

# NECA-IBEW WELFARE TRUST FUND

January 1, 2024

**This notice is addressed to you and everyone in your family who meets eligibility requirements under the NECA-IBEW WELFARE TRUST FUND. Please read the information contained in this notice very carefully.**

**This notice contains important information about your right to continue your health care coverage in the NECA-IBEW Welfare Trust Fund (the Fund), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace at [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.**

**IMPORTANT NOTE: If you are retired, you may be eligible to participate in the Supplemental Retiree Plan instead of, or in addition to, electing COBRA Continuation Coverage. If you have questions about your eligibility for the Supplemental Retiree Plan, please contact the Fund Office at 1-800-765-4239 x116.**

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

If you do not elect COBRA continuation coverage, your coverage under the Fund will terminate on the end date shown on the enclosed Certificate of Group Health Plan Coverage.

Each person (“qualified beneficiary”) is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Fund for up to 36 months:

If elected, COBRA continuation coverage will begin on the 1<sup>st</sup> day of the month following the date of loss of eligibility as shown on the enclosed Certificate of Group Health Plan Coverage.

COBRA continuation coverage will cost: **\$1169.00** per month. 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 will 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 this notice or your rights to COBRA continuation coverage, you should contact the Fund Office at:

NECA-IBEW Welfare Trust Fund  
2120 Hubbard Avenue  
Decatur, IL 62526-2871  
(800) 765-4239 extension 150 - **Telephone**  
(217) 875-9563 – **Fax**

# NECA-IBEW WELFARE TRUST FUND

## COBRA Continuation Coverage Election Form

**Instructions:** To elect COBRA continuation coverage, complete this Election Form and return it to the Fund Office. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Fund. If mailed, it must be post-marked no later than 60 days from the date of the enclosed statement.

Send completed Election Form to:

NECA-IBEW Welfare Trust Fund  
2120 Hubbard Avenue  
Decatur, IL 62526-2871

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 NECA-IBEW Welfare Trust Fund (the Fund) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____
e.	_____	_____	_____
f.	_____	_____	_____

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed above

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone Number

# NECA-IBEW WELFARE TRUST FUND

## 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 special enrollment rights.

### How long will continuation coverage last?

In the case of a loss of coverage due to termination of employment, reduction in hours, death of the employee, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child aging out of coverage, coverage generally 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.

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 first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first 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 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 preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect 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 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 the Fund Office 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 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, as determined by the postmark. 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. It is your responsibility to make timely payments.**

#### *Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you will be given a grace period of 31 days after the first day of the coverage period to make each periodic 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 continuation coverage under the Plan.

**Please include your Policy ID # from your Blue Cross insurance card on the memo area of your check.**

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

NECA-IBEW Welfare Trust Fund  
ATTN: COBRA  
2120 Hubbard Avenue  
Decatur, IL 62526-2871

**You may also make payment online at [www.neca-ibew.org/echeck](http://www.neca-ibew.org/echeck).**

### **Coordination of COBRA Continuation Coverage with Medicare**

If you have elected COBRA Continuation Coverage and you or your spouse is enrolled in Medicare, the Plan pays benefits after Medicare. Benefits paid by the Plan will be reduced so that the sum of benefits paid under the Plan and Medicare do not exceed the total allowable charge. Contact the Fund Office if you have questions about your benefits and Medicare.

### **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 Fund Office.

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:

NECA-IBEW Welfare Trust Fund  
2120 Hubbard Avenue  
Decatur, IL 62526-2871

(800) 765-4239 - **Telephone**  
(217) 875-9563 - **Fax**

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, you should contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272, visit the EBSA website at [www.dol.gov/ebsa](http://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](http://www.healthcare.gov).

## **Keep Your Plan Informed of Address Changes**

In order to protect your and your family's rights, you should keep the Fund Office 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 Fund Office.