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

Dear Dependent:

This is to advise you that you are no longer eligible to be covered under the Employee Health Plan of the Chicago Public Schools (CPS) as of the last day of the month in which you cease to be a dependent under the terms of the plan. You have 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 coverage under the Employee Group Health Plan terminates to elect continuation coverage. If you elect to continue coverage, your benefits can be continued until whichever of the following occurs first:

- the expiration of 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- our Employee Health Plan is no longer in force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 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 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

IMPORTANT EMPLOYEE, SPOUSE, AND DEPENDENT NOTIFICATIONS REQUIRED

Under the law, the Chicago public school employee, his or her spouse or other family member (dependents) have the responsibility to inform The Talent Office, Benefits Employee Services 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.

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.

**CHICAGO PUBLIC SCHOOLS
TALENT OFFICE**

PREMIUMS AND PAYMENTS

The current charge for each period depends upon the coverage option or options you elect. The charge for each option is shown on the attached 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.

DISABLED INDIVIDUALS

The 18-month COBRA period may be extended to 29 months if an individual is determined disabled according to the Social Security Act (SSA). If you qualify, you will be charged 150% of the applicable premium from the 19th month 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**

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

SELECT ONE:

FORMER EMPLOYEE DEPENDENT CHILD / SPOUSE ADDRESS CHANGE
 NAME CHANGE ACTIVE COVERAGE EXPIRED DENTAL (12 WEEKS EXPIRED)
 ADD DEPENDENT DROP DEPENDENT

NAME: _____ ID #: _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____

BUSINESS PHONE _____ HOME PHONE _____ BIRTHDATE _____

MALE FEMALE CIRCLE ONE: SINGLE MARRIED DIVORCED WIDOW(ER)

IF YOU ARE NOT THE CPS EMPLOYEE, PLEASE FILL IN THE EMPLOYEE'S NAME, SOCIAL SECURITY NUMBER, AND YOUR RELATIONSHIP TO THE CPS EMPLOYEE UNDER WHOM YOU WERE PREVIOUSLY COVERED:

EMPLOYEE NAME _____ ID #: _____ / _____ / _____

YOUR RELATIONSHIP TO THE EMPLOYEE: SPOUSE SON DAUGHTER OTHER DEPENDENT

IF YOU WISH TO CANCEL ALL PHSA HOSPITAL / MEDICAL INSURANCE, CHECK HERE: _____

IF YOU ARE NOT CONTINUING COVERAGE, PLEASE SIGN, DATE, AND RETURN TO THE PHSA ADMINISTRATOR.

SIGNATURE

DATE

.....
IF YOU ARE ELECTING TO CONTINUE MEDICAL COVERAGE, CHECK ONE:

SINGLE COVERAGE COUPLE COVERAGE FAMILY COVERAGE

I understand I must notify the PHSA Administrator when:

- * I become a covered employee under any medical insurance group plan.
- * I become entitled to medicare benefits
- * I reach the limiting age for coverage
- * Any dependents under my plan become covered by another group plan
- * I am divorced from a covered spouse

IF YOU ELECT TO CONTINUE IN THE ENHANCED VISION COVERAGE, CHECK ONE:

ENHANCED VISION (VSP)

Please check one: Single Couple Family

(You must have been enrolled in the enhanced vision plan prior to enrolling for COBRA and must be enrolled in a COBRA medical plan currently to be eligible for the enhanced vision plan).

IF YOU ARE ELECTING TO CONTINUE DENTAL COVERAGE, CHECK ONE:

HMO DENTAL (Delta Dental) PPO DENTAL (Delta Dental)

Please check one: Single Couple Family

(Dependents are only eligible to continue dental if they were previously covered under the employee's group dental plan.)

**CHICAGO PUBLIC SCHOOLS
OFFICE OF HUMAN CAPITAL**

**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