**COBRA Continuation Coverage Election Notice**

Date: _____

Dear _____ and Family:

**This notice contains important information about your right to continue your health care coverage in the ABX Air, Inc. Cafeteria Plan also known as the medical, dental, and vision 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. You are receiving this election notice because you experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 and you may be eligible for the temporary premium reduction for up to nine 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, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form.**

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

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on _____ due to:

- ☒ End of employment
  - ☒ Involuntary ☐ Voluntary
- ☐ Divorce or legal separation
- ☐ Death of employee
- ☐ Entitlement to Medicare
- ☐ Reduction in hours of employment
- ☐ Loss of dependent child status

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

_____ and eligible dependents

If elected, COBRA continuation coverage will begin on _____ and can last until _____(18 months).

You may elect any of the following coverage options in which you are already enrolled for COBRA continuation coverage:

_____ MEDICAL PLAN
DENTAL PLAN
VISION PLAN

To change the coverage option(s) for your COBRA continuation coverage to something different than what you had on the last day of employment, complete the "Form for Switching COBRA Continuation Coverage Benefit Options" and return it to us. Available coverage options are:

Enhanced PPO Plan
Value PPO Plan
Health Savings Account PPO Plan

*The different coverage must cost the same or less than the coverage the individual had at the time of the qualifying event; be offered to active employees; and cannot be limited to only dental coverage, vision coverage, counseling coverage, a flexible spending arrangement (FSA), including a health reimbursement arrangement that qualifies as an FSA, or an on-site medical clinic.*

COBRA continuation coverage will cost: $_____ per month

If you qualify as an "Assistance Eligible Individual" this cost will be $_____ per month, for up to nine months. 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.

**If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact Edna Rickard at (800) 736-3973 ext. 62567 or Vickie Hurt at ext. 62531.**

Sincerely,

Jeffrey S. Walling, CEBS
Manager, Benefits

# COBRA Continuation Coverage Election Form

**Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. 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 Plan.**

**Send completed Election Form to:**

**ABX Air Benefits Dept.**
**Mail Code 2061B**
**145 Hunter Drive**
**Wilmington, OH 45177**
**Fax: (937) 366-3145**

**This Election Form must be completed and returned by mail or fax. If mailed, it must be post-marked no later than _____(60 days).**

**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.**

I (We) elect COBRA continuation coverage in the ABX Air Cafeteria Plan (the Plan) as indicated below:

_____ MEDICAL PLAN
DENTAL PLAN
VISION PLAN

| Name | Date of Birth | Relationship to Employee | SSN (or other identifier) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____ Employee Number: _____

_____

_____ _____
Print Address Telephone number

**Form for Switching COBRA Continuation Coverage Benefit Options**

**Instructions: To change the benefit option(s) for your COBRA continuation coverage to something different than what you had on the last day of employment, complete this form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.**

**Send completed form to:**

**ABX Air Benefits Dept.**
**Mail Code 2061B**
**145 Hunter Drive**
**Wilmington, OH 45177**
**Fax: (937) 366-3145**

**This form must be completed and returned by mail *or fax*. If mailed, it must be post-marked no later than _____(90 days).**

***THIS IS NOT YOUR ELECTION NOTICE***
**YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR COBRA CONTINUATION COVERAGE.**

I (We) would like to change the COBRA continuation coverage option(s) in ABX Air Cafeteria Plan (the Plan) as indicated below:

Old Coverage Option: _____

New Coverage Option: _____

| Name | Date of Birth | Relationship to Employee | SSN (or other identifier) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____ Employee Number: _____

_____

_____ _____
Print Address Telephone number