INDIANA UNIVERSITY
HUMAN RESOURCES

To: IU Fellowship Recipient COBRA Participants in an IU-sponsored Healthcare Plan
From: Indiana University Human Resources
Date: November 3, 2023
Subject: 2024 Open Enrollment

Open Enrollment is your annual opportunity to elect certain changes to your healthcare plan. **If you would like to continue your current coverage, you do not need to take any action at this time**.

What's Changing in 2024?

Medical Plan

- Medical premiums will increase for all coverage levels.
- **New CVS Caremark partnership with GoodRx.** With the Caremark Cost Saver program, IU medical plan members will have automatic access to GoodRx prescription pricing, which allows you to pay lower costs, when available, on generic medications. No action or separate registration is required to participate—simply present your Anthem ID card at your preferred network pharmacy. The amount paid will be automatically applied to your deductible and out-of-pocket maximum.

Dental Plan

- No plan changes.

2024 IU Fellowship Recipient Medical and Dental Premium Rates

Medical Coverage Level	Monthly Premium
Participant	$364.71
Spouse	$1,126.64
Child(ren)	$851.68
Spouse and Child(ren)	$1,978.32
Participant and Spouse	$1,491.35
Participant and Child(ren)	$1,216.39
Family	$2,343.03

Dental Coverage Level	Monthly Premium
Participant	$13.11
Spouse	$20.15
Child(ren)	$30.25
Spouse and Child(ren)	$50.40
Participant and Spouse	$33.26
Participant and Child(ren)	$43.36
Family	$63.51

Please visit our website at hr.iu.edu/benefits/fellowship_recipients.html for additional information.

Do I need to complete Open Enrollment?

Your current enrollment, subject to premium payments and eligibility, will continue unless you submit a change by November 22, 2023. Premium payment slips for 2024 will automatically be mailed to participants in December, with Open Enrollment plan and premium changes taking effect on January 1, 2024.

If you would like to change your current benefits coverage, please complete the enclosed change form and mail it to IU Human Resources by November 22, 2023. Our mailing address is noted at the bottom of the enclosed enrollment form.

INDIANA UNIVERSITY

COBRA Open Enrollment for IU Fellowship Recipients

2024 Benefit Change Form

Note: If you do not wish to make changes to your medical and/or dental coverage for 2024, you do not need to complete this form.

SECTION 1—PARTICIPANT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**

Social Security Number:	**Gender:**	**Date of Birth:**

Enter your contact information below and indicate if this is new information. This information will be used to update your IU record and to contact you, as needed, if additional details are needed for your 2024 enrollment.

Phone Number:

Email Address:

Mailing Address:	**City:**	**State:**	**Zip:**

SECTION 2—MEDICAL PLAN OPTIONS

Select all changes that apply. Select the **No changes** option if you wish to keep your current coverage and enrolled dependents the same in 2024.

- ☐ **No changes to medical plan or covered family members in 2024**
- ☐ **Add** medical
- ☐ **Add child(ren)** to medical *(documentation required)*
- ☐ **Add spouse** to medical *(documentation required)* [1]
- ☐ **Drop** medical
- ☐ **Drop child(ren)** from medical [2]
- ☐ **Drop spouse** from medical [2]

[1] **If you are enrolling a spouse or child due to marriage**, indicate the date of marriage: ______________________________

[2] **If you are dropping a spouse or child due to divorce,** indicate the date of divorce: ________________________________

Select the medical plan and level of coverage you wish to participate in for 2024.

Plan Name: ☐ Anthem IU Fellowship Recipient PPO Plan

Coverage Level: ☐ Participant Only ☐ Participant w/Spouse ☐ Participant w/Child(ren) ☐ Family

SECTION 3—DENTAL PLAN OPTIONS

Check all changes that apply. Please check NO CHANGES box if you wish to keep your current coverage the same in 2024.

- ☐ **No changes to dental plan or covered family members in 2024**
- ☐ **Add** dental
- ☐ **Add child(ren)** to dental *(documentation required)*
- ☐ **Add spouse** to dental *(documentation required)* [1]
- ☐ **Drop** dental
- ☐ **Drop child(ren)** from dental [2]
- ☐ **Drop spouse** from dental [2]

[1] **If you are enrolling a spouse or child due to marriage**, indicate date of marriage: ______________________________

[2] **If you are dropping a spouse or child due to divorce,** indicate date of divorce: ________________________________

Coverage Level: ☐ Participant Only ☐ Participant w/Spouse ☐ Participant w/Child(ren) ☐ Family

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SECTION 4—DEPENDENT INFORMATION

If you indicated changes to your medical or dental coverage, complete this section by listing ALL covered dependents (spouse and/or children) that you wish to have enrolled in medical or dental coverage in 2024. Remember to submit all required documentation (e.g. marriage certificate or birth certificate) with this form.

Full Legal Name*	Relationship to You*	Date of Birth* (mm/dd/yyyy)	Sex*	SSN	Enroll in Medical?*	Enroll in Dental?*

*Required information

SECTION 5—COORDINATION OF BENEFITS

Enter the details about any other medical or dental coverage your or your dependents have. If none, skip to the next section.

Covered Individual name	Medical or Dental?	Carrier/Plan Name	Coverage Start Date

SECTION 6—AUTHORIZATION/CERTIFICATION

1. I request membership for myself and/or my dependent(s) in the plans I have elected on this form, for which I am also an eligible COBRA participant. I further understand I am responsible for the premium payments in order to keep my coverage active.
2. I have read and understand the university's plan eligibility requirements; the dependents listed on this form meet all eligibility requirements.
3. I understand it is my duty to notify the university within 30 days of any changes that affect the eligibility of any of my covered dependents; for example, marriage or divorce.
4. I understand that the plan may use my personal health information for the purposes of treatment, payment, health care operations, and other uses as outlined in the plan's privacy notice, and consistent with federal HIPAA regulations.
5. The information supplied on this form is true and complete. I understand that any intentional false information or statements will be grounds for IU to void my coverage.

Signature:	Date:

Make a Copy of this form for your records.

Return to: IU Human Resources, ATTN: COBRA Benefits Specialist, 2709 E 10th Street, Suite 321, Bloomington, IN 47408.