

COBRA CONTINUATION COVERAGE ELECTION NOTICE

Date of Notice: _____

To: (Qualified beneficiary(ies)) _____
(Address) _____
(City, State, Zip Code) _____

From: (Plan Administrator) _____
(Address) _____
(Telephone No.) _____

This notice contains important information about your right to continue your health care coverage in the _____ (the Plan). Please read the information contained in this entire notice very carefully.

To elect COBRA continuation coverage, complete the attached COBRA Continuation Coverage Election Form and submit it to the Plan Administrator. 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. This Election Form must be completed and returned by mail. If mailed, this Election Form 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.

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"/> Eligibility for Medicare | <input type="checkbox"/> Loss of dependent child status |
| <input type="checkbox"/> Exhaustion of FMLA Leave | |

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. The qualified beneficiaries and their applicable group health plan components are listed below:

- 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 _____. You may elect any of the options for COBRA continuation coverage which are listed on the attached COBRA Continuation Coverage Election Form.

The cost of COBRA continuation coverage is also provided on the attached COBRA Continuation Coverage Election Form (note that you will be informed of any future premium changes). You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in this notice.

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

WHAT IS COBRA CONTINUATION COVERAGE?

Federal law requires that most group health plans (including this Plan) give employees and their families (“qualified beneficiaries”) 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. Note that dependent children may include any child born to or placed for adoption with a covered employee during the period of COBRA coverage who is thereafter properly enrolled in the Plan, or a child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order.

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA continuation coverage. However, COBRA continuation coverage only applies to the group health benefits offered under the Plan. Further, the Plan provides only those rights that COBRA requires. Each qualified beneficiary who elects COBRA continuation coverage of the group health benefits offered under the Plan will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment, if applicable, and special enrollment rights.

HOW LONG WILL COBRA 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 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 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 may last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of COBRA continuation coverage available to the qualified beneficiaries.

COBRA 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 COBRA 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 qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA continuation coverage,
- the employer ceases to provide any group health plan for its employees, or

- there has been a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

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

WHEN THE MAXIMUM PERIOD SHOWN ON PAGE 1 OF THIS NOTICE IS LESS THAN 36 MONTHS, THE FOLLOWING THREE (3) PARAGRAPHS APPLY:

1. HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

If you elect COBRA 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 the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA continuation coverage. Failure to provide notice of a disability or second qualifying event will terminate your right to extend the period of COBRA continuation coverage.

2. DISABILITY

In general, 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 61st day after the qualifying event and must last at least until the end of the period of COBRA continuation coverage that would be available without the disability extension (in general, 18 months). The Plan procedures for requiring notice of disability determination, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, the time period for giving notice and the consequences of failing to provide such notices, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator.

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. Each qualified beneficiary who has elected COBRA continuation coverage will be entitled to the 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 Administrator of that fact within 30 days after SSA's determination.

3. SECOND QUALIFYING EVENT

In general, an 18-month extension of coverage will be available to spouses and dependent children who are eligible and elect COBRA continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of COBRA 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 Administrator within 60 days after a second qualifying event occurs if you want to extend your COBRA continuation coverage. The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator.

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

To elect COBRA continuation coverage, you must complete the Election Form and timely furnish it according to the directions in the next paragraph. Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA continuation coverage even if the employee does not. COBRA continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue COBRA continuation coverage on behalf of any dependent children. The employee or the employee's spouse who is a Qualified Beneficiary can elect COBRA continuation coverage on behalf of all of the qualified beneficiaries. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage.

To elect COBRA continuation coverage, complete the attached COBRA Continuation Coverage Election Form and submit it to the Plan Administrator. This Election Form must be completed and returned by mail. If mailed, this Election Form 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.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage through a COBRA election will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get 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 COBRA continuation coverage if you get COBRA 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 COBRA 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 COBRA 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 COBRA continuation coverage. The required payment for each continuation coverage period for each option is described in the attached COBRA Continuation Coverage Election Form.

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 Coverage 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/2002act_index.asp.]

WHEN AND HOW MUST PAYMENT FOR COBRA CONTINUATION COVERAGE BE MADE?

1. FIRST PAYMENT FOR COBRA CONTINUATION COVERAGE

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. (This is the date the Election Form is post-marked, if mailed, or the date the Election Form is received by the Plan Administrator, if hand delivered.) If you do not make your first payment for COBRA continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

2. PERIODIC PAYMENTS FOR COBRA CONTINUATION COVERAGE

After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period 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 periodic payments for COBRA continuation coverage is due on _____ for that coverage period. If you make a periodic 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.

3. 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 COBRA 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. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period 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 COBRA continuation coverage under the Plan.

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

(Plan Administrator) _____
(Address) _____
(Telephone No.) _____

Payment is made on the date that it is postmarked, if mailed, and on the date personally received at the address above, if hand delivered. Returned checks cancel this payment.

FOR MORE INFORMATION

This notice does not fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA 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 the Plan Administrator at:

(Plan Administrator) _____
(Address) _____
(Telephone No.) _____

Please refer to the Plan's most recent summary plan description for any updated Plan contact information.

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 Administrator informed of the current addresses and 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.