



**CHICAGO PUBLIC SCHOOLS
TALENT OFFICE
PHSA (COBRA)
NOTICE/ELECTION FORM**

Dear Employee:

It is important that all covered individuals (employees, spouses, and dependent children, if able) read this notice carefully and become familiar with its contents. If your covered dependents are not living with you, please provide the PHSA Administrator with their correct addresses so copies of this notice can be sent to them as well.

As of the last day of the month in which your employment terminates (**QUALIFICATION DATE**), you, your spouse, and/or dependents will no longer be eligible to be covered under the Employee Health Plan of the Chicago Public Schools (CPS). However, each of you has the option to continue your benefit plan under the Public Health Services Act (PHSA), formerly known as COBRA. You have 60 days from the date your Employee Group Health Plan terminates to elect continuation coverage. If you elect continuation coverage, benefits can be continued until whichever of the following events occurs first:

- the expiration of 18/36 months following the qualification date
- you become a covered employee under any group health plan
- you become entitled to Medicare
- you fail to pay the monthly charge for coverage on time
- you submit a check which cannot be processed by the expiration of your grace period
- our Employee Health Plan is no longer in force

QUALIFYING EVENTS

Each **covered individual** has the right to elect continuation coverage whether or not the employee chooses to continue coverage. The following are qualifying events which allow you to elect to continue coverage:

Qualifying Events for Covered Employee: If you are the employee of the Chicago Public Schools, you have the right to elect this Continuation Coverage if you lose your group health coverage due to termination of your employment (for reasons other than gross misconduct) or a reduction in hours of employment.

Qualifying Events for Covered Spouse: If you are the covered spouse of an employee of the CPS, you have the right to elect continuation coverage for yourself if you lose group health coverage for any of the following reasons:

- 1) a termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment,
- 2) the death of your spouse,
- 3) divorce from your spouse

Qualifying Events for Covered Dependent Children: If you are the covered dependent child of an employee of the CPS, you have the right to elect continuation coverage for yourself if you lose group health coverage for any of the following reasons:

- 1) the termination of your parent's employment with the CPS (for reasons other than gross misconduct) or the reduction in his or her hours of employment with the CPS
- 2) the death of the your parent who works for the CPS
- 3) your parents divorce or
- 4) you cease to be a dependent under the terms of the plan

To verify that you have read the enclosed material, please sign on the line below and insert today's date. Return this page with the attached election form.

Signature

Date

NOTE: PLEASE KEEP A COPY OF THIS PACKAGE FOR YOUR REFERENCE.

IMPORTANT EMPLOYEE, SPOUSE, AND DEPENDENT NOTIFICATIONS REQUIRED

Under the law, a CPS employee, his or her spouse, or his or her dependents have the responsibility to inform The Talent Office, Benefits Customer Service unit, of a divorce, legal separation, or a child losing dependent status under the terms of the plan. This notification must be made within 60 days from whichever date is later: the date of the event **or** the date on which coverage would be lost because of the event.

IMPORTANT: SECOND QUALIFYING EVENT

Every PHSA participant must notify the PHSA Administrator in the event of a second qualification. Multiple qualifying events occur when the first qualifying event (termination or a reduction in hours) is followed by another qualifying event. If this happens, the original 18-month period may be extended to 36 months from the date of the original qualifying event. **EXAMPLE:** A married employee was terminated from employment. As a result, he and his spouse lost their coverage. Both elected PHSA continuation coverage. If another qualifying event (such as death or divorce) were to occur during the 18-month period, the 18-month period may be extended to 36 months from the date of the original qualifying event.

PREMIUMS AND PAYMENTS

The current charge for each period depends upon the coverage option or options you elect as shown on the hospitalization rate chart. The premium charge includes a 2% administration fee. The premium charges shown reflect the individual's monthly cost.

Your initial payment will be for the period beginning on your **QUALIFICATION DATE** through the month in which you make your election. Your initial payment must be received within 45 days of the date you sign the enrollment form. If any regular monthly premiums are due during the 45-day billing period, those premiums must also be paid by the initial billing due date. After enrollment, you will receive an "Initial Billing Statement" and a set of coupons. Your initial billing and coupons will indicate your due date, amount due, and where to send payment. If you do not receive your coupons in the mail, please forward your monthly payment to us without a coupon and notify us so we can send you another coupon packet.

If your first payment, or any subsequent payment, is not received by the date on which payment is due, or, if you submit a check that comes back as "NON-SUFFICIENT FUNDS (NSF) " or which can otherwise not be processed before the expiration of your grace period, you will lose your option to continue coverage. Please note: effective January 1, 2004, a \$34.00 processing fee is required on all checks returned by your bank.

Once you have paid all amounts due within the INITIAL 45-day period, subsequent monthly payments are due on or before the first of each month. There is a 30-day grace period ending on the last day of the month for which payment is due. **Please be advised that your insurance carrier will NOT render services at any time unless that month's premium has been paid.**

RETIREES:

If you are retiring and will be receiving a pension from one of the pension funds, and if you are enrolled or will be enrolled in an annuitant health care plan, disregard the medical plan option listed in this notice. Your MEDICAL COVERAGE IS AVAILABLE TO YOU UNDER YOUR ANNUITANT MEDICAL PLAN.

Two commonly-used terms that pertain to an individual's ability to receive Medicare benefits are: 1) **eligible for** or 2) **entitled to**. An important distinction exists between these two terms. A person is generally eligible for Medicare when he or she reaches age 65 and is qualified to receive Social Security benefits. To be entitled to Medicare, a person must actually apply to commence Social Security income payments or file an application for hospital insurance benefits under Part A (hospital insurance) of Medicare. Certain individuals under age 65 and disabled are also entitled to Medicare after they have received Social Security disability payments for 24 months. For PHSA purposes, being eligible for Medicare has no meaning. Under the statutory language and the proposed regulations of the IRS, only entitlement to Medicare affects PHSA coverage. As long as an individual is entitled to benefits under Part A or Part B of Medicare at the time of the qualifying event, that person is considered entitled to Medicare for PHSA purposes. Whether an individual has applied to receive benefits under Part A and not Part B (which is a supplemental medical insurance program) has no bearing on the individual's Medicare entitlement status for PHSA purposes.

DISABLED INDIVIDUALS:

The 18-month COBRA period may be extended to 29 months if an individual is determined to be disabled according to the Social Security Act (SSA). If you qualify, you will be charged 150% of the applicable premium from the 19th through the 29th month of coverage. To qualify for the disability extension, you must get a formal disability determination from the Social Security Administration (SSA) that shows you were disabled at the time (or within 60 days) of your COBRA qualifying event. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11 month disability extension if one qualifies. After receiving the SSA decision, you must give the health plan administrator written notice of the SSA's determination within 60 days of receiving the letter and within your 18 month COBRA eligibility period.

HOW TO ENROLL IN PHSA (COBRA)

Please complete the enclosed PHSA (COBRA) Election Form and submit it with your initial payment to the following address:

**Chicago Public Schools Employee Services
320 North Elizabeth Street, First Floor
Chicago, Illinois 60607**

IF YOU WISH TO DROP A DEPENDENT, INSERT DEPENDENT'S INFORMATION HERE:

NAME _____ **BIRTHDATE** _____

CHECK ONE:

- (1.) _____ Coverage to be continued for myself only.
- (2.) _____ Coverage to be continued for myself and the eligible dependents shown below:

I understand that I can only continue coverage for dependents that were covered under my plan on the day before the event causing my qualification.

The dependent(s) I am requesting continuation coverage for are the following:

LAST NAME	FIRST	BIRTHDATE	MALE / FEMALE

PLEASE CIRCLE THE PLAN YOU WERE PREVIOUSLY ENROLLED IN:

- Blue Cross Blue Shield HMO Illinois**
- UnitedHealthcare HMO (Select EPO)**
- UnitedHealthcare PPO w/HRA**
- UnitedHealthcare PPO**
- Blue Cross Blue Shield PPO**

Please list PCP Site here for HMO plans: _____

I understand that this completed form must be returned to the PHSA Administrator within 60 days of my Notice Date. PHSA (COBRA) payments are retroactive to the last day of active group coverage, and I must back pay for that period before paying current months.

CHECK ONE OF THE FOLLOWING:

- _____ I am enclosing the first payment.
- _____ I will make the payment due within 45 days of the date I sign this form. **I am aware that no services will be rendered until payment for the month that I wish to receive services or get medication has been made.**

SIGNATURE OF CONTINUATION APPLICANT

DATE

MAKE CHECKS PAYABLE TO: CHICAGO PUBLIC SCHOOLS

Please submit your PHSA (COBRA) election form and initial payment to the following address:

**Chicago Public Schools Employee Services
320 North Elizabeth Street, First Floor
Chicago, Illinois 60607**

All subsequent payments must be mailed directly to the following COBRA lockbox address:

**Chicago Public Schools - COBRA
15669 Collections Center Drive
Chicago, Illinois 60693**

If you have any questions, please call 773-553-2820

**CHICAGO PUBLIC SCHOOLS
TALENT OFFICE**

**PHSA (COBRA) RATES
EFFECTIVE JANUARY 1, 2011 THROUGH DECEMBER 31, 2011**

PROVIDER	MONTHLY COBRA RATES:
BLUE CROSS HMO ILLINOIS	
SINGLE COVERAGE	\$305.09
COUPLE COVERAGE	\$577.97
FAMILY COVERAGE	\$862.32
UNITED HEALTHCARE HMO (Select EPO)	
SINGLE COVERAGE	\$422.65
COUPLE COVERAGE	\$808.81
FAMILY COVERAGE	\$1,226.46
UNITED HEALTHCARE PPO w/HRA	
SINGLE COVERAGE	\$259.18
COUPLE COVERAGE	\$491.80
FAMILY COVERAGE	\$737.34
UNITED HEALTHCARE PPO	
SINGLE COVERAGE	\$316.87
COUPLE COVERAGE	\$601.98
FAMILY COVERAGE	\$906.36
BLUE CROSS BLUE SHIELD PPO	
SINGLE COVERAGE	\$397.55
COUPLE COVERAGE	\$654.28
FAMILY COVERAGE	\$876.29
ENHANCED VISION (VSP)	
SINGLE COVERAGE	\$7.55
COUPLE COVERAGE	\$11.03
FAMILY COVERAGE	\$19.78
HMO DENTAL (Delta Dental)	\$19.77
PPO DENTAL (Delta Dental)	
SINGLE COVERAGE	\$20.44
COUPLE COVERAGE	\$40.89
FAMILY COVERAGE	\$63.71