PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

COBRA CONTINUATION COVERAGE ELECTION FORM

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage through the Health Fund.

Send this completed Election Form to:

Eligibility Department
Writers' Guild-Industry Health Fund
2900 W Alameda Ave Suite 1100
Burbank, CA 91505

This Election Form must be completed and returned no later than 60 days after the coverage ends.

If you do not submit a completed Election Form within 60 days of the date of this notice, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form within the 60-day window. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form. Your payment is due within 45 of receipt of the date we received your election form, though you may submit payment with this form to expedite activation of your coverage.

_____ I (We) have read the above information and do not want to continue health coverage.

_____ I (We) have read the above information and want health coverage continued for the persons listed on this enrollment form.

_____

Writer's Name Date of Birth Unique ID#

_____

Or other eligible person electing COBRA Date of Birth

_____

Street Address City State Zip Code

Telephone (_____)_____ E-Mail Address _____

Check One: Single_____ Married_____ Separated _____ Divorced _____ Widowed _____
Are you or your spouse covered by Medicare? Yes_____ No_____
If yes, check the appropriate space and submit a copy of your/their Medicare ID card. Self___ Spouse___

YOUR COBRA PLAN WILL BE SECONDARY TO MEDICARE.

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List all persons (including yourself) to be covered under the COBRA continuation health coverage provided by the Writers' Guild - Industry Health Fund. Only persons listed below will be covered, provided they meet the eligibility requirements for this coverage, as set forth in this material. (If you need more space, you may use another sheet of paper.)

1. _____
   (Writer- only if electing coverage) Date of Birth Other Insurance? Yes/no
2. _____
   (Spouse) Date of Birth Other Insurance? Yes/no
3. _____
   (Dependent) Date of Birth Other Insurance? Yes/no
4. _____
   (Dependent) Date of Birth Other Insurance? Yes/no
5. _____
   (Dependent) Date of Birth Other Insurance? Yes/no

_____ _____
Signature of writer or person electing (over age 18) Date

PLEASE REFER TO THE ENCLOSED COBRA SCHEDULE FOR MONTHLY RATES

IMPORTANT CHECK ONE:

_____ Plan **C/RC** Regular PPO Medical/Hospital, RX, Vision, Wellness, Delta Dental (DPO)

_____ Plan **B/RB** Regular PPO Medical/Hospital, RX, Vision, Wellness (no Dental)

_____ Plan **CU/RU** Regular PPO Medical/Hospital, RX, Vision, Wellness, Delta Care (DMO)**

****For individuals who reside in California only. If you choose Plan CU, contact the Fund office immediately to request the directory and enrollment form.**

_____ Plan **L/RL** Low-Option Medical & Hospital Only

****This plan has a $750 deductible and does not include Dental, RX, Vision, Wellness, or Life Insurance**

WRITERS' GUILD-INDUSTRY HEALTH FUND – REGULAR COBRA MONTHLY RATES APRIL 1, 2022 THROUGH MARCH 31, 2023			
	Single	**Two-Party**	**Family**
Plan C - Regular Medical/Hospital, Delta Dental (DPO), Rx, Vision, Wellness	$1,044.21	$2,065.96	$2,804.71
Plan B - Regular Medical/Hospital, Rx, Vision, Wellness (no dental)	$994.91	$1,970.98	$2,676.71
***Plan CU** - Regular Medical, Delta Care Dental (HMO), Rx, Vision, Wellness	$1,068.51	$2,004.62	$2,692.02
Plan L - Low Cost **Medical/Hospital ONLY -** $750 Deductible	$696.26	$1,376.83	$1,868.97
COBRA MONTHLY RATES FOR CHILDREN OR EX-SPOUSES OF CERTIFIED RETIREES			
	Single	**Two-Party**	**Family**
Plan RC - (same as Plan C above)	$705.21	$1,378.26	$1,880.38
Plan RB - (same as Plan B above)	$642.19	$1,264.70	$1,714.78
***Plan RU** - (same as Plan CU above)	$705.12	$1,302.16	$1,740.55
Plan L - (same as Plan L above)	$735.92	$1,459.23	$1,982.17
***The CU & RU plans are available to California residents only. If you are choosing the CU or RU plan please contact the Eligibility Department and ask for the DeltaCare USA enrollment information.**			

HOW TO LOCATE A BLUECARD® NETWORK PROVIDER

There are two ways you can <u>find doctors and hospitals</u> that participate in the PPO plan:

You may call at (800) 810-BLUE (2583) for assistance in finding a PPO physician or hospital. Be sure to tell the Customer Service Representative that your three digit alpha prefix is WRX.

You may also use our website, www.pwga.org, and click on the ***Find Participating Provider*** link to select a hospital network or physician in your area. Your ID# is 12 digits: a 3-digit alpha prefix (WRX) is followed by your unique ID# (**A12345678).** It is very important for your providers to use the entire 12 digit ID# on claims submission to *<u>all medical and dental providers.</u>* Please be sure to follow the claim submission information that is located on the back of your new ID card.

MAINTAINING COVERAGE BETWEEN ASSIGNMENTS
DESCRIPTION OF THE LOW OPTION PLAN (PLAN L)*

With the cost of health care being what it is, no one should be without coverage if at all possible. To make COBRA Continuation coverage more affordable to Writers who don't qualify for plan coverage, we have adopted a couple of changes to the COBRA Continuation Coverage plans offered under the Health Fund.

First, life and accidental death and dismemberment insurance has been deleted from the COBRA Continuation coverage plan options with an accompanying reduction in cost.
Second, we have adopted an additional comprehensive medical plan referred to as The Low Option Plan (Plan L) which can be purchased at a lower cost than the current Cobra Continuation plan options (which will continue to be available).

Before any benefits are payable under Plan L, hospital or otherwise, you must satisfy the annual deductible. The key provisions of Plan L are as follows:

Annual Deductible	$750 per individual $2,250 per family
In Network	Plan pays 70% You pay 30%
Out of Network	Plan pays 60% You pay 40%
Annual Out-of -Pocket Maximum	$4,500 per individual in network $20,000 per individual out of network

In addition, if your care requires hospitalization or outpatient surgery, you will need to have the hospital stay or surgery pre-certified. If you do not get the required pre-certification, there will be a $500 reduction in benefits in addition to the deductible and coinsurance required on hospital confinements.

*Plan L provides medical and hospital coverage only. Life, accidental death and dismemberment insurance, prescription drug benefits, dental benefits, vision, and wellness benefits ***are not included***.

For more details on this coverage, you may contact our offices and reach the Participant Services Department by dialing 1 when prompted, then dialing 1 again. You may also visit our website for additional information at:
https://wgaplans.org/health/forms/Summary_Of_Benefits_Booklet.pdf

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

The Fund's health care plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, or sex. The Plan:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters and information written in other languages

If you need these services, please contact Linda Abruzzo, Program and Compliance Manager, at 1-800-227-7863.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Linda Abruzzo, Program and Compliance Manager, 2900 W. Alameda Avenue, Suite 1100, Burbank CA 91505, Telephone: 1-818-846-1015, TTY: 1-818-526-3199, Fax: 1-818-526-6522, Email: Compliance@wgaplans.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Linda Abruzzo, Program and Compliance Manager is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHS Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at https://www.hhs.gov/ocr/filing-with-ocr/index.html.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
English	ATTENTION: Language assistance services are available to you free of charge. Call 1-800-227-7863 (TTY: 1-818-526-3199).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدما المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم - 800-227-7863 - ! (قم هاتف الصم البكم: 818-526-3199 - !).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-227-7863（TTY：1-818-526-3199）。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-227-7863 (ATS : 1-818-526-3199).
French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-227-7863 (TTY: 1-818-526-3199).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-227-7863 (TTY: 1-818-526-3199).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-227-7863 (TTY: 1-818-526-3199).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-227-7863（TTY:1-818-526-3199）まで、お電話にてご連絡ください。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-227-7863 (TTY: 1-818-526-3199) 번으로 전화해 주십시오.
Persian	**توجه:** اگر به زبان فا سی گفتگو می نید، تسهیلا زبانی بصو ایگان برای شما فراهم می باشد. با 1-800-227-7863 (TTY: 1-818-526-3199) تماس بگیرید.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-227-7863 (TTY: 1-818-526-3199).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-227-7863 (TTY: 1-818-526-3199).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-227-7863 (телетайп: 1-818-526-3199).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-227-7863 (TTY: 1-818-526-3199).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-227-7863 (TTY: 1-818-526-3199).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-227-7863 (TTY: 1-818-526-3199).