 Pays)	\$ 37.14
\$ 34.72	Monthly Retiree Rate 50/50	\$ 98.82
\$ 58.18	Monthly COBRA Rate	\$ 163.39

Retiree Dental High Plan Group # 2896-0002

Individual	Altus Vision Group # 2895-9001	Family
\$ 5.06	Full Monthly Premium 100%	\$ 17.24
\$ 6.07	Monthly Employee Share (20 Pays)	\$ 20.69
\$ 5.06	Monthly Employee Share (24 Pays)	\$ 17.24
\$ 3.04	Bi-Weekly (20 Pays)	\$ 10.34
\$ 2.53	Bi-Weekly (24 Pays)	\$ 8.62
\$ 5.06	Monthly Retiree Rate 100%	\$ 17.24
\$ 5.16	Monthly COBRA Rate	\$ 17.58

Retiree Vision Group # 2896-9001

	Symetra Life Ins Basic Policy 01-020377-00	Vol. Policy
\$ 6.10	Full Monthly Premium \$10,000 policy	
\$ 4.26	Monthly Employer/DCRSD Share	
\$ 2.20	Monthly Employee Share (20 Pays)	
\$ 1.84	Monthly Employee Share (24 Pays)	
\$ 1.10	Bi-Weekly (20 Pays)	
\$ 0.92	Bi-Weekly (24 Pays)	
\$ 1.53	Monthly Retiree Rate 50/50 \$5,000 policy	

RETIREE 65+ ONLY

1/1/2026	Aetna Medicare Advantage Plan	Group # 467555
\$ 555.61	Full Monthly Premium	Rx # RXAETD
\$ 277.81	Monthly Retiree Rate 50/50	Aetna 1-888-267-2637

May and June deductions for those on 20 pay deduction schedule
will reflect any cost changes for new plan year effective July 1

**** Renews January 1st of each year, RetireeFirst (833) 217-5312 (age 65+ retiree advocates)**

Retireefirst (833) 217-5312 (65+ retiree advocates)



Dudley-Charlton Regional School District

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [Dudley-Charlton Regional School District], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Benefits Coordinator, Dudley-Charlton Regional School District, 68 Dudley-Oxford Road, Dudley, MA 01571. A copy of the court ordered divorce or legal separation of the employee and spouse is required.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions:

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Benefits Coordinator
Dudley-Charlton Regional School District
68 Dudley-Oxford Road
Dudley, MA 01571

Tel: 508-943-6888