Notice Regarding Right to Opt-Out of the 4th District IBEW Health Plan's

Health Reimbursement Arrangement

Under federal health care reform law, the Plan is required to notify you annually regarding your right to opt-out of participation in the 4th District IBEW Health Plan's Health Reimbursement Arrangement ("HRA").

If you are eligible for HRA benefits, you will be considered to have employer-sponsored coverage that will prevent you from being eligible for a government-issued subsidy if you purchased health insurance coverage on the Marketplace Exchange. Keep in mind that other factors, such as your household income, will impact whether you are eligible for a subsidy to offset the cost of coverage you may purchase on the Marketplace Exchange.

If you elect to opt out of coverage under the HRA, you will not be allowed to re-enroll (and receive benefits using money deposited to your account) for the duration of the time you are eligible for coverage under the 4th District IBEW Health Plan. If you elect to permanently opt-out, any money that you have in your HRA account will be forfeited, and will revert to the general assets of the Plan. Because the HRA is funded pursuant to a collective bargaining agreement, you will not have the option of electing to receive HRA money as wages, in lieu of a contribution to an HRA account.

If you have questions regarding your coverage under the HRA, please contact American Benefit Corporation. For information regarding coverage through the Marketplace Exchange and federal subsidies, see www.healthcare.gov or call 1-800-318-2596.

To exercise your opt-out rights under the HRA, please complete the form below and submit it to American Benefit Corporation no later than February 1, 2014.

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Participant Name: _____

Name(s) of Dependents Covered under the Plan: _____

Address: _____

Phone Number: _____

I, _____(print name of Participant) elect to permanently opt out of participation in the 4th District IBEW Health Plan Health Reimbursement Arrangement. I understand that I will not be able to participate in the HRA for the remainder of the time I am eligible in the 4th District IBEW Health Plan. I understand that all monies in my HRA will be immediately forfeited and I will not be able to seek reimbursement for any medical expenses for myself or my dependents from funds previously held in my HRA account.

_____ (Signature of Participant) _____(Date)