August 24, 2020

JOE BOILERMAKER
101 MAIN ST
ANYTOWN, MO 64999

RE: COBRA Subsidy Approved by the Board of Trustees

Dear JOE BOILERMAKER:

Due to the impact of the coronavirus (COVID-19) pandemic, the Board of Trustees of the Boilermakers National Health & Welfare Fund have approved a subsidy to reduce COBRA premiums by 90%, when certain criteria are met. **The subsidy is effective from August 1, 2020 through October 31, 2020.**

Who Qualifies for the COBRA Subsidy:

- Participants working as a Boilermaker dispatched by the Local who have lost or will lose active H, G or GR coverage as of July 31, 2020 due to a COBRA Qualifying Event of loss of employment or reduction in work hours; AND are
- Actively seeking employment as a field construction Boilermaker or eligible for referral on a qualifying out-of-work list/pool. (Please reference Articles 5.1-5.6 of the International Brotherhood of Boilermakers' Model Uniform Referral Standards and Joint Referral Rules for qualifying out-of-work list/pool.); OR
- Have been required to quarantine for a period of time due to COVID-19/CDC requirements.

If you meet the above criteria for the COBRA subsidy, you must take the following actions within 60 days of the date of this letter:

☐ Complete and return the COBRA Subsidy Verification Form

You and your Local must complete the enclosed COBRA Subsidy Verification Form to verify that:

(i) You are actively seeking employment as a field construction Boilermaker and/or eligible for referral requirements; or

(ii) You are actively working as a Boilermaker dispatched by the Local requirements.

If you are unavailable for employment due to COVID-19 provide a signed personal written statement, in addition to the COBRA Subsidy Verification Form, to verify that:

(i) You were required to quarantine for a period of time due to COVID-19/CDC requirements. Your written statement must include details describing your situation and the dates in which you were required to quarantine.

☐ Complete the enclosed COBRA Election/Rejection Form with your benefit selection; and

☐ Submit your payment

If you do not take action within 60 days or do not qualify for the subsidy you are still entitled to COBRA benefits, but you will not receive the subsidy.

You were recently sent a notice regarding a qualifying event that made you eligible to elect COBRA effective August 1, 2020. This notice does not change your full COBRA rights that were provided to you at the time of your qualifying event. If you need another copy, please contact the Fund Office.

If you have already elected COBRA coverage:

- You must provide the required documents above to receive the subsidy.
- You may change your previous COBRA election.

- If you qualify for the subsidy and have already submitted COBRA premiums to the Fund, any overpayment will be credited towards your future COBRA premiums. If you would prefer a refund please request by contacting the Fund Office at 866-342-6555.

COBRA rates and subsidized rates are as follows:

	Full Coverage (Medical/RX/Dental/Vision)	Core Coverage (Medical/RX)	**Full Coverage with Subsidy**	**Core Coverage with Subsidy**
Single Coverage	$461.09	$444.46	**$46.11**	**$44.45**
Two Person Coverage	$922.18	$888.92	**$92.22**	**$88.89**
Family Coverage	$1,706.03	$1,644.50	**$170.60**	**$164.45**

Your first payment and all monthly payments for continuation coverage should be sent to:
Boilermakers National Health and Welfare Fund
PO Box 909700
Kansas City, MO 64190-9700

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 Boilermakers National Health and Welfare Fund at 866-342-6555 or by mail: Boilermakers National Health and Welfare Fund, Attention: COBRA Department, PO Box 909700 Kansas City, MO 64190-9700 or visit www.bnf-kc.com.

"always protecting our Boilermaker family"
BOILERMAKERS
NATIONAL HEALTH & WELFARE FUND

COBRA Subsidy Verification Form

THIS FORM IS REQUIRED to determine COBRA Subsidy eligibility as of August 1, 2020 through October 31, 2020.

Participant's Name & Social Security Number ____

Who Qualifies for the COBRA Subsidy:

- Participants working as a Boilermaker dispatched by the Local who have lost or will lose active H, G or GR coverage as of July 31, 2020 due to a COBRA Qualifying Event of loss of employment or reduction in work hours (unless excluded below); AND are

- Actively seeking employment as a field construction Boilermaker /or eligible for referral on a qualifying out-of-work list/pool. (Please reference Articles 5.1-5.6 of the International Brotherhood of Boilermakers' Model Uniform Referral Standards and Joint Referral Rules for qualifying out-of-work list/pool.); OR

- Have been required to quarantine for a period of time due to COVID-19/CDC requirements.

Verification Requirements:

1. ***Applicants unavailable for employment will not be considered for the subsidy.*** To verify your status, you must provide the *required* signatures below to verify that you meet the qualifications as stated above.

   Employment status:

   ☐ Actively seeking employment and/or eligible for referral requirements
   ☐ Actively working as a Boilermaker dispatched by the Local requirements

   ____
   Participant Signature ***(REQUIRED)*** Date

   ____
   Business Manager/Agent of Local Lodge Signature ***(REQUIRED)*** Date

   By signing this document you are authorizing the Local to provide the required qualification information to the Fund office to process your request.

2. Applicants who are unavailable for employment due to COVID-19/CDC quarantine requirements must provide a signed personal written statement with this Form that includes details describing your situation and the dates in which you were required to quarantine.

Acknowledgement:

FRAUD WARNING: Any person who, knowingly and with intent to defraud the Fund or other person: (1) files an application for benefits or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact hereto, commits a fraudulent act and may be subject to legal action. I understand that if I or my dependents provide false information to the Boilermakers National Health & Welfare Fund or conceal information, we could be subject to severe penalties under state and federal law and the Fund may seek to recover benefits wrongfully paid or pursue legal remedies against us. I declare under penalty of perjury that the foregoing is true and accurate.

PO Box 909700, Kansas City, MO 64190-9700

COBRA Continuation Coverage Election/Rejection form (All)

Instructions: To elect COBRA continuation coverage, complete this COBRA Election/Rejection Form and return it to us. Under federal law, you have 60 days from the **later of** the date your coverage with the Fund is terminated or the date of the attached letter to elect COBRA continuation coverage under the Plan.

Please complete this form and return it to the Fund Office in an envelope postmarked within 60 days of the date your coverage with the Fund is terminated or the date of the attached letter.

Participant Information

_______________ _______________ _______________
Last Name First Name Middle Initial

_______ - _______ - _______ (_______) _______ - _______
Social Security Number Area Code Phone Number

_______________ _______________ _______________
Home Address Apartment Number Local Number

_______________ _______________ _______________
City State Zip Code

Check One: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced: _______________
Date of Divorce (MM/DD/YYYY)

Check if you are eligible for Medicare: ❑ _______________
Date you were first eligible for Medicare (MM/DD/YYYY)

Spouse, Ex-Spouse or Primary Dependent Information

_______________ _______________ _______________
Last Name First Name Middle Initial

_______ - _______ - _______ (_______) _______ - _______
Social Security Number Area Code Phone Number

_______________ _______________ _______________
Home Address Apartment Number Local Number

_______________ _______________ _______________
City State Zip Code

Check One: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced: _______________
Date of Divorce (MM/DD/YYYY)

Check if you are eligible for Medicare: ❑ _______________
Date you were first eligible for Medicare (MM/DD/YYYY)

Please refer to the attached letter to determine your initial payment amount

No election of coverage will be permitted at a later date, unless you are declining enrollment for yourself or your dependents (including your spouse) because of other group health insurance coverage currently in effect. If at least one family member continues to maintain COBRA coverage under this plan they may, at a future date, be able to enroll their qualified dependents if the other group health coverage terminates, for the remaining period of COBRA coverage, provided enrollment is requested within 30 days after the other coverage ends. In addition, an individual who has elected COBRA coverage may enroll additional qualified dependents if they have a new dependent as a result of marriage, birth, adoption or placement for adoption, provided enrollment is requested within 30 days of the event If your other group health coverage does terminate and you wish to elect this COBRA coverage, you must submit proof of the termination of the other coverage.

FOR INTERNAL USE ONLY
EFF DATE: _______ 2 MO PMT REC: _______ MCR EFF DATE: _______

*Check only **one box** to either elect or reject coverage.*

Election of Coverage

☐ I (We) have read the above information and want health coverage continued for the persons listed below. **(You must list those you want covered below)**. I (We) understand the coverage options as described in the attached letter.

I (We) want coverage for (check one): ❑ All Benefits ❑ Core Benefits

Signature (on behalf of all those electing coverage) ____________ Social Security Number ____________ Today's Date (MM/DD/YYYY) ____________

List below all persons to be covered under the self-pay health coverage extension provided by the Boilermakers National Health and Welfare Fund, including yourself, if you are to be covered.

Individual Electing Coverage	Social Security Number	Last Name	First Name and Middle Initial	Date of Birth (MM/DD/YYYY)	Does this person have other Group Health or Medicare coverage?	Is this person disabled?
Participant					❑ Yes ❑ No	❑ Yes ❑ No
Spouse					❑ Yes ❑ No	❑ Yes ❑ No
Dependent ❑Son ❑Daughter ❑Other					❑ Yes ❑ No	❑ Yes ❑ No
Dependent ❑Son ❑Daughter ❑Other					❑ Yes ❑ No	❑ Yes ❑ No
Dependent ❑Son ❑Daughter ❑Other					❑ Yes ❑ No	❑ Yes ❑ No
Dependent ❑Son ❑Daughter ❑Other					❑ Yes ❑ No	❑ Yes ❑ No
Dependent ❑Son ❑Daughter ❑Other					❑ Yes ❑ No	❑ Yes ❑ No

Once you elect benefits, you cannot change to another type of coverage.

Only persons listed above will be covered under the self-pay health coverage extension provided by the Boilermakers National Health and Welfare Fund, providing they meet the eligibility requirements for this coverage, as set forth in the enclosed letter. If more space is needed, please use a separate sheet. Also, if the address where you want the monthly billing statements sent is different from the address shown on Page 1 of the Election/Rejection Form, please write the billing address on a separate sheet and return.

Rejection of Coverage due to Other Group Health Coverage

☐ I (We), have read the previous information and do not want our health coverage continued under the self-pay program because I (we) are currently covered by another group health plan. **(You must complete the other health coverage Information below, regarding this coverage now In effect)**

Participant Signature	Today's Date (MM/DD/YYYY)
Spouse Signature	Today's Date (MM/DD/YYYY)
Signature of Participant's Child over the age of 18	Today's Date (MM/DD/YYYY)
Signature of Participant's Child over the age of 18	Today's Date (MM/DD/YYYY)

If you are rejecting coverage due to other group health coverage, please complete the information below about your other health coverage

Individual	Other Policy Information
Participant ______ Last Name ______ First Name	Policyholder:______ Group Health Plan/Insurance Company Name:______ Group Health Plan/Insurance Company Address:______ Group Health Plan/Insurance Company Phone #:______ Policy or Group Number:______ Effective Date of Coverage:______
Spouse ______ Last Name ______ First Name	Policyholder:______ Group Health Plan/Insurance Company Name:______ Group Health Plan/Insurance Company Address:______ Group Health Plan/Insurance Company Phone #:______ Policy or Group Number:______ Effective Date of Coverage:______
Dependent ❑Son ❑Daughter ❑Other ______ Last Name ______ First Name	Policyholder:______ Group Health Plan/Insurance Company Name:______ Group Health Plan/Insurance Company Address:______ Group Health Plan/Insurance Company Phone #:______ Policy or Group Number:______ Effective Date of Coverage:______
Dependent ❑Son ❑Daughter ❑Other ______ Last Name ______ First Name	Policyholder:______ Group Health Plan/Insurance Company Name:______ Group Health Plan/Insurance Company Address:______ Group Health Plan/Insurance Company Phone #:______ Policy or Group Number:______ Effective Date of Coverage:______
Dependent ❑Son ❑Daughter ❑Other ______ Last Name ______ First Name	Policyholder:______ Group Health Plan/Insurance Company Name:______ Group Health Plan/Insurance Company Address:______ Group Health Plan/Insurance Company Phone #:______ Policy or Group Number:______ Effective Date of Coverage:______

Rejection for Other Reasons

☐ I (We) have read the previous information and do not want our health coverage continued under the self-pay program. I (We) understand that by rejecting this coverage, I (we) will not be eligible to elect it again.

Participant Signature	Today's Date (MM/DD/YYYY)
Spouse Signature	Today's Date (MM/DD/YYYY)
Signature of Participant's Child over the age of 18	Today's Date (MM/DD/YYYY)
Signature of Participant's Child over the age of 18	Today's Date (MM/DD/YYYY)

I (We) understand the following:

1. This coverage is for a maximum of a set number of consecutive months, as described in the attached letter, if the premiums are paid on time for that period. The monthly self-payment premiums are for the amounts stated in the attached letter, and these amounts are subject to change.

2. I (and my eligible dependents) may choose to be covered for **COBRA Benefits** as those terms are described in the attached letter. If this form is not returned in an envelope postmarked within the required time period, no coverage can be provided under the self-pay program, unless I regain my eligibility under the plan and another qualifying event occurs.

3. The initial payment must include each monthly premium owed, retroactive to my COBRA effective date. If the initial payment has not been included with this form, it will be sent within 45 days of the election date (date the envelope submitting the election form is postmarked) or I (and any dependents) will not be eligible for this self-pay health coverage. **All payments must be made by money order or cashier's check.**

4. After the initial payment is received, the Fund Office will send the first billing statement which will acknowledge receipt of the first payment and bill for monies due. The Fund will then send monthly statements showing the monthly amount due. It is understood subsequent premiums are due on the 15th of the month preceding each coverage month. If payment is not mailed by the end of each coverage month, I and/or dependents will no longer be enrolled in the self-pay program.

5. If the monthly billing statement is lost or not received, it is my and/or any eligible dependents' responsibility to continue making payments for the COBRA coverage on a timely basis.

6. If I, as an employee, reject the self-pay continuation coverage, my spouse may elect the continuation coverage. If I and my spouse reject the self-pay continuation coverage, each eligible dependent child may individually elect coverage for him/herself and make the required self payments. Additional election forms may be obtained from the Fund Office.

7. Any qualified beneficiary can add a new spouse or child to his or her COBRA coverage, as explained in the attached letter. However, the only newly added family members who have the rights of a qualified beneficiary, such as the right to stay on COBRA coverage longer in certain circumstances, are children born to, adopted or placed for adoption with the covered employee.

8. If the health benefits change for active employees, they will also change exactly for this self-pay program. In addition, the monthly premium may be adjusted accordingly.

9. If the Fund ceases to provide health care coverage, the benefits under this program will end.