I.B.E.W. LOCAL 688

HEALTH AND WELFARE FUND

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

Dear _____;
SSN:_____

Under the provisions of the I.B.E.W. Local 688 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 in accordance with the eligibility rules of the I.B.E.W. Local 688 Health and Welfare Fund.

As a result your coverage has terminated under the provisions of the I.B.E.W. Local 688 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

I.B.E.W. Local 688 Health and Welfare Fund
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

I.B.E.W. LOCAL 688

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 I.B.E.W. Local 688 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: **$780 per month family, $300 per month single.** 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 I.B.E.W. Local 688 Health and Welfare Fund, 33 Fitch Boulevard, Austintown, Ohio 44515, Telephone: (330) 270-0453, Toll Free: 1-800-589-8041.

I.B.E.W. LOCAL 688
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:

I.B.E.W. Local 688
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 $780.00 family, $300.00 single.

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 I.B.E.W. Local 688 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 I.B.E.W. Local 688 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

I.B.E.W. LOCAL 688
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 I.B.E.W. Local 688 Health and 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 I.B.E.W. Local 688 Health and 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 I.B.E.W. Local 688 Health and Welfare Fund, to confirm the correct amount of your first payment. Your check should be made payable to the I.B.E.W. Local 688 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:

I.B.E.W. Local 688
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:

I.B.E.W. Local 688
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.