IBEW/Western Utilities Health & Welfare Trust Fund

PACIFICORP

2024 Local 77 COBRA Enrollment

To: Local 77 COBRA Participants of the IBEW/Western Utilities Health and Welfare Trust Fund

From: Board of Trustees

Welcome to your 2024 COBRA enrollment opportunity with the IBEW/Western Utilities Health and Welfare Trust Fund. The Enrollment Guide contains information for active employees, but it also provides COBRA participants with the Trust Fund's medical plan information.

As a COBRA participant with the Trust Fund, you are eligible to enroll in one of the medical plans — the Consumer Driven Health Plan, the Comprehensive Health Plan, the Premium Health Plan, or the Premium Plus Plan. You are also eligible for dental and vision coverage.

The elections you make will take effect January 1, 2024, and continue through December 31, 2024, as long as you are eligible for COBRA coverage and you make the required monthly contributions. You will not be allowed to make changes in your coverage until the next open enrollment period (if you are eligible for coverage at that time) unless you have a qualified change in status.

Therefore, please:

- Disregard information in the Enrollment Guide about enrollment procedures, life and accident insurance, and flexible spending accounts.
- Complete an enrollment form to:
  - Indicate your medical option, and
  - Update your dependent information.

Contribution Rates

The 2024 contribution rates for COBRA participants are shown in the chart below. COBRA participants pay 100% of the group rate cost of coverage, plus a 2% administrative fee, for a total of 102%. For payment information, contact the Administrative Office at **855-617-2478**.

	Consumer Driven Health Plan	Comprehensive Health Plan	Premium Health Plan	Premium Plus Plan	Dental Plan	Vision Plan
Regular COBRA						
You only	**$670.00**	**$753.00**	**$831.00**	**$893.00**	**$50.00**	**$7.00**
You + spouse or You + 1 child	**$1,321.00**	**$1,500.00**	**$1,660.00**	**$1,790.00**	**$99.00**	**$14.00**
You + children or You + family	**$1,912.00**	**$2,211.00**	**$2,450.00**	**$2,645.00**	**$145.00**	**$21.00**
Extended COBRA						
You only	**$986.00**	**$1,108.00**	**$1,222.00**	**$1,314.00**	**$73.00**	**$11.00**
You + spouse or You + 1 child	**$1,944.00**	**$2,206.00**	**$2,441.00**	**$2,633.00**	**$145.00**	**$21.00**
You + children or You + family	**$2,812.00**	**$3,252.00**	**$3,604.00**	**$3,890.00**	**$214.00**	**$31.00**

What You Need To Do

For COBRA medical, dental, and vision coverage, you must complete an enrollment form and return it to the Administrative Office, BeneSys Administrators, at P.O. Box 215, San Ramon, CA 94583.

If you do not complete and return a form, you will not have COBRA coverage.

Questions?

If you have any questions regarding the COBRA contribution rates or the enrollment process, contact the Administrative Office at **855-617-2478**.

The Trustees

IBEW/Western Utilities Health & Welfare Trust Fund

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2024 Local 77 COBRA Enrollment Form

Participant Information

Please Print

Name: _____ **Employee #:** _____

Address: _____ **Social Security #:** _____

City, State, ZIP: _____ **Phone #:** _____

Birth Date: _____

Instructions:

1. Indicate if you are a former employee or dependent electing coverage.
2. Select the plan and level of coverage you would like for 2024.
3. If you are covering dependents, complete the Dependent Information section.
4. Sign and date this enrollment form.

Reason for COBRA enrollment:

☐ **Former Employee — maximum 18-month COBRA continuation coverage. Employment Termination Date:** _____

☐ **Dependent — maximum 36-month COBRA continuation coverage.**

	Choose One Medical Plan Only:						
		Consumer Driven Health Plan	**Comprehensive Health Plan**	**Premium Health Plan**	**Premium Plus Plan**	**Dental Plan**	**Vision Plan**
Regular	You only	☐ $670.00	☐ $753.00	☐ $831.00	☐ $893.00	☐ $50.00	☐ $7.00
	You + spouse or You + 1 child	☐ $1,321.00	☐ $1,500.00	☐ $1,660.00	☐ $1,790.00	☐ $99.00	☐ $14.00
	You + children or You + family	☐ $1,912.00	☐ $2,211.00	☐ $2,450.00	☐ $2,645.00	☐ $145.00	☐ $21.00
Extended	You only	☐ $986.00	☐ $1,108.00	☐ $1,222.00	☐ $1,314.00	☐ $73.00	☐ $11.00
	You + spouse or You + 1 child	☐ $1,944.00	☐ $2,206.00	☐ $2,441.00	☐ $2,633.00	☐ $145.00	☐ $21.00
	You + children or You + family	☐ $2,812.00	☐ $3,252.00	☐ $3,604.00	☐ $3,890.00	☐ $214.00	☐ $31.00

Dependent Information — Use separate paper to provide information for additional dependents.

Relationship	**Name** (First, MI, Last)	**Social Security Number**	**Gender (M/F)**	**Birthdate** (MM/DD/YYYY)
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

SIGNATURE

All of the statements I have made on this form are true and accurate to the best of my knowledge. I authorize the release of any medical information necessary for processing claims submitted under these plans. I understand I cannot change my elections unless I have a qualified family status change or until next year's open enrollment period, if eligible. I understand that if I fail to notify the Administrative Office within 31 days of a dependent no longer qualifying to be covered, I will continue to be charged for that coverage even though the dependent is no longer on the plan. Your COBRA contribution rate is due by the first day of the coverage month, but there is a 30-day grace period to make those payments. If payments are not made within this time frame, COBRA Continuation Coverage will be canceled as of the due date (first day of the month). I agree to abide by the terms of the plan and to notify the Administrative Office of any changes affecting eligibility. I agree to and acknowledge that if I fail to abide by plan terms or defraud the plan in any manner, my benefits will be denied, my coverage will be terminated, and disciplinary action may be taken against me.

_____ _____

Participant Signature Date

RETURN COMPLETED FORM TO: BeneSys Administrators at P.O. Box 215, San Ramon, CA 94583
If you have questions, call the Administrative Office at 855-617-2478