IMPORTANT INFORMATION ABOUT YOUR COBRA ACCOUNT
- READ CAREFULLY - ACTION REQUIRED

This notice includes important information about your annual open enrollment. As a COBRA participant, you may add or drop coverage, change a benefit, or add or drop an eligible dependent from your COBRA plan(s) during the open enrollment period. **If you wish to make a change, you must complete the open enrollment materials included with this letter. If you do not wish to make any changes, you do not need to take any action with this notice.**

Complete and return the enclosed "Open Enrollment Form" and postmark it **within 14 days** from the date on your open enrollment notification.

If you have yet to elect COBRA, you will also need to complete and return your COBRA election forms by the Last Day to Elect provided to you in a previous mailing.

Please send the applicable forms to:

WEX Health Inc., a WEX Company
PO Box 2079
Omaha, NE 68103-2079
Fax: (888) 408-7224
Email: cobraforms@wexhealth.com

Any requested changes are subject to approval by the insurance carrier. Open enrollment changes will not be accepted if you are no longer eligible for COBRA on the rate effective date.

Please contact WEX Health Inc., a WEX Company at (866) 451-3399, or cobraadmin@wexhealth.com if you have any questions regarding open enrollment or your participation in COBRA. Please contact your insurance carrier with any questions related to plan or coverage details. Carrier contact information is located on the back of your insurance card.

Upon approval, changes will be effective January 1, 2023.

Rates effective January 1, 2023:

*Please note, if you are on the Social Security Disability Extension, your rates may vary from what is listed below.

BCBS CA Medical HDHP	
EE	$479.52
EE+DOMESTICPARTNER	$1,054.96
EE+SPOUSE	$1,054.96
EE+CHILD	$959.06
EE+CHILDREN	$959.06
EE+FAMILY	$1,438.56

BCBS CA Medical PPO	
EE	$633.04
EE+DOMESTICPARTNER	$1,392.69
EE+SPOUSE	$1,392.69
EE+CHILD	$1,266.08
EE+CHILDREN	$1,266.08
EE+FAMILY	$1,899.10

BCBS CA Medical Trio HMO (CA Only)	
EE	$525.79
EE+DOMESTICPARTNER	$1,156.72
EE+SPOUSE	$1,156.72
EE+CHILD	$1,051.57
EE+CHILDREN	$1,051.57
EE+FAMILY	$1,577.34

CIGNA Dental HMO	
EE	$18.32
EE+DOMESTICPARTNER	$36.49
EE+SPOUSE	$36.49
EE+CHILD	$37.78
EE+CHILDREN	$37.78
EE+FAMILY	$52.49

CIGNA Dental PPO	
EE	$44.47
EE+DOMESTICPARTNER	$96.66
EE+SPOUSE	$96.66
EE+CHILD	$100.11
EE+CHILDREN	$100.11
EE+FAMILY	$139.07

CIGNA Eap	
Single	$1.44

VSP Vision

EE	$5.94
EE+DOMESTICPARTNER	$10.18
EE+SPOUSE	$10.18
EE+CHILD	$10.39
EE+CHILDREN	$10.39
EE+FAMILY	$16.76

PO Box 2079, Omaha, NE 68103-2079
cobraforms@wexhealth.com
866-451-3399
888-408-7224

Open Enrollment Form

Please fill out this enrollment form and have it postmarked, faxed, or emailed no later than 14 days from the date of the attached open enrollment letter. Omitting any information may delay coverage changes with the carriers.

Section 1: Primary Participant's Information Please provide the primary participant's information. Check elect to continue coverage or add a new plan. Check waive to decline or terminate existing coverage. Changes will be made as of the effective date in the packet.

Primary Participant Name (First, MI, Last) | Social Security Number | Date of Birth (mm/dd/yyyy)

Phone Number | Email Address

Elect/Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other _________ **Waive/Terminate:** ☐ Medical ☐ Dental ☐ Vision ☐ Other _________

Section 2: Plan and Level of Coverage Please specify the plan and level of coverage. Level of coverage examples: EE, EE + Spouse, EE + Child(ren), EE + Family, Child Only. **Please refer to the enclosed information for the type of coverage available to you.**

Medical Plan Name:	Medical Level of Coverage:
Dental Plan Name:	Dental Level of Coverage:
Vision Plan Name:	Vision Level of Coverage:
Other Plan Name:	Other Plan Level of Coverage:

Section 3: Dependent Information Please provide spouse/dependent information. Check elect to continue coverage or add a new plan. Check waive to decline or terminate existing coverage. Changes will be made as of the effective date in the packet. To terminate coverage from a spouse, the spouse's signature is required in section 4. **Please refer to the enclosed information for the type of coverage available to you.**

Spouse Name (First, MI, Last) | Date of Birth (mm/dd/yyyy) | Social Security Number | Gender (M/F)

Elect/Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other _________ **Waive/Terminate:** ☐ Medical ☐ Dental ☐ Vision ☐ Other _________

Dependent Name (First, MI, Last) | Date of Birth (mm/dd/yyyy) | Social Security Number | Gender (M/F)

Elect/Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other _________ **Waive/Terminate:** ☐ Medical ☐ Dental ☐ Vision ☐ Other _________

Dependent Name (First, MI, Last) | Date of Birth (mm/dd/yyyy) | Social Security Number | Gender (M/F)

Elect/Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other _________ **Waive/Terminate:** ☐ Medical ☐ Dental ☐ Vision ☐ Other _________

Dependent Name (First, MI, Last) | Date of Birth (mm/dd/yyyy) | Social Security Number | Gender (M/F)

Elect/Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other _________ **Waive/Terminate:** ☐ Medical ☐ Dental ☐ Vision ☐ Other _________

Section 4: Authorization

The information is complete and correct to the best of my knowledge. During the open enrollment period, I authorize WEX to make changes to my benefits that are stated on this form.

I understand that any changes postmarked, emailed or faxed after the open enrollment period will not be honored and therefore my benefits will stay at the current level or may terminate.

Primary Participant Signature | Date

Spouse Signature (Only required if coverage is being terminated for the spouse) | Date