COBRA Continuation Coverage Election Notice

TODAY'S DATE: _____/_____/_____

COVERAGE END DATE: _____/_____/_____

Dear: _____

This notice contains important information about your right to continue your health care coverage in the Lobue Laser & Eye Medical Centers, Inc. Health Plan. Please read the information contained in this notice very carefully. If you are married, both you and your spouse should read this Notice and review the Election Form. If your spouse and/or any dependent child does not live with you, you must advise the Company immediately of his, her or their address(es) so we can provide them this Notice and Election Form.

Because of the Qualifying Event specified at the end of this Notice, coverage under the Company health plan for you (and your covered spouse or dependent children, if any) has ended or will end shortly. Federal law (known as COBRA) permits you, your covered spouse and dependent children to elect to continue your company's health plan coverage for a limited time. This coverage is called "continuation coverage" or "COBRA coverage." You (and your covered spouse or covered dependent child, if any) are sometimes called a "Qualified Beneficiary" in this Notice.

If you or your covered spouse or dependent child want COBRA coverage, complete the enclosed Election Form and return it to the Company within the election period described below (and specified on the Election Form).

Continuation coverage consists of the coverage under the Company's group health plan that you and other Qualified Beneficiaries had immediately before your Qualifying Event. If the Company health plan changes benefits, premiums, etc., continuation coverage changes accordingly. During open enrollment, each Qualified Beneficiary will have the same options under COBRA coverage as active employees covered under the Company health plan.

How to Elect to Continue Health Plan Coverage

You may elect to continue your coverage by completing the attached COBRA Election Form and returning it to the Company. You also may elect to continue your covered spouse's or dependent child(ren)'s coverage on the Election Form. Your covered spouse and adult dependent child(ren) also have the right to elect coverage themselves. This means that even if you don't elect to continue coverage for them, they may independently elect to continue their coverage.

You must send us the completed COBRA Election Form on or before the date specified on the Election Form. The election period ends 60 days after the date of this Notice or 60 days after the Company health plan coverage expires, whichever period is longer. If we don't receive the Election Form by the date specified on the Election Form, neither you nor any other Qualified Beneficiary will be entitled to COBRA coverage.

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 coverage end date above due to:

- ☐ End of employment
- ☐ 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 for Federal COBRA, and an additional 18 months of state COBRA**:

- ☐ Employee or former employee
- ☐ Spouse or former spouse
- ☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- ☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin the day after coverage end date above.

Premium For COBRA Coverage
You must pay the entire premium for your COBRA coverage. See the attached COBRA Premium Schedule for rates. The rates include a 2 percent add-on allowed by COBRA to cover administrative expenses. These rates are subject to change once a year as of the beginning of the "determination year" as indicated on the schedule.

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.

Payment of Initial Premium for COBRA Coverage
Initial payment of premiums for COBRA coverage must be made on or before the 45th day after electing COBRA coverage. For example, Joe completes and mails his Election Form on May 15. Joe must make his initial premium payment on or before June 29.

The initial payment must include payment for the premiums for all prior months of continuation coverage. The premium for the current month must be made within 30 days of the first day of the month. For example, Sandy's employment terminated in September and her first day of continuation coverage is October 1. Sandy elects continuation coverage and makes her initial premium payment in December. Sandy's initial premium must include payment for coverage for October and November.

No claims under the group health plan incurred after the Qualifying Event will be paid until the applicable premium is paid. If the full initial premium payment is not made within the 45-day period, COBRA coverage for the affected Qualified Beneficiary will be canceled. If, for whatever reason, you received any benefits under the Plan during a month for which the premium was not timely paid, you will be required to reimburse us for the benefits you received.

Payment of Premiums After the Initial Premium
After the initial premium, your premium payment is due the first of each month for that month's COBRA coverage. There is, however, a grace period for late payment, which expires on the 31st day after the first of the month. If you don't make the premium payment within the 31-day grace period, your COBRA coverage will be canceled retroactive to the last full month for which premiums have been paid. If, for whatever reason, you received any benefits under the Plan during a month for which the premium was not timely paid, you will be required to reimburse us for the benefits you received.

If the payment received is less than the full premium by an insignificant amount, there will be a 30-day grace period to make up the difference. If the full premium is not received by the end of the grace period, coverage will end as of the end of the month for which the full premium has been received.

Duration of COBRA Coverage
36-month maximum. Generally, when there has been a termination of employment or a reduction in hours that causes coverage to be lost, COBRA coverage for a Employee or Qualified Beneficiary begins the day after the Company-provided health plan coverage is lost, and continues for up to 36 months or begins as of the first day of the next month. For example, Bob's employment terminates in January and his last day of the company health plan coverage is January 31, 1999. If Bob properly elects COBRA coverage, it begins February 1, 1999 and can continue up through January 31, 2002.

36-month period if you become entitled to Medicare. If the former employee becomes entitled to Medicare before expiration of the 18-month COBRA coverage period (including before your employment with the company terminated), the COBRA coverage period for your covered spouse or dependent child(ren) is a period that ends 36 months after you become entitled to Medicare, or the 18-month coverage period described above, whichever is longer.

29-month period for disabled qualified beneficiaries. If a Qualified Beneficiary (including you) is disabled, COBRA coverage for all Qualified Beneficiaries may continue for up to 29 months from the date the 18-month period would begin. The 29-month period applies only if the following conditions are satisfied: (1) the Social Security Administration determines the Qualified Beneficiary is disabled at the time of the qualifying event or within 60 days of when COBRA coverage begins; and (2) the Qualified Beneficiary provides the company a copy of the determination within the 18-month coverage period and not later than 60 days after the determination is made. The premium for COBRA coverage increases after the 18th month of coverage to 150% of the applicable premium for the disabled Qualified Beneficiary, as well as other Qualified Beneficiaries, if they are in the same rate band.

Early Termination of COBRA Coverage
COBRA coverage can terminate before the 36-month or 29-month period described above expires. COBRA coverage for a Qualified Beneficiary terminates on the earliest of: the month for which the premium for the Qualified Beneficiary's COBRA coverage is not timely paid; the date the company ceases to maintain any group health plan; after electing COBRA coverage, the date the Qualified Beneficiary becomes (a) entitled to Medicare or (b) covered by another group health plan that contains no exclusion or limitation for pre-existing conditions of the Qualified Beneficiary, or which exclusion or limitation does not apply due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If a Qualified Beneficiary is entitled to 29 months of COBRA coverage on account of disability, but is later determined not to be disabled, coverage ends with the first month beginning more than 30 days after that determination. For further information, please contact the Company's plan administrator

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.

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 about this notice or your rights to COBRA continuation coverage, you should contact:

HR Department
Lobue Laser & Eye Medical Centers, Inc.
40700 California Oaks Rd., #106
Murrieta, CA 92562
(951) 696-1135

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov.