— COBRA NOTICE INSTRUCTIONS —

Continuation of State Health Benefits Coverage Under Cobra

State Health Benefits Program and School Employees' Health Benefits Program

EXTENDED COBRA BENEFITS

Under The American Recovery and Reinvestment Act

An extension of the American Recovery and Reinvestment Act (ARRA) of 2009 provides for an expansion of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) into 2010 and creates a fifteen-month, federal subsidy of COBRA premiums for certain involuntarily terminated employees.

The following is a brief description of the eligibility criteria and extended COBRA benefits provided under the ARRA.

- To be eligible for the COBRA premium subsidy, an individual must have been *involuntarily* terminated from employment on or after September 1, 2008 and prior to May 31, 2010. Qualifying dependents may also be eligible for a COBRA premium subsidy.
- Eligible individuals currently enrolled in COBRA (covered *involuntarily* terminated employees and qualifying dependents), will receive a COBRA premium subsidy for up to fifteen months that can begin no earlier than March 1, 2009. Eligible individuals are responsible for paying only 35% of the regular COBRA premium.
- Eligibility as an *involuntarily* terminated employee must be verified by the employer and indicated on the COBRA notice.
- Assistance eligible individuals whose continuation coverage was discontinued following the expiration of their nine-month subsidy period have the right to pay back premiums and be retroactively reinstated. To qualify for reinstatement, the individual should contact the Health Benefits Bureau of the Division of Pensions and Benefits immediately to arrange for the payment on any back premiums.
- Assistance eligible individuals who maintained continuation coverage by paying the full COBRA premium after the nine-month subsidy period will have their COBRA bill adjusted to reflect the subsidy amount. Individuals who reached the end of the reduced premium period before the subsidy extension will receive a credit for any overpayment due on a future bill.
- **The provisions of the ARRA <u>do not</u> extend the period of COBRA coverage eligibility period.** In most cases 18-months is the period of COBRA eligibility following termination of employment.
- Individuals with incomes over certain salary limits[1], who become eligible for another group health plan or Medicare, who voluntarily terminated employment, or who were *involuntarily* terminated for reasons of gross misconduct are not eligible for the subsidy.

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[1]Individuals with annual income exceeding $145,000 per year, and couples with income exceeding $290,000 per year, are not eligible for the subsidy and will pay the full COBRA premium. The subsidy is also phased out starting at $125,000 for individuals and $250,000 for couples. Individuals who receive subsidies during a year in which they exceed these income limits will be required to repay the subsidy. Subsidy repayments are captured on the individual's federal income tax return. Individuals may also make a permanent election to waive the subsidy. It is not the employer's responsibility to verify the income of former employees.

HC-0070-0110

— COBRA NOTICE —
CONTINUATION OF STATE HEALTH BENEFITS PROGRAM COVERAGE UNDER COBRA

This page is to be completed by Employer (Please print or type)

To the Family of —

_____

_____

_____

_____

SS#: _____

Notice Date: _____

Employer Name: _____

Emp ID #: _____

EMPLOYEE TYPE:

☐ 10 month

☐ 12 month

Dear Employee and/or Dependent(s):

Your health care coverage under the State Health Benefits Program (SHBP) terminates as shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage, the type(s) of coverage lost and the last day of coverage(s) are shown in the notice below. Under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you are entitled to continue your medical benefits with the group program for a limited time.

If you wish to continue coverage under the provisions of COBRA, you must enroll at this time. Otherwise, you will lose coverage and you cannot enroll later.

You may continue the group coverage(s) shown below under COBRA, at your own expense, for the time period shown in the COBRA Continuation Term or until one of the following conditions occur: (1) you voluntarily cancel your coverage; (2) you become covered under MEDICARE or another group plan after you elect COBRA coverage (Note: Exceptions are made if your other group has a pre-existing condition clause that affects you); (3) you fail to pay your premiums in a timely manner; or (4) your employer ends participation in the State Health Benefits Program.

If you are retiring, you may be eligible for lifetime health and prescription drug coverage through the Retired Group of the State Health Benefits Program. Consult your employer or the Division of Pensions and Benefits **PRIOR** to enrolling for health and prescription drug benefits under COBRA.

In considering whether to elect continuation of coverage under COBRA, you should take into account that you cannot enroll at a later date and that a failure to continue your group health coverage may affect your future rights under federal law. Please refer to Fact Sheet #30, *Continuation of Coverage Under COBRA,* for more information on your election of COBRA coverage.

If you wish to continue your group coverage under the provisions of COBRA, complete the application on the reverse side and send it to the **Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ, 08625-0299**. If you elect to continue coverage, you will be enrolled so you have no break in coverage. After your application is processed (allow up to three weeks), you will be sent a letter of confirmation of enrollment indicating the beginning date(s) of your COBRA coverage(s) and the length of your COBRA eligibility. The SHBP will send you an invoice of premiums that are due for your coverage (this may include retroactive premiums).

You should make a copy of this notice and your completed application for your records prior to mailing the originals to the Division of Pensions and Benefits. After mailing, if you do not receive the confirmation of enrollment identified in the preceding paragraph, you should contact the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524 or by e-mail at *pensions.nj@treas.state.nj.us*

COBRA EVENT: (check one)

- ☐ Retirement
- ☐ Privatization
- ☐ Termination other than Retirement/Privatization
- ☐ Reduction in Hours
- ☐ Leave of Absence
  - — State/Federal Family Leave
  - — Other
- ☐ Death
- ☐ Divorce or Separation/Dissolution of Civil Union or Domestic Partnership
- ☐ Dependent ineligibility
  - — Over age 23
  - — Marriage/Civil Union
  - — Moved out
- ☐ Medicare Entitlement

CURRENT COVERAGE TYPE: (check one)

	HEALTH PLAN		NON-CORE PLAN		
	HMO	NJ PLUS	Dental	Rx	Vision (State Only)
	( ) S ( ) M&S/CU ( ) M&DP ( ) P&C ( ) F	( ) S ( ) M&S/CU ( ) M&DP ( ) P&C ( ) F	( ) S ( ) M&S/CU ( ) M&DP ( ) P&C ( ) F	( ) S ( ) M&S/CU ( ) M&DP ( ) P&C ( ) F	( ) S ( ) M&S/CU ( ) M&DP ( ) P&C ( ) F

S = Single M&S/CU = Member and Spouse or Civil Union Partner
M&DP = Member and Domestic Partner P&C = Parent and Child
F = Family

HMO Plan _____

Dental Plan _____

DATE OF COBRA EVENT: _____

CONTINUATION TERM: _____ months of COBRA eligibility.

LAST DATE OF COVERAGE (Month/Date/Year): Health _____ Dental _____ Rx _____ Vision _____

EMPLOYER CONTACT AND TELEPHONE #: _____

_____

Signature of Certifying Officer

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE OR THE LAST DATE OF COVERAGE, WHICHEVER IS LATER, TO ELECT COVERAGE UNDER COBRA. FAILURE TO RESPOND WITHIN THIS TIME PERIOD IS CONSIDERED A DECISION NOT TO CONTINUE COVERAGE.

NEW JERSEY STATE HEALTH BENEFITS PROGRAM COBRA APPLICATION

HC-0070-0110

1. APPLICANT INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number ___ - __ - ____ Last Name _____ Title (Jr., Sr., etc.) ___

First Name _____ MI ___

Street Address (Include Apartment #) _____

City _____ State __ ZIP Code + 4 _____ - ____

Date of Birth (mm/dd/yy) ____ Gender (M/F) ___ Relationship to Employee _____

Status (Check One) ☐ - Single ☐ - Married ☐ - Civil Union ☐ - Domestic Partnership ☐ - Divorced ☐ -Widowed

(Area Code) ___ - ___ - ____ Home Telephone Number

2. CHANGE INFORMATION (if applicable)

Type ☐ Open Enrollment
☐ Special Enrollment
☐ Status Change (Indicate reason below)

Moved Out of Coverage Area (Date of Move) _____

Add Spouse (Date of Event) _____
(Attach Marriage Certificate)

Add Civil Union/Domestic Partner (Date of Event) _____
(Attach Civil Union or Domestic Partnership Certificate)

Add Dependent Child ☐ Birth ☐ Adoption/Guardianship (Proof Required)

(Date of Event) _____

Other (Specify) _____

DIVISION USE ONLY

Effective Dates: Event Reason:

H _____ _____ _____
P _____ _____ _____
D _____ _____ _____
V _____ _____ _____

Location # ____ Term (mos) ___

Note: A **Spouse** is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* is required for enrollment.

A **Civil Union Partner** is a person of the same sex with whom you have entered into a civil union. A photocopy of the *Civil Union Certificate* is required for enrollment.

A **Domestic Partner** is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. A photocopy of the *Certificate of Domestic Partnership* is required for enrollment. Your local/educational employer must have elected to provide SHBP domestic partner coverage.

Note: Your local/educational employer must have elected to provide the SHBP Group Dental Plans as a separate dental benefit to be eligible for this coverage. If you are eligible for dental coverage through another employer provided plan, do not complete this application.

Note: Your local/educational employer must have elected to provide the SHBP Employee Prescription Drug Plan as a separate prescription drug benefit to be eligible for this coverage. If you are eligible for prescription drug coverage through another employer provided plan, or if your employer does not provide any drug coverage, your SHBP medical plan will include a prescription drug benefit.

3. EMPLOYEE INFORMATION (if different from applicant)

Social Security Number ___ - __ - ____

Last Name _____

First Name _____

Date of Birth (mm/dd/yy) ____

4. COVERAGE ELECTION - Select the coverage desired and indicate with an **X** in the appropriate box.

TYPE OF COVERAGE	Single	Member & Spouse/Civil Union Partner	Member & Domestic Partner	Parent & Child(ren)	Family
Health: NJ PLUS					
Health: HMO					
Dental Expense Plan					
Dental Plan Organization					
State Prescription Drug Coverage					
Vision Care (State Only)					

5. HEALTH PROVIDER INFORMATION FOR APPLICANT

a. Name of HMO Plan _____

b. Your NJ PLUS or HMO Physician ID # _____

c. Name of DPO _____

d. Your DPO Dental Provider Name and Address _____

_____

6. DEPENDENT INFORMATION - List all eligible dependents you wish to enroll for coverage. Use a separate page for additional dependents.

☐ Spouse/Civil Union/Domestic Partner - Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's NJ PLUS or HMO Primary Care Physician ID#	Name of Dependent's Dentist or ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
Children								

7. ☐ **SSA DISABILITY EXTENSION** — Check this box if you have an approved Social Security Administration Disability and wish your COBRA term extended to up to 29 months. Attach a copy of the Social Security Administration Disability approval letter.

8. I certify that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend my group insurance coverage under the terms of the program. I understand that my coverage under COBRA will be continuous from the date benefits end. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments and further agree to make further payments in a timely fashion. I understand this COBRA coverage will terminate without notice if payment is not made on time. I understand that if I waive my right to coverage at this time, enrollment is not normally permissible at a later date. I also understand that there is no guarantee of continuous participation by medical or dental service providers, either doctors, dentists, or facilities in the NJ PLUS, HMO, or DPO plans. If my physician, dentist, or medical/dental center terminates participation in my selected plan, I must elect another doctor/dentist or medical/dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical or dental plan or its assignee with such medical or dental information about myself or my covered dependents as the assignee may require. I agree to notify the COBRA Administrator if I or any of my covered dependents become covered under another group health or dental plan or become entitled to Medicare after I elect coverage under COBRA.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Applicant's Signature _____ Date Completed _____

DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED

HB-0840-0510

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and their eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex to whom you are legally married.	A photocopy of the *Marriage Certificate* **and** a photocopy of the top half of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the top half of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the top half of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
CHILDREN	Your unmarried children under age 23 who: live with you in a regular parent-child relationship; are away at school; or are divorced children living at home provided that they are dependent upon you for support and maintenance. If you are a single parent, divorced, or legally separated, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you, are under the age of 23, and are substantially dependent upon you for support and maintenance.	**Natural Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren)** – Photocopies of Affidavits of Dependency, Final Court Orders with the presiding judge's signature and seal, **or** Adoption Final Decree with the presiding judge's signature and seal. **AND** **Along with the documentation listed above,** a photocopy of the top half of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the child.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 23 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "Child" dependent type as noted above (including tax forms*) **and** if Social Security disability has been awarded, or is currently pending, please include this information in the documentation submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVER AGE CHILDREN	Certain dependent children may be eligible for continued coverage under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "Child" dependent type as noted above (including tax forms*) **and** if the over age child is not listed on the employee/retiree's tax return, a copy of the top half of the child's most recently filed filed federal tax return* (*Form 1040*) is required **and** if the child resides outside of the State of New Jersey, documentation of full-time student status must be provided.

****Note:** For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org***
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: ***www.state.nj.us/health/vital/index.shtml***