Perth Amboy Board of Education

ADMINISTRATION HEADQUARTERS BUILDING
178 Barracks Street
Perth Amboy, New Jersey 08861
Tel: (732) 376-6200 Fax: (732) 638-1004

Derek J. Jess
School Business Administrator/
Board Secretary

TO: Those Concerned

Enclosed please find the **Consolidated Omnibus Budget Reconciliation Act Fact Sheet (COBRA)** and a **Continuation Form**, which we ask you to read carefully.

Employees that are eligible for and want COBRA benefits must complete the designated form and forward it to the Business Office **(Attn: Leyshla Moscoso)** with a check to cover the first monthly payment. All insurance coverage begins on the first of the month; therefore, premium payments **must** be received by the Business Office before the first of each month. If you do **not** want/need coverage, please indicate this on the form, sign and return it to the Business Office.

If you have questions concerning COBRA coverage, please contact Leyshla Moscoso via phone (732) 376-6200, Ext 30-124 or e-mail: leysmoscoso@paps.net.

Very truly yours,

Derek J. Jess
School Business Administrator/Board Secretary

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

FACT SHEET

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers of state and local government agencies to continue health benefit coverage for employees, spouses and dependents in the event certain qualifying events take place which would normally separate them from eligibility for these benefits. As enumerated below, the following qualifying events must take place for you, your spouse or dependent to be eligible for COBRA benefits:

1. termination of employment (except for gross misconduct)
2. reduction of hours so that you or your dependent(s) no longer meet the eligibility requirements for coverage
3. in the event of death
4. in the event of divorce or legal separation
5. for covered dependent(s), when you enroll in Medicare
6. your child no longer qualifies as a dependent

In the event that one of the above occurs, you must notify the Board of Education Office within sixty (60) days of the occurrence. Individuals qualifying for COBRA benefits are responsible to prepay monthly premiums at a rate, which is consistent with the present cost to the Board of Education plus a 2% administrative fee. Failure to remit payment on time will result in termination of coverage on the 5th day following the month for which the prepayment is not received. You will not receive a statement or an invoice from the Board of Education but will be responsible to remit payment in a timely manner. Coverage may continue for up to 18 months for a single employee or 36 months for your dependents in the event of your death; or for your spouse in the event of your divorce or legal separation. I would emphasize that this process would only take place if one or more of the six (6) items listed above occur. If you are enrolled in Medicare but remain as an active employee, your spouse and dependents remain covered under your present health benefits coverage. In this event, COBRA does not apply.

The purpose of the legislation resulting in COBRA benefit coverage was to provide for a continuation of health benefits for individuals during an interim period when they or their dependents suddenly become ineligible for health benefits. It is not intended as a permanent arrangement. If within the 18 or 36 month period the individual or dependent becomes covered under another form of insurance either through employment or marriage, it is advisable at that time to relinquish the COBRA coverage from the Board of Education.

Enclosed is a Health Benefit Continuation Notice and Election form along with a premium rate schedule. This form must be completed and returned to the Board of Education Office with a check in the amount of the premium selected no later than ten (10) days prior to the "qualifying event" taking place. Coverage will remain identical to that is offered all full-time employees unless you elect what is termed as "core benefits". Core benefits are defined as medical and prescription, excluding insurance coverage for dental and vision.

Core benefit premiums are proportionately reduced. Please see the attached rate schedule for the correct premium prior to remittance.

Read all the accompanying material carefully. If you have any questions regarding your rights under COBRA legislation, please write to Mr. Derek J. Jess, School Business Administrator/Board Secretary, or to Mrs. Leyshla Moscoso of the Business Office.

PREMIUM RATES EFFECTIVE 7/1/2018

If you elect the **Health Benefit Continuation** as an **Applicant,** you must:

(1) Complete and return the Health Continuation Election Form to:

Perth Amboy Board of Education
178 Barracks Street
Perth Amboy, NJ 08861
Attn: Mrs. Leyshla Moscoso

(2) Pay:

a) the initial premium required for the Health Benefit Continuation.

Note:

The initial premium must cover the period from the date the qualifying event occurred.

b) subsequent monthly premiums in accordance with provisions of the Group Policy.

Monthly Premium Amount:

Coverage Type:	**Single**	**Family**
Medical/Prescription (only)	$ 1,110.00	$ 3,370.00
Medical/Prescription/Dental/Vision	$ 1,155.00	$ 3,510.00

Please make your check or money order payable to the "**Perth Amboy Board of Education**" and forward to the Board Office prior to the first of each month**.**

HEALTH CONTINUATION ELECTION FORM

1. ☐ Yes, I request continuation of my coverage under the Group Plan named above. I understand I must notify the Plan Administrator when I become:

   A. a covered employee under any group health plan;
   B. eligible for Medicare benefits;
   C. covered under another group plan. (This applies if the continuation applicant is a former/widowed spouse.)

2. The "Qualifying Event" which has occurred making me eligible for continuation benefits is checked below:

   ☐ termination of employment for any reason other than gross misconduct or reduction of hours.
   ☐ divorce or legal separation.
   ☐ death of employee or employee's spouse.
   ☐ employee or employee's spouse becoming eligible for Medicare.
   ☐ you as a dependent child ceasing to qualify under our plan.

   ☐ No, I do **not** wish to continue my coverage.

If "Yes" is checked in item "1" above, please complete items "3" and "4" below. Date, sign and return this form.

If "No" is checked in item "2" above, please date, sign and return this form to Mrs. Leyshla Moscoso.

3. Coverage is to be continued for:

Single Coverage	Family coverage
☐ Medical/Prescription only	☐ Medical & Prescription only
☐ Medical/Prescription/Dental/Vision	☐ Medical/Prescription/Dental/Vision

Names of dependents: DOB:

_____ _____

_____ _____

_____ _____

NOTE: Dependents may be continued only if they are covered as dependents under the group health plan on the date their coverage would otherwise terminate.

4. Continuation Applicant:

Effective date of insurance _____

Birth date (day, month, year) _____

Social Security Number _____

Street Address _____

City, State, Zip Code _____

Telephone number (_____) - _____

_____ _____
(Print Name of Applicant) (Print Name of Employee)

_____ _____
(Signature of Applicant) (Date Signed)