Open Enrollment Offered to:

COBRA Participants: Local 88, MCCDA, Painters, Elected Officials and Non-Represented

MULTNOMAH COUNTY EMPLOYEE BENEFITS

COBRA OPEN ENROLLMENT FORM - MEDICAL and DENTAL PLANS
Changes Effective January 1, 2019 and remain in force through December 31, 2019

An annual enrollment provides each participant with the opportunity to:

- ***Change medical plan choice***
- ***Change dental plan choice***
- ***Add or remove family dependent(s) from coverage***

This is the annual opportunity to make plan or enrollment changes. During the plan year, you can only make changes that meet Federal guidelines due to Family Status Change Events. These life events dictate what type of changes are allowed and when you can make changes. For instance, the birth of a child is a recognized Family Status Change Event that would allow a mid-year change. In the absence of a recognized event, you can only alter your elections during an annual open enrollment period.

Information outlining the coverage provided through each plan and the cost associated with each plan are available at **www.multco.us/benefits/cobra.**

OPEN ENROLLMENT DEADLINES AND COVERAGE EFFECTIVE DATES

Completed open enrollment forms must be received by the Employee Benefits Office on or before October 31, 2018 or postmarked no later than October 31, 2018.

Coverage/Enrollment changes are effective January 1, 2019

Please return your completed and signed original form via mail, or electronically by fax or scan and email.

Email:	employee.benefits@multco.us
Fax:	503-988-6257
US Mail:	Employee Benefits - COBRA 501 SE Hawthorne, Suite 400, Portland, OR 97214
Hand Delivered:	501 SE Hawthorne, Suite 320
Questions?	Please contact the Employee Benefits Office at 503-988-3477 or e-mail us at employee.benefits@multco.us

The County plans allow for enrollment of the following types of dependents:

1. Participant's Spouse or Domestic Partner.
2. Children who are under age 26 and are the participant's biological child, step-child, adopted child, child in participant's custody pending adoption, a child for whom participant is required by court order to provide coverage, child for which the participant is a court appointed legal guardian (up to the age of majority, or age specified by the court), or biological/adopted child of domestic partner.
3. A child reaching the birthday that would otherwise cause the child to lose eligibility who has a permanent disability and has been continuously enrolled as your dependent under a County Health Plan, may be eligible for an extension of coverage. The parent participant is responsible for contacting the participant Benefits Office (prior to child's 26th birth date) in order to evaluate whether extension of coverage is appropriate.
4. Grandchildren born to (enrolled) covered and unmarried dependent(s) prior to the birth parent's 23rd birthdate are eligible for coverage, if both the grandchild and their birth parent are continuously enrolled from date of birth of the grandchild. Continuously enrolled grandchild remains eligible up to the enrolled birth parent's 23rd birthdate or marriage, whichever occurs first. Although birth parent may remain enrolled past age 23 - the grandchild is no longer eligible.

The County's health plans allow for enrollment of a broader range of dependent children than the IRS recognizes as Children, Qualified Children or Qualified Relatives. (examples: domestic partner's children or a newborn child of the participant's enrolled child=participant's grandchild)

County Health Plans do not allow for enrollment of other types of household members who may qualify as the participant's tax dependents. For instance, County health plans do not allow for enrollment of an participant's parents or siblings under the participant's County sponsored health plan coverage.

OPEN ENROLLMENT INSTRUCTIONS BY SECTION

If a completed enrollment form is not returned, currently enrolled, eligible dependents will remain enrolled for coverage with the plans already elected.

TYPE OF CHANGE - TELL US WHAT YOU WANT TO DO

- **Important Note: If you are removing a dependent from coverage, please provide the reason for removing the dependent and if a loss of eligibility event occurred. This information is necessary to determine whether or not dependent should receive a secondary COBRA offer. If you do not provide this information, dependent's coverage will be terminated December 31, 2018 and no COBRA offer will be sent.**

ENROLLMENT INFORMATION - LIST YOURSELF AND ALL FAMILY MEMBERS YOU WANT TO COVER

- Use the dependent codes provided on the form to indicate the relationship between the participant and the dependent.
- Indicate whether you want to enroll in medical and/or dental coverage for each dependent listed.
- Copies of legal documents are required for enrollment of children who are adopted or are pending adoption, or for whom you are legal guardian (if not previously submitted).
- If you are enrolling a new spouse or domestic partner, you must also complete and return an Affidavit of Marriage or Domestic Partnership with this form. Review the Affidavit form for additional instructions. Forms can be found on the web at: http://www.multco.us/benefits or from the Employee Benefits Office.

PLAN ELECTIONS

Plan elections apply to everyone you have chosen to cover. Dependents must be on the same plan as the participant.

PARTICIPANT AGREEMENT and SIGNATURE

Sign and date your form. Retain a copy for your records and submit your completed form to the Employee Benefits Office.

MULTNOMAH COUNTY - MEDICAL AND DENTAL OPEN ENROLLMENT FORM
COVERAGE PERIOD - Changes Effective January 1, 2019 through December 31, 2019

COBRA PARTICIPANT INFORMATION

COBRA Participant Last Name	First Name	SS#	Birth Date

Street Address	Home Phone Number

City	State	Zip Code	Alternate Phone Number	Gender	

TYPE OF CHANGE - INDICATE WHAT YOU WANT TO DO

☐ Plan Change
☐ Add Dependent(s) to coverage
☐ Remove Dependent(s) from coverage

Name of removed dependent(s):
Reason for removing dependent:
Date dependent became ineligible: (if applicable)

Attach a Statement of Termination of Marriage/Domestic Partnership if removing spouse/domestic partner due to divorce or end of partnership

ENROLLMENT INFORMATION - LIST YOURSELF AND ALL FAMILY MEMBERS YOU WANT TO COVER

	Last Name	First Name	MI	Birth Date	SS#	Gender	Check Choice	✓
Subscriber							Medical Dental	

LIST DEPENDENTS BELOW using one of these Dependent Codes:

- ► A = Legal Spouse
- ► B = Domestic Partner
- ► C = Biological/Adopted Son/Daughter
- ► D = Stepson/Stepdaughter
- ► E = DomPtnr's Son/Daughter
- ► F = Court Appointed or child placed for adoption
- ► G = Grandchild*

Dep Code	Last Name	First Name	MI	Birth Date	SS#	Gender	Check Choice	✓
							Medical Dental	
							Medical Dental	
							Medical Dental	
							Medical Dental	
							Medical Dental	

COBRA PARTICIPANT AGREEMENT

- To the best of my knowledge, the information furnished on this form is complete and accurate.
- I understand that COBRA coverage remains in force only if required premiums are paid within the period allowed by law. Failure to pay premium in timely manner will cause COBRA coverage to terminate.
- I understand that enrolling ineligible dependents can be considered fraud and that I may be held liable for benefits paid by the plan on an ineligble dependent.
- I will report changes to my enrolled dependent's status immediately to the Employee Benefits Office.
- All Open Enrollment changes are effective January 1, 2019.
- If I do not submit Open Enrollment form by the deadline, currently enrolled and eligible participants will remain on the previously elected coverage, pending receipt of appropriate premiums.

COBRA PARTICIPANT SIGNATURE

COBRA Participant Signature **Date**

OFFICE USE ONLY

Action	PLAN OPTIONS		Start/Term Date	Notes	Date Stamp
	PPO 400	Class			
	MAJ MED	Class			
	DELTA DEN 50	Class			
	KAISER 10/20	1569-			
	MAINTENANCE PLN	1569-			
	KAISER DEN 15	1569-			
	WILLAMETTE DEN	OR 331			

INSTRUCTIONS: Each COBRA participant should select ONE (1) Medical Plan Option, and/or ONE (1) Dental Plan Option

PARTICIPANT NAME _____ **SS#** _____

MEDICAL PLAN OPTIONS

☐ KAISER 10/20 MEDICAL PLAN

Monthly Cost for COBRA coverage	
1-Party	$720.20
2-Party	$1,438.73
Family (3 or More)	$2,050.61

Rates for Medicare eligible participants are available upon request.

☐ KAISER MAINTENANCE PLAN

Monthly Cost for COBRA coverage	
1-Party	$568.43
2-Party	$1,136.85
Family (3 or More)	$1,620.09

Enrollment limitation - Available only to:

Employees in part-time status at separation.

Dependents of employees in part-time status at the loss of dependent eligibility.

Non-Medicare County Retirees and former dependents of County Retirees.

☐ MODA PPO 400 MEDICAL PLAN - Connexus Network

Monthly Cost for COBRA coverage	
1-Party	$784.16
2-Party	$1,568.27
Family (3 or More)	$2,233.72

☐ MODA MAJOR MEDICAL PLAN - Connexus Network

Monthly Cost for COBRA coverage	
1-Party	$378.40
2-Party	$756.78
Family (3 or More)	$1,078.39

DENTAL PLAN OPTIONS

☐ KAISER 15 DENTAL PLAN

Monthly Cost for COBRA coverage	
1-Party	$87.90
2-Party	$175.85
Family (3 or More)	$250.57

☐ DELTA 50 DENTAL PLAN

Monthly Cost for COBRA coverage	
1-Party	$58.96
2-Party	$117.87
Family (3 or More)	$167.73

☐ WILLAMETTE DENTAL PLAN

Monthly Cost for COBRA coverage	
1-Party	$62.93
2-Party	$125.87
Family (3 or More)	$179.42