Southern Ohio Painters
33 Fitch Blvd
Austintown, Ohio 44515
1-800-435-2388

COBRA CONTINUATION COVERAGE ELECTION NOTICE

Date of notice:

Dear:

This notice contains important information about your right to continue your health care coverage. More detailed information about COBRA is set forth in your Summary Plan **Description.** ***To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit the Form to the Fund office at the above address and telephone.*** **You are provided a period of** ***sixty (60) days from the date of this*** *notice* to elect this continued coverage under COBRA. You must also submit a monthly COBRA premium of ***$652.80*** no later than the second day of each month for which coverage is provided. If you fail to make payment when due, your coverage will cease at the end of the period for which payment has been made. **ONCE YOU FAIL TO REMIT COBRA PAYMENT, YOUR COVERAGE WILL TERMINATE AND CANNOT BE REINSTATED.**

If you do not elect COBRA continuation coverage, your coverage under the Plan will end. You will have a "qualifying event" when your coverage ends on due to:

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

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 33 Fitch Boulevard, Austintown, Ohio 44515 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 the termination of your coverage, and provide the date that this decision was made.

If you do not elect COBRA or fail to make COBRA payments timely, you may lose certain legal rights in addition to losing coverage under this Fund. If you have more than a 63-day gap in health coverage, a successor plan may apply a pre-existing conditions provision. If you do not get continuation coverage for the maximum time available, you also lose the guaranteed right to purchase individual policies that do not impose such pre-existing condition exclusions.

Alternatively, you may want to consider any special enrollment rights. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (for example, a plan sponsored by your spouse's employer) because of the qualifying event shown above. You must request special enrollment within 30 days after your coverage under this Fund ends.

Further information about special enrollment and legal rights may be obtained by contacting the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visiting: www.dol.gov/ebsa.

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.

- □ 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 .

Coverage shall be terminated earlier, however, 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 qualified beneficiary becomes entitled to Medicare Parts A and/or B after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Coverage may be extended if a second qualifying event occurs or a qualified beneficiary is disabled:

> If a qualified beneficiary is entitled to 18 months' continuation and a second qualifying event occurs during that time, coverage may be extended up to a maximum of 36 months. Such second qualifying event may include the death of a covered employee, divorce or separation from the covered employee or a dependent child ceasing to be eligible for coverage as a dependent under the Fund. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. You must notify the fund within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

> If a qualified beneficiary is disabled at the date of the initial qualifying event (or within the first 60 days of continuation coverage), an 11-month extension may be available. A disability award must be issued by the Social Security Administration and a written request to extend COBRA must be sent to the Fund Office before the end of the initial 18-month period. If the Social Security Administration determines that the qualified beneficiary is no longer disabled, the employee or beneficiary must notify the Fund within 30 days of the Administration's determination.

It is important that you keep the Fund Office advised if you or any other qualified beneficiaries change your address.

Sincerely,

Board of Trustees

COBRA ELECTION FORM

I ______________________________ , understand that on   my coverage under the Southern Ohio Painters will terminate unless I elect continued coverage within 60 days of the letter ,   (Date on which notice was mailed) or my loss of coverage under the Fund.

In accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), I am eligible to continue coverage for myself and any of my eligible dependents for a total of 18 months from   -

I further understand that if I elect such continued coverage, I am responsible for the payment of the cost of such coverage, and that I must pay $***652.80*** within 45 days of the date I file this election with the Administrative Office. Furthermore, I understand that all subsequent payments are due on the 2nd of the month. Failure to pay the premium will result in cancellation of coverage and terminate any further continuation of coverage rights. While a grace period of up to 30 days may be allowed for payment of premium, any health coverage is suspended until my payment is received.

After being sufficiently informed of my right to continue coverage, I

- □ Elect to continue coverage under the Southern Ohio Painters by paying the required monthly premium of **$652.80** and providing the Administrative Office with necessary information to continue my coverage.
- □ Elect not to continue coverage under the Southern Ohio Painters.

NOTE - Each qualified beneficiary has a right to elect continuation coverage independently. Except as otherwise specified, any election made by the employee or employee's spouse shall be deemed to include an election on behalf of all other qualified beneficiaries who would lose coverage under the Plan by reason of the qualifying event. A parent or legal guardian may elect continuation coverage on behalf of a minor child.

Additionally, I verify on the date that I lost eligibility for coverage under the Southern Ohio Painters, I (and any other Qualified Beneficiary) was not covered by 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.

Participant Signature ____________________ Social Security No.___________________ Date_____________

Participant's Spouse______________________________ Date _____________

Participant's Dependent ___________________________ Date _____________

Date Group Coverage Terminates _______________________________