

**I.B.E.W. LOCAL 688
HEALTH & WELFARE FUND**

Cobra Continuation Coverage Election Form

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 & WELFARE FUND (the Plan), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. 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 :

- | | |
|--|---|
| <input type="checkbox"/> End of employment | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee | <input type="checkbox"/> Divorce or legal separation |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> Loss of dependent child status |

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

- | |
|---|
| <input type="checkbox"/> Employee or former employee |
| <input type="checkbox"/> Spouse or former spouse |
| <input type="checkbox"/> Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage |
| <input type="checkbox"/> 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 _____. You may elect any of the following options for COBRA continuation coverage:

COBRA continuation coverage will cost: **\$300.00 per month for single coverage and \$780.00 per month for family coverage.** 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.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums

right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you have any questions about your rights to COBRA continuation coverage, you should contact I.B.E.W. Local 688 Health & Welfare Fund, 33 Fitch Boulevard, Austintown, OH 44515, Telephone: (330) 270-0453, Toll Free: 1-800-589-8041.

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA 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 completed Election Form to:

I.B.E.W. Local 688 Health & Welfare Fund
33 Fitch Boulevard
Austintown, OH 44515

This Election Form must be completed and returned by mail. If mailed, it must be post-marked no later than _____. If you do not submit a completed Election Form by the due date shown above, 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 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.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the I.B.E.W. Local 688 Health & Welfare Fund (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____			
		Coverage option elected:	_____
b. _____			
		Coverage option elected:	_____
c. _____			
		Coverage option elected:	_____

I (We) decline COBRA continuation coverage. I understand that my coverage under the I.B.E.W. Local 688 Health & Welfare Fund (the Plan) will terminate on _____. I also understand that I am not eligible to continue coverage under this Fund by virtue of making any other payments.

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
------	---------------	--------------------------	---------------------------

a. _____
Coverage option declined: _____

b. _____
Coverage option declined: _____

c. _____
Coverage option declined: _____

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.

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

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 an employer’s 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 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 end of employment or reduction in hours of employment, coverage generally may be continued 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 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 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 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 (note: there are limitations on plans’ imposing

a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),

- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, 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 COBRA 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 & Welfare Fund 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.

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 & 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 no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

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 amount 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 (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 within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA 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.

In considering whether to elect continuation coverage, 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 get continuation coverage for the maximum time available to you.

How much does COBRA 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 each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA 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 not later than 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 & Welfare Fund to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent month. The amount due for each month for each qualified beneficiary is shown in this notice. The periodic payments can 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 coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period 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 coverage period, you will lose all rights to continuation coverage under the Plan.

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

I.B.E.W. Local 688 Health & Welfare Fund
33 Fitch Boulevard
Austintown, OH 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 Administrator.

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 & 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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

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