

Separation of Service

2027

Separation of Service

Retirement or Termination

How do I continue insurance coverage after retirement or termination from employment?

Many of the insurance benefits offered through Citrus County School Board allow you to continue coverage once you leave employment. Employees can continue coverage in one of the following ways:

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Group health benefits include:

- **Health Insurance** *offered through* **Florida Blue**
- **Dental Insurance** *offered through* **Ameritas**
- **Vision Insurance** *offered through* **Ameritas**
- **Hospital Indemnity** *offered through* **American Public Life**
- **Flexible Spending Accounts** *offered through* **National Benefit Services**

Portability & Conversion Option

Employees may also continue other benefit plans that are not COBRA eligible through Portability or Conversion options. These plans include:

- **Telehealth Service** *offered through* **Access Medical**
- **Emergency Medical Transportation** *offered through* **MASA**
- **Identity Theft Protection** *offered through* **LifeLock**
- **Term Life Insurance** *offered through* **OneAmerica**
- **AD&D** *offered through* **Cigna**
- **Permanent Life Insurance** *offered through* **Texas Life**
- **Universal Life Insurance** *offered through* **Mass Mutual**
- **Accident Insurance** *offered through* **American Public Life**
- **Cancer Insurance** *offered through* **American Public Life**
- **Critical Illness Insurance** *offered through* **Sun Life**

Important Information: **Coverage terminates the end of the month following your last contracted day.**

Please review the information found within this packet for specific instructions on how to continue your insurance coverage once you leave employment.

COBRA

Dental, Vision, Hospital Indemnity & FSAs

COBRA Administration

Dental, Vision, Supplemental Medical & Flexible Spending Accounts

Administrative Contact Information:

Health Plan	Provider	Administrator	Phone Number
Dental	Ameritas	CBG Services	800-749-6458
Vision	Ameritas	CBG Services	800-749-6458
Hospital Indemnity	American Public Life	CBG Services	800-749-6458
Flexible Spending Account	National Benefit Services	CBG Services	800-749-6458

Total Monthly Cost:

Dental	Basic Plan	Select Plan
Employee Only	$21.44	$37.68
Employee + One	$40.88	$71.24
Employee + Family	$72.92	$123.76

Vision	
Employee Only	$9.60
Employee + Family	$27.06

Hospital Indemnity	$1,500 HIP	$2,500 HIP	$3,000 HIP
Employee Only	$23.34	$36.66	$46.92
Employee + Family	$46.08	$72.84	$93.42

Flexible Spending Accounts	
	Current Monthly Premium Deducted From Payroll

Premium Remittance:

Participants will need to remit COBRA premiums to the following address beginning the first day of the month COBRA coverage goes into effect. If payments are not received within 60 days of the due date, then the insurance company will terminate the participant's coverage. Participants will not receive a monthly billing and it is the responsibility of the participant to remit premiums in a timely manner.

Make Checks Payable to: **CBG Services FBO CCSB**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco, TX 76703

Premium Due Date:	9/1	10/1	11/1	12/1	1/1	2/1
Coverage Effective Date:	September	October	November	December	January	February

Premium Due Date:	3/1	41	5/1	6/1	7/1	8/1
Coverage Effective Date:	March	April	May	June	July	August

CCSB

COBRA Continuation Coverage Election Form

Employee Information:

Name:_____ SSN:_____

Mailing Address:_____

City:_____ State:____ Postal Code:_____

I (We) elect COBRA continuation coverage in the following plans listed below:

- ☐ Dental Circle all that apply: Employee | Spouse | Child(ren)
- ☐ Vision Circle all that apply: Employee | Spouse | Child(ren)
- ☐ Supplemental Medical Circle all that apply: Employee | Spouse | Child(ren)
- ☐ Flexible Spending Account

Dependent Information:

Name	Relationship	SSN	DOB

_____ _____

Signature Date

_____

Print Name

Mail Completed Form with first Month Premiums to:

CBG Services FBO CCSB
PO Box 827
Waco, TX 76703

Month 1 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 2 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 3 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 4 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 5 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 6 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 7 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 8 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 9 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 10 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 11 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 12 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 13 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 14 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 15 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 16 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 17 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Month 18 **COBRA Premium Remittance** **Date:_____**

Remit Premiums to: **CBG Services FBO CCSB**
PO Box 827
Waco Texas

Amount Remitted:
_____

Portability & Conversion

Portability & Conversion

Participants have 31 days from the date benefits terminate to elect portability and/or conversion for all eligible benefits

CCSB's Employee Benefit Portal: **https://portal.mycbgbenefits.com/ccsb**

Term Life Insurance *offered through* **OneAmerica**

Click on the **Continue Coverage Options** found on CCSB's Employee Benefit Portal. Once complete please submit your application to OneAmerica **within 31 days of your date of termination.**

Contact ***OneAmerica*** at **800.553.5318** for more information.

Emergency Medical Transportation *offered through* **MASA**

Download, Review and Complete the **Continuation Application** found on CCSB's Employee Benefit Portal. Once complete please return to MASA Medical Transportation Solutions.

Identity Theft Protection *offered through* **Norton LifeLock**

If you decide to continue your coverage you will be signing up for Norton LifeLock's consumer plan with a 35% discount for the first year. Contact **Norton LifeLock** at **866-456-9316** to continue your coverage. Make sure to mention Promo Code: **WB3**

Telehealth *offered through* **Access Medical**

Contact ***Combined Benefits Group*** at **800.749.6458** to convert your plan to an individual plan.

Accidental Death & Dismemberment *offered through* **Cigna / New York Life**

Download, Review and Complete the **Conversion Application** found on CCSB's Employee Benefit Portal. Once complete please return to CCSBs Risk Management Department within 31 days of your date of termination. If you have questions regarding your coverage contact 800.441.1832.

Universal Life *offered through* **Mass Mutual**

Contact ***Mass Mutual*** at **844.975.7522 option 1** to continue your current coverage through direct billing or bank draft.

Permanent Life *offered through* **Texas Life**

Contact ***Texas Life*** at **800.283.9233** to continue your current coverage through direct billing or bank draft.

Accident *offered through* **American Public Life**

Contact ***American Public Life*** at **800.256.8606** to continue your current coverage through direct billing or bank draft.

Cancer Insurance *offered through* **American Public Life**

The cancer insurance can be continued under the group portability coverage after you have been covered for 12 continuous months. Contact ***American Public Life*** at **800.256.8606** for more information.

Critical Illness *offered through* **Sun Life**

Contact ***Sun Life Financial*** at **800.786.5433** to continue your current coverage through direct billing or bank draft.

COBRA Notification

** CONTINUATION OF COVERAGE RIGHTS UNDER COBRA**

INTRODUCTION

THIS NOTICE HAS IMPORTANT INFORMATION ABOUT YOUR RIGHT TO CONTINUE COVERAGE UNDER COBRA, 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.

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."

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;
- 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 THE DISTRICT.

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. [*ADD DESCRIPTION OF ANY ADDITIONAL PLAN PROCEDURES FOR THIS NOTICE, INCLUDING A DESCRIPTION OF ANY REQUIRED INFORMATION OR DOCUMENTATION, THE NAME OF THE APPROPRIATE PARTY TO WHOM NOTICE MUST BE SENT, AND THE TIME PERIOD FOR GIVING NOTICE*.]

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.

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.

CITRUS COUNTY SCHOOL BOARD
MANNY NEGRON
1007 WEST MAIN STREET
INVERNESS, FL 34452

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.