Dear COBRA participant:

ICUBA's Annual Enrollment for COBRA benefits begins **March 10, 2025**, and ends **March 21, 2025**. If you are not making changes to your benefits, no action is required to maintain your current elections.

If you are making changes to your benefits, complete the enclosed COBRA Open Enrollment form and return to Ameriflex at the address below.

For more information about COBRA, visit ICUBA's iHUB at www.icubabenefits.info.

ICUBA PREMIUM FOR THE PLAN YEAR BEGINNING APRIL 1, 2025

MEDICAL	TIER	RATE	ANNUAL ENROLLMENT INFORMATION
PREFERRED PPO PLAN	Individual + Spouse + Child(ren) + Family	$916.98 $1,955.34 $1,653.42 $2,575.50	During annual enrollment you can make changes to benefits you have already elected, such as switching from one medical insurance plan to another, but you can't make new elections for benefits you are not currently enrolled in. For more information about your rights visit the Department of Labor website online at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra#employees. To view this document and plan summaries for the new plan year visit ICUBA's iHUB online at www.icubabenefits.info/documents. If you are not making any changes to your current elections, your coverage will carry forward with the new premium in the table to the left effective April 1, 2025. To view your current elections, including your eligibility period login to your Ameriflex account online at myameriflex.com/resources/ or email cobra@myameriflex.com.
HIGH DEDUCTIBLE PPO PLAN	Individual + Spouse + Child(ren) + Family	$910.86 $1,939.02 $1,315.80 $2,203.20	
DENTAL	**TIER**	**RATE**	
PPO BASE PLAN	Individual + 1 dependent + Family	$24.28 $56.43 $93.42	
PPO BUY UP PLAN	Individual + 1 dependent + Family	$42.52 $84.70 $142.44	
DENTAL HMO PLAN	Individual +1 dependent + Family	$12.07 $24.20 $37.59	
VISION	**TIER**	**RATE**	
PPO BASE PLAN	Individual + Family	$5.08 $13.02	
PPO BUY UP PLAN	Individual + Family	$7.91 $20.21	

If you are not making changes to your benefits, no action is required.

If you have any questions, please contact Ameriflex by calling (888)-868-3539, emailing cobra@myameriflex.com, or by visiting the Ameriflex resource page online at myameriflex.com/resources/.

Warm regards,

The ICUBA Benefits Team
www.icubabenefits.info

COBRA Open Enrollment Form

Ameriflex

Company Name: _____ Date: _____

Applicant Name (first, middle, last): _____

Member ID (which may be your SSN): _____

Address: _____

City: _____ State: _____ Zip+4: _____ Tel: _____

Gender: M ☐ F ☐ DOB: _____ Marital Status: Single ☐ Married ☐

HRA Enrolled: ☐ Email: _____

APPLICANT COVERAGE

Coverage: Add ☐ Remove ☐ Decline ☐ Keep Same ☐

Plan Name: Medical _____ Dental _____ Vision _____ Rx _____

SPOUSE COVERAGE

Applicant Name (first, middle, last): _____

Address (if different from applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add ☐ Remove ☐ Decline ☐ Keep Same ☐

Plan Name: Medical _____ Dental _____ Vision _____ Rx _____

DEPENDENT COVERAGE: Son ☐ Daughter ☐

Applicant Name (first, middle, last): _____

Address (if different from applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add ☐ Remove ☐ Decline ☐ Keep Same ☐

Plan Name: Medical _____ Dental _____ Vision _____ Rx _____

DEPENDENT COVERAGE: Son ☐ Daughter ☐

Applicant Name (first, middle, last): _____

Address (if different from applicant): _____

City: _____ State: _____ Zip: _____ SSN: _____ DOB: _____

Coverage: Add ☐ Remove ☐ Decline ☐ Keep Same ☐

Plan Name: Medical _____ Dental _____ Vision _____ Rx _____

I verify that the information given is true and correct.

Applicant Signature **Date**

Please mail or email: **Ameriflex COBRA Department** 2508 Highlander Way, Suite 200, Carrollton, TX 75006

Email: service@myameriflex.com