

COBRA CONTINUATION COVERAGE ELECTION NOTICE

February 2010

This notice contains important information about your right to continue your health care coverage in the IUOE Local 4 Health and Welfare Plan (the Plan) . Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium **in some cases** where **the reason for your loss of coverage is related to involuntary termination** from employment, including being laid off from your job. **A mere reduction in hours is not an involuntary termination. This law was amended in December 2009 to extend both the eligibility period and subsidy period.**

You are receiving this election notice because you will experience a loss of coverage on **February 28, 2010** due to insufficient hours of employment in 2009. If the lack of hours was due to an involuntary layoff you may be eligible for the **temporary** premium reduction for up to 15 months. **To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the “Summary of the COBRA Premium Reduction Provisions under ARRA” with details regarding eligibility, restrictions, and obligations and the “Application for Treatment as an Assistance Eligible Individual.”**

If you believe you meet the criteria for the premium reduction, you must complete the attached “Request for Treatment as an Assistance Eligible Individual” and return it with your completed Election Form. Under federal law, you have 60 days after the date of this notice to return your completed Election Form and Request for Treatment as an Assistance Eligible Individual.

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

Each Covered Employee and eligible dependent (“qualified beneficiary”) is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to 18 months.

The cost of your continuation coverage will vary based on the plan option selected. A description of the plan options and the current monthly costs is included in the enclosed Election Form. If you qualify as an “Assistance Eligible Individual” this cost will be 35% of the cost of coverage for up to 15 months. and the Election Form also includes these amounts. 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. Please be sure to read this information in its entirety.**

If you are eligible for other group health coverage (such as through a new employer's plan or a spouse's plan) or Medicare, you are not eligible for the premium reduction. If you become eligible for coverage under another group health plan or Medicare and are receiving the premium reduction, you must notify this Plan using the attached Form. Failure to do so can result in a penalty to you in the amount of 110% of the subsidy that you should not have received.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed by the Department of Labor. Additionally, certain high-income individuals may have to repay the amount of the premium reduction through an increase in their income taxes. (Your income for the year would have to be more than \$125,000 (\$250,000 for married couples) before you would have to repay all or part of the premium reduction.)

For more information regarding reviews or for general information about the ARRA Premium Reduction go to: <http://www.dol.gov/ebsa/COBRA.html>

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact COBRA Coordinator, IUOE Local 4 Health and Welfare Fund, PO Box 660, Medway, MA 02053. 1-508-533-1400