COBRA / Retirees

WHAT IS COBRA? COBRA is a federally mandated program providing continuation of group vision benefits to qualified beneficiaries after loss of group coverage due to a qualifying event, at a specific group rate, for a specified period of time.

WHO IS A QUALIFIED BENEFICIARY? Qualified beneficiaries include an employee, or the spouse or dependent child of an employee, who on the day before the qualifying event is covered under the employee's vision plan.

WHAT IS A QUALIFYING EVENT? Voluntary or involuntary termination of employment for reasons other than "gross misconduct," reduction in the number of hours of employment, retirement of an employee, divorce or legal separation of covered employee, death of covered employee, loss of children's status based on plan dependent/child eligibility rules. **NOTE THAT VISION PLANS ARE NOT PART OF THE NEW HEALTH CARE LEGISLATION.**

WHAT IS THE MAXIMUM TIME PERIOD COBRA BENEFITS MAY BE CONTINUED? The period for which coverage may be continued varies depending on circumstances. In general, COBRA coverage may be continued for:

-18 months for retirees and family members, terminated employees, and that employee's family members, or for employees working reduced hours and that employee's family members.

-36 months is available for all others eligible for continued benefits.

IN NO CASE WILL COBRA CONTINUATION EXTEND BEYOND 36 MONTHS.

HOW DO I ELECT TO CONTINUE MY VISION COVERAGE? STA members who wish to continue Vision Coverage under COBRA must return the enclosed enrollment card with payment of the first two months premium within 60 days of the receipt of this notice, or 60 days from the qualifying event, whichever is later. If the form is not received within the applicable 60 days, the option to continue benefits under COBRA is lost. Payment must be sent to:

STA Benefit Fund
Att: Rich Rogers
450 West Kirkpatrick Street
2nd Floor
Syracuse, NY 13204

Vision benefits are retroactively reinstated when the Enrollment form is received. Thereafter, payments are due on the 1st of each covered month. Coverage is only in effect for the period of time that payment has been received.

COBRA PREMIUMS FOR 2023/2024

Individual Vision Coverage **$7.57/month** **$15.14 initial payment (Sept/Oct)**

Family Vision Coverage* **$19.72/month** **$39.44 initial payment (Sept/Oct)**
***must be currently carrying family coverage**

Full 18 months Premium (2% fee waived) through February 28, 2025.

Individual **$133.53**

Family **$347.86**

If you wish to enroll in COBRA, please complete and return the enrollment form along with payment.

Retiree COBRA Vision Enrollment Form

_____

Name (Last, First, Middle Initial Social Security Number

Home Address City State Zip

Date of Birth Home Phone Work Phone Male Female

Please indicate Coverage Type: Individual Family
If you are electing family coverage, list below the names of spouse and unmarried children under 25 years of age. Unmarried, dependent children ages 19 to 25 are eligible for benefits only if they are full time students. Unmarried children 19 years of age or older who are incapable of self-support because of mental or physical disability are covered provided that the disability began before the age of 19.

First Name, MI Last Name	Relationship	Date of Birth	Full Time Student
	Spouse Son Daughter		Yes No
	Spouse Son Daughter		Yes No
	Spouse Son Daughter		Yes No
	Spouse Son Daughter		Yes No

Signature_____ Date: _____