Warehouse Employees Union Local No. 730
Health and Welfare Trust Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (800) 730-2241
www.associated-admin.com

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~~**The Warehouse Employees Union Local No. 730**~~
~~**Health and Welfare Fund**~~
~~**911 Ridgebrook Road**~~
~~**Sparks, Maryland 21152-9451**~~
~~**(800) 730-2241**~~

NOTICE OF RIGHT TO ELECT GROUP HEALTH INSURANCE CONTINUATION OF COVERAGE

This notice contains important information about your right to continue your health care coverage in t~~T~~he Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund. Please read the information contained in this notice very carefully.

Date:
Name:

Dear

You have suffered a Loss of Eligibility and as a result, your health and welfare benefits will terminate on unless you make the election and required payments described in the Important Information about Your COBRA Continuation Rights and enclosed Election Form.

Your coverage under the plan will end due to:

Reduction of Hours

The enclosed Election form must be completed, signed and returned to the Fund Office within sixty (60) days from the later of: (1) the date of this notice; or (2) the date your Plan coverage terminates. Failure to return the Election Form by the end of this election period will terminate the right to continue coverage.

COBRA ELECTION FORM (page 1)

Name: **Date of Notice:**
Telephone No.:

Date of Birth **Date Employed** **Date of Qualifying Event**

If you do NOT elect COBRA continuation coverage, your coverage under the plan will end on due to:

Reduction of Hours

Each person ("qualified beneficiary") listed below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to 18 months.

Qualified Beneficiary Number	Name	Relationship to Employee	Birth Date	Sex

I (We) elect COBRA continuation coverage in t~~T~~he Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund as indicated below.

In the Plan Elected section below, please check the box for the benefit plan and circle the qualified beneficiary number(s) for whom you are electing coverage.

Plan Elected:

	Plan	*Monthly Premium*	*QB# Eligible*

If elected, upon receipt and posting of applicable premium payments, COBRA continuation coverage will begin on and can last until.

Important additional information on premium costs and payment for COBRA continuation coverage is included in the pages following the Election Form. If you elect continuation coverage, you do not have to send any payment with the Election Form. However, your coverage will be pended until election **and** payment for COBRA continuation coverage is received, and then coverage will be activated retroactively. 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.

COBRA ELECTION FORM (page 2)

You are responsible for making sure that the amount of your first payment is correct. These rates may change from time to time depending on the cost of benefits. Any changes in these rates will be communicated to you.

If you have any questions about this notice or your rights to COBRA Continuation Coverage, you should contact: ~~The~~ Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund, 911 Ridgebrook Road, Sparks, MD 21152, Telephone number 1-800-730-2241.

Instructions: To elect COBRA continuation coverage, complete the Election Form and return it to us. Under federal law, you have 60 days from the date of the notice or the date of the coverage end date whichever is later to elect COBRA coverage under the plan. This Election Form must be completed and returned by mail.

Send completed Election Form to: Warehouse Employees Union Local No. 730
Health & Welfare Trust Fund
911 Ridgebrook Road
Sparks, Maryland, 21152-9451

If you do not submit a completed Election Form by the due date, 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 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.

Are you entitled to, or do you have, any other group health insurance (i.e. Medicare)?

Yes _____ No _____ If yes what? _____

As of the date of your COBRA election, are you or any of your Qualified Beneficiaries currently enrolled in Medicare Part A or Part B? If so, who? (Please print name and date of Enrollment)

Print Name Medicare Enrollment Date

Print Name Medicare Enrollment Date

This will acknowledge that I have received, read and understand the attached Continuation of Coverage Notice from the Warehouse Employees Union Local No. 730 Health & Welfare Trust Fund and,

( ) hereby apply for COBRA continuation coverage and understand I must pay for such coverage at the applicable rate for the coverage I have chosen. I understand that every individual covered on the date of the qualifying event, including eligible dependents, has the right to elect COBRA coverage.

( ) hereby decline the continued coverage offered under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Signature Date

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. 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.

You may elect to continue coverage for yourself, your spouse and any eligible dependents that were properly enrolled as such on the day before the Qualifying Event noted above. Each qualified beneficiary has a separate right to elect continuation coverage. Continuation coverage may be elected for only one, several or for all dependant children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependant children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries. You may choose Core coverage or Core and Non-Core coverage. You may not elect Non-Core coverage alone.

You may NOT elect COBRA coverage for a benefit you were not eligible for on the day the "qualifying event" took place. For example, if you were not yet eligible for optical coverage on the day you terminated employment or otherwise became eligible for COBRA, you cannot elect to receive that coverage under COBRA.

Newborn children, newly adopted children, and children placed for adoption will be treated as individual qualified beneficiaries, with independent COBRA rights. If the birth, adoption, or placement occurs while COBRA coverage is in effect, you may add the new individual to your COBRA Coverage. You must complete an enrollment form before the child's coverage can begin.

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 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 lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Your continuation coverage will be terminated before the end of the maximum period for any of the following reasons:

(1) If the Warehouse Employees Union Local No. 730 Health and Welfare Fund no longer provides group health coverage to any of its plan participants, your COBRA Coverage will terminate on the date your Participating Employer establishes a new plan, or joins an existing plan, that makes health coverage available to a class of employees formerly covered under the Warehouse Employees Union Local No. 730 Health and Welfare ~~Plan~~Trust Fund;

(2) The appropriate premiums for the continuation coverage are not paid on time.

(3) A qualified beneficiary becomes covered, after electing continuation coverage, under any other group health plan that does not exclude or limit coverage of a pre-existing condition (this applies separately to each individual continuing coverage), whether as an employee or otherwise. Please provide the Fund office with a copy of the other plan; (another plan's application of pre-existing condition exclusions may be restricted by the Health Insurance Portability and Accountability Act.)

(4) A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage. However, in this event, a dependent spouse or child continuing coverage may be able to continue for up to 18 months.

You or your eligible dependent(s) must notify the Fund Office immediately if you become covered by any other plan of group health benefits through your employment or your spouse's employment, or if you or your spouse becomes entitled to Medicare. You must repay the Fund for any claims paid in error as a result of your failure to notify the Fund Office of any other health coverage.

As noted above, your group health insurance coverage under this Fund will end if your former employer no longer provides group health coverage to any of its employees through this Fund. In that event, you may be entitled to continuation coverage under another group health arrangement maintained by your employer. Further, if your former employer changes the level of group health coverage provided through this Fund to its similarly situated active employees, your coverage provided by this Fund will be changed accordingly, with an appropriate adjustment of your premium.

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).

Once your COBRA Coverage terminates for any reason, it cannot be reinstated. You and your eligible dependents can only become covered under the Fund again if you return to covered employment and meet the Fund's eligibility requirements.

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 tThe ***Warehouse Employees Union Local No. 730 ~~Heath~~ Health & Welfare Trust 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.

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Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined within the meanings of Titles II or XVI of the Social Security Act 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. To be eligible for the 11-month extension of coverage, the Fund must be notified within 60 days of the

Social Security Administration's disability determination. An additional premium charge will be made for the last 11 months. 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.

The written notice of a second qualifying event or disability must include the following information: name and address of Participant and/or dependent, Participant and/or dependent's medical identification number, Participant and or dependent's Social Security Number, date of occurrence of event or date of disability determination, evidence reasonably necessary to aid the Fund in determination (for example a copy of the: divorce decree, separation agreement, death certificate, Medicare eligibility/enrollment, dependent's birth certificate, SSA disability determination)

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 a failure to continue your group health coverage 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 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 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 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.

The rates shown on the attached document may be revised at the same time every year for all COBRA recipients or if there is a change in benefits provided to active employees. Therefore, these rates may change before you have been on COBRA Continuation Coverage for 12 months. You will be notified of any change in rates and the reason for the change.

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.cfm. This program is offered by the federal government and the Fund Office has no role in its administration.

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, your coverage will be pended until election **and** payment for COBRA continuation coverage is received, and then coverage will be activated retroactively. You must make your first payment for continuation coverage no 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 no 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 tThe **Warehouse Employees Union Local No. 730 Health & Welfare Trust Fund, 911 Ridgebrook Road, Sparks, MD 21152, Telephone: (800) 730-2241** to confirm the correct amount of your first payment.

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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 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 continuation coverage is due on the first day of the month 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. However, if you elect COBRA continuation coverage, an 18-month premium payment coupon book will be sent to you after the Fund office receives your completed COBRA election form and payment

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. 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 proper premiums are not paid, these claims will be your total responsibility.

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 made payable to *The Warehouse Employees Union Local No. 730 Health & Welfare Fund.* Send the Election Form and your payment, in the form of check or money order, to:

The Warehouse Employees Union Local No. 730
Health & Welfare Fund
911 Ridgebrook Road,
Sparks, MD 21152-9451

Should you have any questions about these procedures, or your benefits, please contact the Participant Services Department at (800) 730-2241.

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 the Fund Office at:

The Warehouse Employees Union Local No. 730
Health & Welfare Fund
911 Ridgebrook Road,
Sparks, MD 21152-9451
Telephone: (800) 730-2241

This notice describes rights under COBRA. It is not intended to fully describe rights under ERISA, the Health Insurance Portability and Accountability Act (HIPAA), the Trade Act of 2002, and other laws. 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 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.

Your loss of benefit coverage is a Qualifying Event under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and you have the right to elect to continue your health and welfare coverage temporarily at group rates by following the procedures listed on the COBRA election form and paying the appropriate premiums to the Fund.

Sincerely,

BOARD OF TRUSTEES