Pittsgrove Township School District

P.R.I.D.E. Patience Respect Integrity Diligence Empathy

2019 NEW HIRE GUIDE

in this guide

Pittsgrove Township School District strives to offer you and your eligible dependents a competitive and comprehensive benefits package. We encourage you to take the time to educate yourself about the benefit options available to you.

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status (see page 3 of this guide for more information).

IMPORTANT ENROLLMENT INFORMATION

Making Plan Changes

Unless you experience a qualified change in status, you cannot make changes to the benefits you elect until the next Open Enrollment period. Qualified status changes include: marriage, divorce, birth or adoption of a child, change in child's dependent status, death of spouse, domestic partner, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in your spouse's benefits or employment status.

If an eligible dependent had other coverage and such coverage is lost, the eligible dependent may be eligible for enrollment during a "special enrollment period," which is usually the 31-day period following the date that other coverage was lost, due to a qualified change in status.

You must notify Human Resources within 31 days of experiencing a qualified status change.

When to enroll in Benefits?

*You **MUST** complete an enrollment form if you choose to enroll you or your dependents in medical/prescription or dental benefits.*

Who is Eligible?

You are a benefits-eligible employee if you are full-time and working 25-30 hours per week (please refer to your negotiated contract).

Please remember that only eligible dependents can be enrolled; this includes your spouse, civil union partner or your eligible dependent(s) to age 26 for medical and prescription drug coverage.

Eligible dependents are covered under the Dental policy until the end of the calendar year in which they turn 23 regardless of student status.

If you have any questions or would like to enroll an eligible dependent, please contact Shelly Ellis for an enrollment form and restrictions.

MEDICAL PLAN OPTIONS: HORIZON

DIRECT ACCESS

BENEFIT DESCRIPTION	IN-NETWORK (BLUECARD NETWORK)	OUT-OF-NETWORK
Deductible Individual/Family	None / None	$100 / $250
Out-of-Pocket Maximum Individual/Family	$400 / $800	$2,000 / $5,000
Preventive Care Services	100%	100%, no deductible
PCP Office Visit	$10 copay	80% after deductible
Specialist Office Visit	$10 copay	80% after deductible
Diagnostic Laboratory	100% - Office or LabCorp 100% - Outpatient Facility	80% after deductible
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	100% - Office 100% - Outpatient Facility	80% after deductible
Emergency Room	$25 facility copay	$25 facility copay
Ambulance	90%	80% after deductible
Inpatient Hospital	100%	80% after deductible
Outpatient Surgery	100%	80% after deductible
Vision Routine Eye Exam Hardware	$10 copay Hardware Not Covered	Not Covered
Prescription Drug	90% MMRX	

MEDICAL PLAN OPTIONS: HORIZON

	POS $5/$10/$20 RX	
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible Individual/Family	None / None	$500 / $1,000
Out-of-Pocket Maximum Individual/Family	$4,000 / $8,000	
Preventive Care Services	100%	60% (no deductible)
Primary Care Physician (PCP) Required?	Required	
PCP Office Visit	$10 copay	60% after deductible
Specialist Office Visit	$10 copay	60% after deductible
Diagnostic Laboratory	100% - Office or LabCorp 100% - Outpatient Facility	60% after deductible
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	100% - Office 100% - Outpatient Facility	60% after deductible
Emergency Room	$35 facility copay	$35 facility copay
Ambulance	100%	60% after deductible
Inpatient Hospital	100%	60% after deductible
Outpatient Surgery	100%	60% after deductible
Vision - Routine Eye Exam/ Hardware	$10 copay (limited to one exam every 24 months) Hardware $100 in a 2-calendar year period	60% after deductible (limited to one exam every 24 months) Hardware $100 in a 2-calendar year period
PRESCRIPTION BENEFITS	**RETAIL** (UP TO A 30-DAY SUPPLY)	**MAIL ORDER** (UP TO A 90-DAY SUPPLY)
Generic	$5 copay	$5 copay
Preferred Brand	$10 copay	$15 copay
Non-Preferred Brand	$20 copay	$25 copay

MEDICAL PLAN OPTIONS: HORIZON

OMNIA 10*
$5/$10/$20 RX

BENEFIT DESCRIPTION	TIER 1	TIER 2 (INCLUDES BLUECARD NETWORK)
Deductible Individual/Family	None / None	$1,500 / $3,000
Out-of-Pocket Maximum Individual/Family	$400 / $800	$2,000 / $4,000
Preventive Care Services	100%	100%
Primary Care Physician (PCP) Required?	No	No
PCP Office Visit	$5 copay	$10 copay
Specialist Office Visit	$5 copay	$10 copay
Diagnostic Laboratory	100% - Office or LabCorp 100% - Outpatient Facility	100% - Office or LabCorp 100% - Outpatient Facility
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	Radiology - 100% in freestanding, hospital outpatient Imaging - 100% in freestanding, hospital outpatient	Radiology - 100% in freestanding, hospital outpatient Imaging - 100% after deductible in freestanding, hospital outpatient
Emergency Room	$25 copay	$25 copay
Ambulance	100%	100%
Inpatient Hospital	100%	Deductible then $150 per admission
Outpatient Surgery	100%	100% after deductible
Vision - Routine Eye Exam/Hardware	Exam: $5 copay Hardware: Not Covered	Exam: $10 copay Hardware: Not Covered
Vision - Pediatric	Routine Pediatric Vision Covered 1/year and Hardware Services are covered up to $125 every 1 year	
PRESCRIPTION BENEFITS	**RETAIL** (UP TO A 30-DAY SUPPLY)	**MAIL ORDER** (UP TO A 90-DAY SUPPLY)
Generic	$5 copay	$5 copay
Preferred Brand	$10 copay	$15 copay
Non-Preferred Brand	$20 copay	$25 copay

* Tier 1 Deductible /Maximum Out-Of-Pocket accumulates to Tier 2 Deductible /Maximum Out-Of-Pocket but Tier 2 Deductible /Maximum Out-Of-Pocket does not accumulate to Tier 1 Deductible /Maximum Out-Of-Pocket . Once Tier 2 Deductible /Maximum Out-Of-Pocket has been met, Consolidated Maximum Out of Pocket is Calendar Year. The deductible, coinsurance, prescription, and copayments apply to the Maximum Out of Pocket. Tier 1 will also have been met.

PRESCRIPTION DRUG PLAN:
HORIZON BCBS/PRIME THERAPEUTICS

If you are enrolled in the medical plans, you are automatically enrolled in the prescription drug plan through Horizon BCBS.

	RETAIL Up to a 30-day supply	MAIL ORDER Up to a 90-day supply
POS OR OMNIA PLANS		
Generic	$5 copay	$5 copay
Preferred Brand	$10 copay	$15 copay
Non-Preferred Brand	$20 copay	$25 copay

Save on your prescriptions with Mail Order

Using the mail order program for your maintenance medications will save you money. You will receive **up to a 90-day (3-month) supply** for two retail copays. In addition to the savings, your prescriptions will be delivered right to your home.

To begin using mail order, simply complete a mail order form at **www.horizonblue.com** and send along with your prescription(s) written for a 90-day supply of medication.

How much can you save when you use Mail Order?
Compare for yourself…

RETAIL PHARMACY	MAIL ORDER	ANNUAL SAVINGS
Preferred Brand-Name Copay **$10**	Preferred Brand-Name Copay **$15**	**$60**
Annual cost *($10 per month x 12 fills)* **$120**	Annual cost *($15 per order x 4 fills per year)* **$60**	

OMNIA DOCTOR FINDER

Use the Doctor & Hospital Finder to find participating doctors, health care professionals and hospitals.

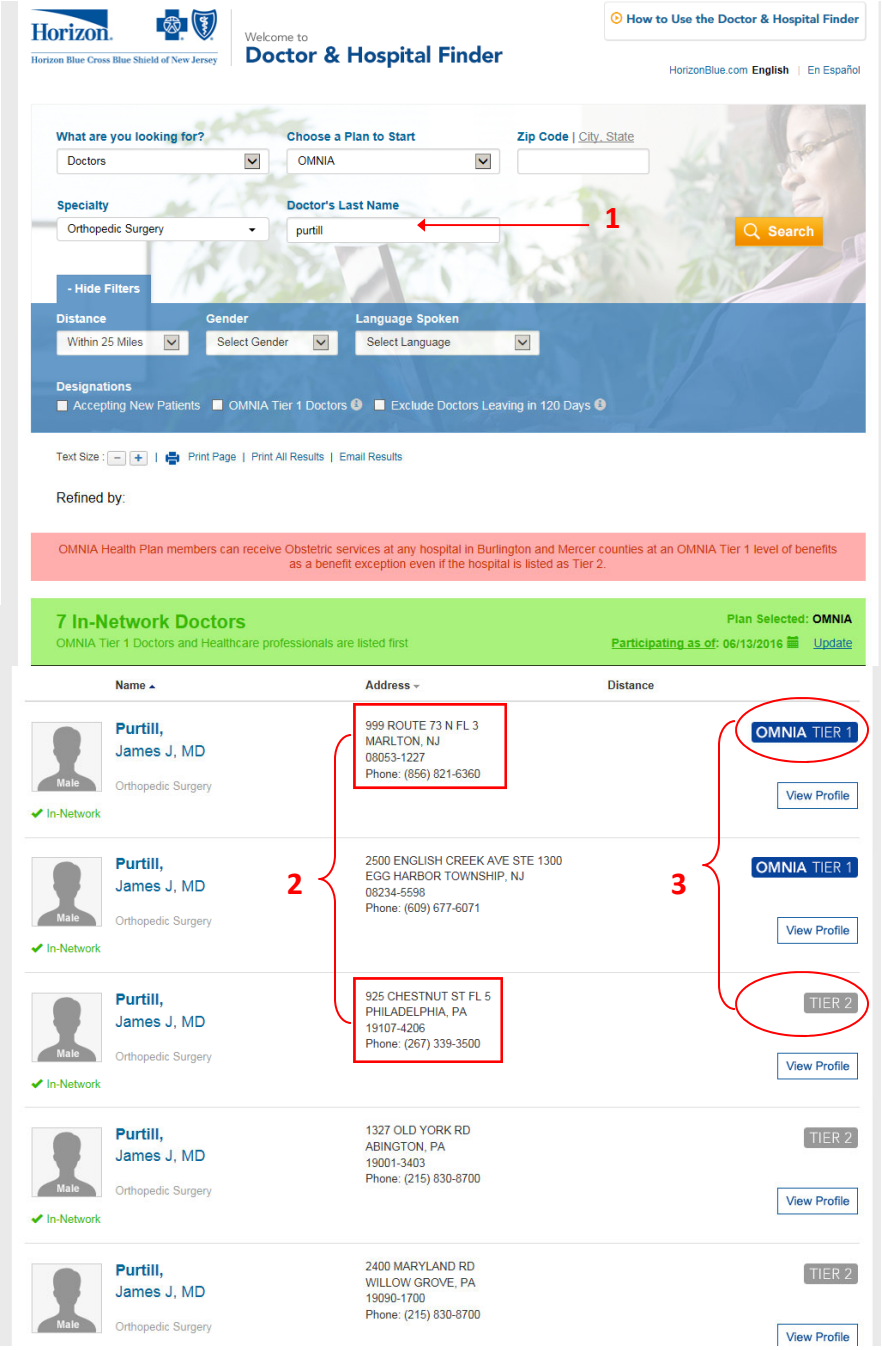
- Select Doctors in the "What are you looking for?" drop down box.
- Select OMNIA in the "Choose a Plan to Start" drop down box.

The status of Tier 1 or Tier 2 is rendered at the TIN/ Practice level of the physician (because physicians can be "affiliated" with multiple facilities/ practices or hospitals).

1. Look up Physician
2. Look at doctor addresses
3. NOTE TIER LEVEL (1 OR 2) before you schedule your appointment.

Physicians can be "affiliated" with multiple facilities/ practices or hospitals so the status of Tier 1 or Tier 2 is rendered at the TIN/ Practice level of the physician.

- Tier status is rendered at the TIN/ practice level
- The OMNIA network uses the Horizon BCBS "Managed Care Network" which is also the provider network for these products: Horizon EPO, Horizon Direct Access, Horizon POS, and Horizon MyWay HRA.
- "The new OMNIA Health Plans offer significantly lower premiums for access to the largest network in New Jersey. Plus, save even more with lower out-of-pocket costs at certain doctors and hospitals. "



MAKING THE MOST OF YOUR OMNIA PLAN BENEFITS

Take the guesswork out of your health care coverage!

Getting Lab Tests with Your OMNIA Health Plan

When you need clinical laboratory tests, your doctor may collect specimens at his or her office or send you to a Laboratory Corporation of America (LabCorp) or AtlantiCare Clinical Laboratories patient service center. Labcorp and AtlantiCare Clinical Laboratories are the exclusive in-network clinical laboratory providers for members enrolled in OMNIA Health Plans.

If your doctor sends you to a lab for services, he or she will give you a LabCorp Requisition Form. This form may be used at Labcorp or AtlantiCare Clinical Laboratories. Simply present the form and your Horizon BCBSNJ member ID card when you check in at the lab. If you get a bill from LabCorp or AtlantiCare Clinical Laboratories, please call Member Services at the phone number on the back of your member ID card.

To find an in-network lab:

- You can find the LabCorp Patient Service Center nearest you at labcorp.com/psc.
- You can find the AtlantiCare Clinical Laboratory nearest you at atlanticare.org/index.php/locations-home.
- IMPORTANT: If you use a testing facility other than LabCorp or AtlantiCare Clinical Laboratories, your tests will not be covered and you will have to pay the total cost.

OMNIA Top 10 Tips

1. Carry your member ID card. It is the key to accessing your Horizon BCBSNJ benefits. Show it when you see your doctor or any health care professional, or go to a hospital.
2. You do not need to choose a Primary Care Physician (PCP).
3. You can see in-network doctors without a referral.
4. You can use doctors and other health care professionals who are in the Horizon Managed Care Network and any hospital in the Horizon Hospital Network. Visit HorizonBlue.com/doctorfinder to look for in-network doctors, other health care professionals and hospitals.
5. You pay less out of your pocket when you use an OMNIA Tier 1-designated doctor, other health care professional or hospital.
6. You have 24/7 access to talk face-to-face with U.S. board-certified, licensed doctors from your computer or web-enabled mobile device through Horizon CareOnline.
7. You have access to more than 96 percent of retail pharmacies in New Jersey to fill your prescriptions, or you can set up convenient home delivery pharmacy service through Horizon Pharmacy.
8. You do not have out-of-network benefits for non -emergency care.
9. Register for Member Online Services1 at register.HorizonBlue.com, then sign in at members.HorizonBlue.com. You can see detailed information about your plan, benefits and claims. You can even print a temporary member ID card. Sign in to take advantage of health and wellness tools, educational resources and more. Have a mobile device? We have an app for that. Download the Horizon Blue App from the App Store or Google Play.
10. Enjoy member-exclusive discounts on fitness and healthy living services. Visit Blue365deals.com for details.

DENTAL PLAN OPTIONS: HORIZON BCBS OF NJ

	Dental Option Plan	Dental TotalCare Plan
Annual Plan Deductible Individual Family	None / None	N/A
Out-of-Network Benefits?	Yes	No
Annual Maximum	$1,000 per person	None
Orthodontia Benefits (children age 19 and below)	N/A	Plan pays 100% (treatment beyond 24 months subject to an office visit copay per visit)
Exams & Preventive Services Eligible exams Fluoride treatment (child) Sealant application Prophylaxis	Plan Pays 100%	Plan Pays 100%
X-rays^ Panoramic Full-mouth X-rays	Plan Pays 100%	Plan Pays 100%
Restorations and Repairs*^	Plan pays 70%	Plan pays 100%
Endodontics*^ Pulp cap/Pulpotomy Root canal therapy – anterior, bicuspid	Plan pays 70%	Plan pays 100%
Periodontics*^ Scaling and root planning Gingivectomy Soft tissues grafts Periodontal maintenance	Plan pays 70%	Plan pays 100%
Oral Surgery *^ Routine extractions Soft tissue surgical extractions Incision and drainage of abscess	Plan pays 70%	Plan pays 100%
Major Restoration *^ Crowns	Plan pays 70%	Plan pays 100%
Dentures*^ Complete and partial dentures	Plan pays 50%	Plan pays 100%
Fixed Bridges*^ Retainers and pontics	Plan pays 50%	Plan pays 100%

* Deductible applies
^ Annual Maximum applies

QUESTIONS & ANSWERS

What forms MUST be completed?

Employee MUST complete the Horizon enrollment form to be enrolled in medical/prescription drug and/or dental coverage.

Where do I find these forms?

Contact Shelly Ellis, the Human Resources Administrator at 856-358-3094 ext 4019 for all forms.

Whom do I contact with questions?

Contact Conner Strong & Buckelew's Member Advocacy Unit at 800-563-9929.

BENESERVICE

AVAILABLE MONDAY-FRIDAY, 8:30 AM - 5:00 PM EST

BeneService, provided by our benefits consultant, Conner Strong & Buckelew, allows you to speak to a specially trained and licensed Client Service Associate who can assist with benefit claims issues, coverage questions, and enrollment inquiries.

You can contact a Client Service Associate in one of two ways:

Call BeneService at 800.563.9929, Mon—Fri, 8:30 am—5:00 pm EST

OR

Submit a request online at www.connerstrong.com/beneservice

Pittsgrove Township School District reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail.

LEGAL NOTICES

HIPAA/CHIP Special Enrollment Notice

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP).

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Human Resources.

Grandfathered Plan Notice

This group health plan believes the Pittsgrove Township School District prescription drug plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury,

Pittsgrove Township School District offers a series of health coverage options. You may request a copy of the SBC from Human Resources. These documents summarize important information about all health coverage options in a standard format. Please contact the Benefits Department if you have any questions.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: www.medicaid.georgia.gov
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739 or 651-431-2670

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Model General Notice of COBRA Continuation Coverage Rights

You're getting this notice because you recently gained coverage under a group health plan Pittsgrove Township Board of Education. 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 Pittsgrove Township BOE, 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: Shelly Ellis.

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.

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

Pittsgrove Township Board of Education
Shelly Ellis
856-358-3094 ext 4019