Youngstown Electrical Health and Welfare Fund

General Notice of COBRA Continuation Coverage Rights

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you are eligible for benefits under this group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Type of coverage. If you choose COBRA continuation coverage, you will be entitled to the same type of coverage that you had before the event that triggered COBRA. This includes Medical, Prescription Drug,. However, COBRA coverage does not include Death, Accidental Death and Dismemberment or Short Term Disability Benefits.

Cost of coverage. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Fund is permitted to charge the full cost of coverage for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 2%. If the 18-month period of COBRA continuation is extended because of disability, the Fund is permitted to charge the full cost for similarly situated participants and dependents (including both the Fund's share and the participant's share, if any) plus an additional 50% for members of a COBRA family unit that includes the disabled person for the 11-month disability extension period.

Qualifying Events

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both). Your spouse's becoming entitled to Medicare means that your spouse:
   a. Was eligible for Medicare benefits; *and*
   b. Enrolled in Medicare (under Part A, Part B, or both).

   The entitlement date is the date of enrollment;

   or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both). Your parent-employee's becoming entitled to Medicare means that your parent-employee:
   a. Was eligible for Medicare benefits; *and*
   b. Enrolled in Medicare (under Part A, Part B, or both).

   The entitlement date is the date of enrollment;
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Administrative Manager has been notified that a qualifying event has occurred.

The Employer Must Give Notice of Some Qualifying Events

The employer must notify the Plan Administrator of the qualifying event when the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

You must notify the Plan in writing within 60 days after the qualifying event occurs for the other qualifying events of divorce or legal separation of the employee and a spouse or a dependent child's losing eligibility for coverage as a dependent child. You should also let the Plan know of the death of a Member because there may be a delay in the employer knowing of the event and sending notice to the Plan. You must send this notice to:

Youngstown Electrical Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

You may use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Administrative Manager of these events.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's entitlement to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to (qualified for *and* enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. However, the covered employee's maximum coverage period will be 18 months. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). The employee's COBRA coverage period in this case is 18 months from the termination of employment and is not related to the employee's Medicare entitlement.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts only for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended that are explained in the next two paragraphs.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan through COBRA is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must notify the Plan of the disability within 60 days of the determination of disability by the Social Security Administration and before the end of the 18-month continuation period. If the Social Security Administration later determines that you are no longer disabled, you must notify the Plan of that determination within 30 days of the determination. You must send written notice to:

Youngstown Electrical Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

You should use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Fund Office of a disability determination.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if:

1. The employee or former employee dies,
2. The employee or former employee becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both),
3. The employee or former employee gets divorced or legally separated, or
4. The dependent child stops being eligible under the Plan as a dependent child.

The extension is available only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
You must notify the Plan within 60 days after the second qualifying event occurs. You must send this notice to:

Youngstown Electrical Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

You may use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Fund Office of these events.

Can You Elect Other Health Coverage Besides Continuation Coverage?

Maintaining eligibility through the Plan's Self-contributions Provisions. If you have become unemployed due to a reduction in the work force, the existing eligibility rules of the Fund provide you the opportunity to continue your (and your dependents') program of health and life insurance benefits. This coverage is available under the Self-contributions provisions of the Plan and is similar to active coverage, except that to be eligible for this coverage you must:

- Make self-payments in a timely manner, and
- You must have worked for an employer who is still contributing to the Plan.
- Be available for work through the local union and register at least every 30-days with the Local Union.

Self-contributions may be made for a period up to (12) twelve months if he meets all the self-contributions eligibility requirements.

If your coverage ends under this self-contribution provision, you will be offered additional COBRA continuation coverage at that time.

Alternate Retiree Coverage. Retiree coverage is provided through self-contributions/dollar bank for you until you reach age 65. You may also cover your dependents until the later of the date you reach age 65 or your spouse reaches age 65. Retiree coverage includes the Medical and Prescription coverage.

You should contact the Fund Office to arrange for Retiree coverage. To maintain your eligibility as a retired member of the Plan, the Fund Office must receive your required monthly premium on a monthly basis by the first day of the month. Your monthly check will cover the upcoming month. There is a grace period of 30 days beyond the monthly due date. However, if your check is not received by the Fund Office within the 30-day grace period, your coverage will be canceled.

It is your responsibility to make payment prior to the expiration of the 30-day grace period. You will be offered additional continuation coverage under COBRA once your coverage in the Retiree program is terminated for any reason including non-payment.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA's website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan's Administrative Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan's Administrative Manager.

Plan Contact Information

Youngstown Electrical Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515
Telephone: (330) 270-0453
Toll-Free: (800) 589-8041

YOUNGSTOWN ELECTRICAL HEALTH AND WELFARE FUND

COBRA NOTICE FORM FOR COVERED EMPLOYEES AND QUALIFIED BENEFICIARIES

From: ______________________________ (Enter your name)

Address: ______________________________ (Enter your address)

To:

Youngstown Electrical Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

Date: ____________________

Re: COBRA Notice to Youngstown Electrical Health and Welfare Fund

Dear Plan Administrator:

This letter is to inform you of the following event(s) [Check the event(s) that apply and include and/ or attach the requested information]:

❑ My spouse and I have/will become divorced or legally separated.

Date of divorce or legal separation: ______________________

Names of covered employee (participant) and all qualified beneficiaries (spouse and other dependents):

____

____

Attach a copy of the decree of divorce or legal separation.

❑ My child will/has ceased to be covered under the Plan as a dependent child of a participant.
Date child has/will no longer be considered a dependent: ________________

Name of child: ______________________________________

Reason why child is no longer a dependent: ______________________

(E.g., no longer a student, over age 19 or 23, if your dependent is a full-time student)

❑ I myself and/or my dependents, who are currently receiving COBRA, have a second qualifying event due to an employee's death, entitlement to Medicare, divorce or legal separation or child losing dependent status.

State the qualifying event that applies: ______________________

Date of the Second Qualifying Event: ______________________

Attach a certified copy of the death certificate or a copy of the decree of divorce or legal separation.

❑ I myself and/or my dependent have been determined to be disabled by the Social Security Administration.

Name of the Disabled person: ______________________________

Date of the Social Security determination: ______________________

Attach a copy of the determination letter from the Social Security Administration.

1. I myself and/or my dependent have been determined to be no longer disabled by the Social Security Administration.

Name of the Disabled person: ______________________________

Date of the Social Security determination: ______________________

Attach a copy of the determination letter from the Social Security Administration.

If you have any questions about this notice please contact me or [my representative ____________________ (enter the name of your representative, if you have named one to act on your behalf)] at the following telephone number ______________.

My current address and that of my dependents is:

____________________________.

____________________________.

____________________________.

Sincerely,

____

(Signature of Covered Employee or Qualified Beneficiary who is completing this Notice)

____

(Print Name of Covered Employee or Qualified Beneficiary who is completing this Notice

YOUNGSTOWN ELECTRICAL HEALTH AND WELFARE FUND

Re: Termination of Coverage Under Plan Due to Lack of Required Hours/ Contribution

Dear ______________;
SSN:__________________

Under the provisions of the Youngstown Electrical Health and Welfare Fund, please be advised that your coverage will terminate on ______________________. The Fund's records indicate that the necessary payments have not been received into your account in order for you to keep your coverage. However, in accordance with the eligibility rules of the Youngstown Electrical Health and Welfare Fund, you may preserve your eligibility if you are actively seeking work through the local union, but you must comply with the provisions of the Summary Plan Description.

However, regardless of the determination that your coverage has terminated under the provisions of the Youngstown Electrical Health and Welfare Plan, COBRA, a federal law, provides you with eligibility to continue participation in the Fund if you have suffered a "qualifying event." A detailed explanation of your rights and obligations under COBRA is included in this Election packet.

All of the terms and conditions which must be satisfied in order to elect COBRA continuation coverage are outlined in the attached Election Notice and Form. These documents must be completed in order for you and/or your eligible dependents to elect COBRA coverage under this Plan.

If you do not wish to elect this right to elect COBRA continuation coverage, please complete the Acknowledgment of Termination of Coverage Portion of the enclosed Election Form and return it to the Fund Office at
33 Fitch Boulevard
Austintown OH 44515

If you wish to appeal the decision which has been made regarding the termination of your coverage, you may make a written request to the Board of Trustees. This written request for an appeal must be received by the Administrative Office at the address listed above within thirty (30) days of the date of this letter. Your written request MUST include your name, address, and state that you are appealing the decision regarding termination of your coverage, and provide the date that this decision was made.

If you have any further questions concerning this information, please contact the Fund Administrative Office.

Sincerely,

BOARD OF TRUSTEES

YOUNGSTOWN ELECTRICAL HEALTH AND WELFARE FUND

COBRA Continuation Coverage Election Notice

Date: ____________________

Dear ______________________

This notice contains important information about your right to continue your health care coverage in the Youngstown Electrical Health and Welfare Fund (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on __________ due to:

- ☐ End of employment
- ☐ Death of employee
- ☐ Entitlement to Medicare
- ☐ Reduction in hours of employment
- ☐ Divorce or legal separation
- ☐ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months:

- ☐ Employee or former employee ____
- ☐ Spouse or former spouse____
- ☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage

  ____
- ☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

  ____

If elected, COBRA continuation coverage will begin on __________ and can last until ___________.

The monthly premium for COBRA continuation coverage will cost: **$681.50 per month.** You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact Youngstown Electrical Health and Welfare Fund, 33 Fitch Boulevard, Austintown, Ohio 44515, Telephone: (330) 270-0453, Toll Free: 1-800-589-8041.

YOUNGSTOWN ELECTRICAL HEALTH AND WELFARE FUND

COBRA Continuation Coverage Election Form

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

Send the completed Election Form to:

Youngstown Electrical Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

This Election Form must be completed and returned by mail. It must be post-marked by _______________.

If you do not submit a completed Election Form by the date shown above, you will lose your right to elect 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 before the due date. 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.

Check either Item A or B below and sign and date this Election Form where applicable.

☐ **A. I elect COBRA continuation coverage.** ____
Print Name

____________________________________ ____/____/________
Signature Date

If you checked Item A, the monthly cost is $681.50.

If you are electing coverage for your family," list the individuals in your family for whom you are electing COBRA continuation coverage.

Name	Date of Birth	Social Security Number	Relationship to Member

I verify that on the date that I lost eligibility for coverage under the Youngstown Electrical Health and Welfare Fund, I (and all other Qualified Beneficiaries listed above,) was not covered under any other insured or uninsured arrangement that provides health care coverage for professional services, appliances, and supplies for individuals or under a group arrangement.

I further agree to notify the Administrative Office immediately if I become covered under any other insured or uninsured arrangement that provides health care coverage for professional services, appliance, and supplies for individuals or under a group arrangement.

Print Name   Social Security Number

_______________________________   ____/____/________

Participant's Signature   Date

_______________________________   ____/____/________

Participant's Spouse   Date

****

☐ **B.** **I decline** COBRA continuation coverage. I understand that my coverage under the Youngstown Electrical Health and Welfare Fund will terminate on ______________________________. I also understand that I am not eligible to continue coverage under this Fund by virtue of making any other payments.

I also understand that my eligible dependents have an individual right to elect COBRA Continuation Coverage and that unless otherwise stated on this Form, any election or denial of coverage by me as the participant shall be deemed to include an election on behalf of all other qualified beneficiaries who would lose coverage under the plan as a result of my termination of coverage.

Print Name   Social Security Number

_______________________________   ____/____/________

Participant's Signature   Date

_______________________________   ____/____/________

Participant's Spouse   Date

_______________________________   ____/____/________

Participant's Dependent   Date

YOUNGSTOWN ELECTRICAL HEALTH AND WELFARE FUND

ELECTION NOTICE

Important Information About Your COBRA Continuation Coverage Rights

What Is Continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under the group health plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same healthcare coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. However, life insurance, Accidental Death and Dismemberment and Short Term Disability coverage are not included in COBRA continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to the end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months.

In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to (qualified for *and* enrolled in) Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to (qualified for *and* enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. However, the covered employee's maximum coverage period will be 18 months.

Becoming entitled to Medicare means that you:

- are eligible for Medicare benefits, *and*
- have enrolled in Medicare (under Part A, Part B, or both). The entitlement date is the date of enrollment.

This notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries. Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a covered employee becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both), or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How Can You Extend the Length of Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Youngstown Electrical Welfare Fund, in writing, of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage. You may use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Administrative Manager of these events.

Extension for Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify Youngstown Electrical Welfare Fund, in writing, of the disability within these time frames. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to be no longer disabled, you must notify the Plan's Administrative Manager of that fact in writing within 30 days of SSA's determination.

Extension for Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum length of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan's Administrative Manager in writing within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How Can You Elect Continuation Coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage, even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

What Should You Consider in Deciding Whether to Elect Continuation Coverage?

In determining whether to elect continuation coverage, you should consider the following consequences if you fail to continue your group health coverage through COBRA:

- First, you may have pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA continuation coverage may help you avoid such a gap.
- Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if you do not elect COBRA continuation coverage for the maximum time available to you.
- Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage

ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

How Much Does Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving continuation coverage. The required payment for continuation coverage for each continuation coverage period for each option is described in this notice. Only those coverage levels where a corresponding monthly premium rate is shown are available to you.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/.

When and How Must Payment for Continuation Coverage Be Made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Youngstown Electrical Health and Welfare Fund, to confirm the correct amount of your first payment. Your check should be made payable to the Youngstown Electrical Health and Welfare Fund .

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent month. The amount due for each month is shown in this notice. The payments must be made on a monthly basis. Under the Plan, each of these monthly payments for continuation coverage is due on the first day of the month for that monthly coverage period. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace Periods for Periodic Payments
Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the monthly coverage period to make each monthly payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. You will not be billed. It is your responsibility to make payment prior to the expiration of the 30-day grace period. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the coverage, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Your first payment and all monthly payments for continuation coverage should be sent to:

Youngstown Electrical Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

For More Information
This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your Summary Plan Description or from the Plan's Administrative Manager.
If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your Summary Plan Description, you should contact:

Youngstown Electrical Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515
Telephone: (330) 270-0453
Toll-Free: (800) 589-8041

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep Your Plan Informed of Address Changes
In order to protect your and your family's rights, you should keep the Plan's Administrative Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrative Manager.

Re: Notice of Unavailability of COBRA Continuation Coverage
To:

____

____

____

Dear ____________________:

Our records indicate that you provided the Fund with a Notice of Qualifying Event seeking to obtain or extend COBRA coverage for yourself and/or your dependents due to one of the following qualifying events: (Check one)

❑ Your divorce or legal separation
❑ A beneficiary ceasing to be covered under the Plan as a dependent child of a participant.
❑ You and/or your dependent who are currently receiving COBRA have a second qualifying event due to an employee's death, entitlement to Medicare, divorce or legal separation or child losing dependent status.

We have determined that you and/or your dependent(s) are not entitled to COBRA continuation coverage for the following reason:

____

____

[Examples:

Although your child is over 18, your child is still covered by the Plan since the child is a full-time college student.

You did not notify the Fund Office of the qualifying event within the correct time frame.

You were terminated for gross misconduct.

Your election form was not received within 60 days of the later of: a) the date you lost eligibility, or b) the date you received the election form.

The initial payment for each full calendar month since you lost eligibility was not received within 45 days from the date the Fund Office received your election form.]

Your coverage under the group health plan is/was terminated effective: __________. **Any claims incurred on or after this date will be returned to you unpaid. Any claims incurred prior to this date should be filed immediately for processing.** If you have any questions about this determination please contact the Fund Administrator.

Sincerely,

____

Youngstown Electrical Health and Welfare Fund

Date: ____________________________
Re: Notice of Termination of COBRA Continuation Coverage

To:

____

____

____

Dear _________________________:

Our records indicate that effective the first day of ____________, 200__ you [and your spouse and/or dependents] will no longer be eligible for COBRA continuation coverage from the Fund for the following reason: (Check one)

❑ You failed to send in your required monthly premium of $_________ by the ____ day of ______________, 200___.

❑ You became covered under another group health plan either as an employee or as the dependent of an employee and we have no records that indicate that the new group health plan contains any preexisting condition that would apply to the qualified beneficiary. Please contact the Fund office if you have a pre-existing condition and that is not covered by the other plan.

❑ You became entitled to Medicare.

❑ The employer that employed you prior to the qualifying event has stopped contributing to this Fund but is making group health plan coverage available through another health plan. You should contact your former employer to determine whether it will assume your COBRA continuation coverage.

❑ You were terminated for gross misconduct,

❑ Your coverage was extended due to disability and you have been determined by the Social Security Administration to no longer be disabled.

❑ The Plan no longer provides group health coverage.

1. Other: ____

Any claims incurred on or after the date your COBRA continuation coverage terminates (see date above) will be returned to you unpaid. Any claims incurred prior to this date should be filed immediately for processing.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends. Additional information about special enrollment is available in the Summary Plan Description or from the Administrator of the Plan in which you are enrolling.

If your coverage is terminating because you became entitled to Medicare, your spouse and dependents will still be entitled to COBRA continuation coverage for an additional ____ months. The Fund Office will be sending them a separate notice if this represents a second qualifying event for them.

If you have any questions, please contact the Fund Office.

Sincerely,

Youngstown Electrical Health and Welfare Fund