Southern Healthcare Agency Field Employees
Summary of Benefits
Blue Cross Blue Shield of MS

Dual Option #1

Plan: **Network Blue**
Deductible: **$5000**
Coinsurance: 70% Network/50% Non-Network
Max Out of Pocket: **$6450**

Employee Only $30.52/week
Employee/Spouse $100.25/week
Employee/Child(ren)$120.75/week
Employee/Family $202.78/week

Family Deductible:
You must pay all of the cost from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible ($10,000) must be met before the plan begins to pay.

Pharmacy Benefits:
Medical deductible has to be met before any benefits are paid. Non-Network not covered
Pharmacy Co-Pay after $5000 Deductible / $10,000 Family Deductible
C1 $15 Generic, **C2 $35** Brand – Preferred, **C3 $75** Brand Non-Preferred.**C4 $100;**

Physician Office Services:
Applies to office visits only (**deductible does not apply if using an in-network provider)**
$35 Primary Care Physician co-pay **$50** Specialist co pay; Non-Network not covered

Outpatient Preventive/Wellness Services:
Healthy You Benefit – When you use an in-network, primary care provider, certain procedures will be covered at 100% of the allowable charge with no co pay, no deductible, and no co insurance.
Non-Network Provider not covered

My Blue Services:
To retrieve your Explanation of Benefits (EOB) and to view your Healthy You status, order new id cards, change your address, or look at your list of medications, please log into www.bcbsms.com and register for **MY BLUE** Your must have your id card or number to do this.
The Patient Protection and Affordable Care Act requires that we provide you with a standard format summary of benefits and coverage. If you aren't clear about any of the bolded terms used in the summary of benefits and coverage, a Glossary is available. Both of these can be viewed under My Benefits towards the end of the page.

Agent Information:
Mississippi Life and Health, Inc
327 Main Street Greenville MS
662-378-4470

Southern Healthcare Agency Field Employees
Summary of Benefits
Blue Cross Blue Shield of MS

Dual Option #2

Plan: **Network Blue**
Deductible: **$3500**
Coinsurance: 80% Network /60% Non-Network
Out of Pocket: **$7350**

Employee Only $45.64/week
Employee/Spouse $128.22/week
Employee/Child(ren) $152.51/week
Employee/Family $249.66/week

Pharmacy Co-Pay:
$50 Yr Ded – 100% after Co-pay
C1 $15 Generic, **C2 $35** Brand – Preferred, **C3 $75** Brand Non-Preferred.**C4 $100;**
www.bcbsms.com Non-Network not covered

Physician Office Services:
Applies to office visits only (deductible does not apply if using an **in-network provider**)
$35 Primary Care Physician co-pay **$50** Specialist co pay; Non-Network not covered

Outpatient Preventive/Wellness Services:
Healthy You Benefit – When you use an in-network, primary care provider, certain procedures will be covered at 100% of the allowable charge with no co pay, no deductible, and no co insurance. Non-Network not covered

My Blue Services:
To retrieve your Explanation of Benefits (EOB) and to view your Healthy You status, order new id cards, change your address, or look at your list of medications, please log into www.bcbsms.com and register for **MY BLUE** Your must have your id card or number to do this.
The Patient Protection and Affordable Care Act requires that we provide you with a standard format summary of benefits and coverage. If you aren't clear about any of the bolded terms used in the summary of benefits and coverage, a Glossary is available. Both of these can be viewed under My Benefits towards the end of the page.

Agent Information:
Mississippi Life and Health, Inc
327 Main Street Greenville MS
662-378-4470

BlueCross BlueShield of Mississippi

Southern Healthcare Agency

Network Blue
Summary of Benefits

This summary is designed for the purpose of presenting general information only and is not intended as a guarantee of benefits. It is not a Summary Plan Description and in the event of a conflict between this document and the Benefit Plan, the terms of the Benefit Plan will prevail. The terms "pay," "paid," "payment," and "payable" appear throughout this Summary of Benefits. These terms reference the benefits provided by Blue Cross & Blue Shield of Mississippi (hereinafter "BCBSMS"), rather than an actual amount paid by BCBSMS. Actual benefits and the limitations, exclusions, terms, conditions and definitions to which such benefits are subject are contained in the Benefit Plan. Complete terms of the plan are contained in the Summary Plan Description.

Important Terms

Allowable Charge – The lesser of the: (1) Covered Charges or (2) the amount established by BCBSMS as the maximum amount for Provider services covered under the terms of the Benefit Plan.

Benefits – The amount provided under the Benefit Plan for covered services. Benefits are based on the Allowable Charge minus any applicable Deductible Amount, Coinsurance or Copayment.

Coinsurance - That portion of the Allowable Charge expressed as a percentage for which the Member is financially responsible under the Benefit Plan in addition to any applicable deductible and copay amounts.

Copay (Copayment) – That portion of the Allowable Charge expressed as an amount for which the Insured is financially responsible under this Benefit Plan, in addition to the Deductible Amount, where applicable.

Covered Services – A service or supply specified in the Benefit Plan for which Benefits are available when rendered by a Provider. A charge for a Covered Service is considered to have been incurred on the date the service or supply was provided to the Member.

Deductible – The amount the Member must pay each calendar year toward covered services. Medical and pharmacy deductibles are separate.

Member – A subscriber or an enrolled dependent.

Max Out-of-Pocket – Unreimburseable expenses incurred by a Member for Covered Services in a Benefit Period. Charges for non-covered services or any charges in excess of the Allowable Charge do not apply.

Precertification/Certification – A determination by BCBSMS that an admission or health care service is medically necessary as well as meets the utilization management requirements of the Benefit Plan.

Primary Care Physician (PCP) – A physician who practices under one of the following specialties: Family Practice, General Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology.

Specialist – A physician who practices under any one of a number of specialties from Allergy to Urology, not including the five specialties of Primary Care Physicians.

Your Network Blue Benefit Plan includes Network Providers such as physicians, hospitals, pharmacies, and others. To ensure that you receive the highest level of benefits, you should always use Network Providers. Some services must be provided by Primary Care Physicians (PCPs) or Primary Care Health Professionals to receive the higher level of benefits, or to be covered at all.

The benefits described below are for general information. You should refer to your Summary Plan Description for complete details regarding benefit maximums, limitations and exclusions, pre-certification requirements and penalties and non-covered services.

BlueCross BlueShield of Mississippi

Register for *my*Blue: WWW.bcbsms.com

Network Blue Summary of Benefits

If you use Network Providers:

- You cannot be billed for any amount (other than your deductible, coinsurance or copay) over the allowable charge for covered services.
- Network Providers will file your claims for you.
- You will be responsible for paying copays as determined by your Benefit Plan.
- You will be responsible for paying any applicable deductibles, coinsurance and non-covered charges (unless otherwise noted below) as determined by your Benefit Plan.

If you use Non-Network Providers:

- You may have to pay for charges that exceed the allowable charge.
- You may have to pay the provider the full amount during the visit and file a claim for reimbursement.
- *Healthy You!* wellness benefits are not covered.
- You may have to pay more for your health care.

Your Benefit Plan includes the following:	**Network**	**Non-Network**
Lifetime Maximum	**Unlimited**	
Medical Deductible Per Calendar Year	**Individual:** $5,000 **Family:** $10,000	**Individual:** $10,000 **Family:** $20,000
Prescription Drug Deductible Per Calendar Year	Integrated with Medical	**Not Covered**
Maximum Out-of-Pocket Per Calendar Year	**Individual:** $6,450 **Family:** $12,900	**Individual:** No Limit **Family:** No Limit
Outpatient Preventive/Wellness Services **Physician Office Visits** **Other Services** - For example: immunizations, mammography, pap smear, complete blood count, urinalysis, prostate specific antigen, stool for occult blood.	*Healthy You!* wellness benefits apply	**Not Covered**
Benefits/Coinsurance	70%	50%
Physician (MD or DO) Office Visit Copay Applies to the office visit only.	**Primary Care Physician (PCP):** $35.00 **Specialist:** $50.00	Benefits/Coinsurance and Deductible Apply
Pharmacy Copay - Community PLUS Pharmacy Network Member must satisfy Prescription Drug Deductible if applicable.	**Category 1:** $15 **Category 2:** $35 **Category 3:** $75 **Category 4:** $100	**Not Covered**

BlueCross BlueShield of Mississippi

Helping You Be Healthy and Stay Healthy

Helping you be as healthy as possible is at the core of our commitment to a healthier Mississippi. We encourage you to practice healthy lifestyle habits that will make a significant impact on your health. Eat healthy, exercise, be tobacco-free and see your healthcare provider each year. These habits can help you avoid chronic medical conditions like heart disease and diabetes, which can increase your healthcare costs and affect your quality of life. By taking care of yourself and your health, you can live a longer, healthier life.

Healthy You! is your first step in taking ownership of your health. *Healthy You!* Is a wellness benefit that provides you and your covered dependents with an annual wellness visit with your Network Provider. This wellness benefit is paid at 100% with no deductible, copay or coinsurance when you use your Network Provider. Remember that *Healthy You!* is about helping you stay on track with a healthy lifestyle. If you are sick on the day of your *Healthy You!* visit, re-schedule your visit for a day that is more appropriate for you to discuss your health and wellness. If illness services are completed at your *Healthy You!* visit, please be aware that these services are not in the list of recommended wellness services and will apply to your medical benefits. Covered wellness screenings and immunizations are based on age and gender to ensure you receive the screenings you need to "know your numbers" and manage your health risks, both at an early age and as you get older.

Register for the *my*Blue website! www.bcbsms.com

We are pleased to provide you with secure, personalized access to your claims and benefit information online through our *my*Blue website. Here's why you should register now:

- Registration is quick, easy, secure and useful. You have access to the health benefit information you want, when you want it.
- You can view claims history for the previous 15 months, including payments, copay and deductible amounts. You can go green and stop the mailing and delivery of paper EOBs.
- You can give us important information online at any time – no need to call during business hours only. You can update your phone number or email, and you can order a new ID card on *my*Blue.

ADMINISTRATIVE POLICY
Health Insurance

POLICY:
Southern Healthcare offers a health insurance plan through Blue Cross Blue Shield of Mississippi to full time employees and eligible variable hour employees. On an employee's start date, he or she will be classified as either a full time employee or a variable hour employee.

PROCEDURE:

Full Time Employee Defined
A new employee is a full time employee if, based on facts and circumstances at the start date, it can be determined that the employee is reasonably expected to work on average at least 30 hours per week. Special rules apply for certain situations.

Variable Hour Employee Defined
A new employee is a variable hour employee if, based on facts and circumstances at the start date, it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week. A new employee who is expected to work initially at least 30 hours per week may be a variable hour employee if, based on facts and circumstances at the start date, the period of employment at more than 30 hours per week is reasonably expected to be of limited duration and it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week over the initial measurement period. Furthermore, Southern Healthcare can properly classify temporary employees as variable hour employees based on the following examples:

- In one example, Southern Healthcare expects, on the employee's start date, that the employee will be offered "short-term" assignments with "several different clients" with "significant gaps" in between, that the assignments will differ in average weekly hours, and that the number and duration of assignments offered and accepted, the gaps between, and the weekly hours, are all uncertain.
- In the other example, an employee is hired on an hourly basis to "fill in for employees who are absent and to provide additional staffing at peak times." In that example, Southern Healthcare expects the employee to work "full-time for the first few months of employment, while assigned to a specific project, but also reasonably expects that the assignments will be of unpredictable duration, that there will be gaps of unpredictable duration between assignments, that the hours per week required by subsequent assignments will vary, and that [the employee] will not necessarily be available for all assignments."

Determining eligibility for Variable Hour Employees:
Southern Healthcare will use a look back period to determine the eligibility of a variable hour employee. Under the look-back method, Southern Healthcare is permitted to determine an employee's full-time status based on a 12 month measurement period. Southern Healthcare's measurement period is November 1st through October 31st and will be the same year after year. If you work an average of 30 hours per week throughout the entire measurement period, you will be eligible for health insurance through Southern Healthcare for the following year. There will be an administrative period of November

1st through December 31st to process all necessary paperwork to enroll you into the plan. The plan will take effect January 1st and will last the entire year whether you continue to work an average of 30 hours per week or not. If you were enrolled into the plan during the measurement period and qualify for the plan the following year as well, you will not lose coverage for an administrative period. There will not be any gap in coverage year after year for those that continue to qualify.

All employees hired after November 1st will have to complete a full 12 months before determining eligibility for health insurance through Southern Healthcare. We will calculate your hours worked on your anniversary date. If you work an average 30 hours per week for the entire 12 months, you will be eligible for health insurance through Southern Healthcare. You will be able to enroll in our health insurance plan for the entire year following your anniversary date whether you continue to work 30 hours per week or not. However, there will be an administrative period to enroll you into the plan before your health insurance takes effect. For new hires, the administrative period will be at least one month but no more than two months. You complete the month your anniversary date lands in plus the entire next month. For example, if you were hired December 3, 2013 we will calculate your hours worked from December 3, 2013 through December 2, 2014. If you work an average 30 hours per week, the administrative period will be from December 3, 2014 through January 31, 2015. If you chose to enroll, your plan would take effect February 1, 2015 and would last through January 31, 2016.

Change in Status
Special rules apply for employees who experience a change in employment status during a measurement period. If the employee was hired as a variable hour or seasonal employee, but was moved to full-time status, then the employee is considered a full-time employee on the first day of the fourth month following the status change (or, if earlier and the employee averages 30 hours or more per week during the initial measurement period, then the first day of the first month following the end of that measurement period).

Rehires
Special rules apply for employees who are terminated but later rehired. An employee will generally retain full-time employee or non-full-time employee status during an entire stability period for as long as the employee continues to be employed by the employer. If not considered a continuing employee, the employee is considered a new employee and enters into a new initial measurement period upon rehire. There are two methods of determining when an employee returning to work following a period of absence (including a termination) will be considered a new employee:

- If the employee is rehired after at least 13 consecutive non-working weeks (approximately 3 1/2 months), the employee is considered a new employee.
- The second method applies for periods of absence less than 13 weeks; if the absence was at least four weeks and exceeds the number of weeks of employment immediately preceding the absence, the employee may be treated as a new employee.

If the employee is not considered a new employee under either of those two methods, then upon rehire the employee is considered a continuing employee, meaning the employer treats the rehired employee as if the employee never left, and full-time or non-full-time status is retained.

Premium Payments
We will payroll deduct your share of the premium a month in advance. If you don't work enough to fully deduct your portion of the premium, you will have the opportunity to pay with a check, cash or money order. You will lose coverage if you can't cover your share of the premium. You will have until the end of the month to pay us for the premiums for the next month or your coverage will be cancelled.

COBRA Rights

COBRA, the Consolidated Omnibus Budget Reconciliation Act, provides the opportunity for employees and their beneficiaries to continue health insurance coverage under the company health plan when a "qualifying event" could result in the loss of eligibility. Qualifying events include resignation, termination of employment, death of an employee, reduction in hours, a leave of absence, divorce or legal separation, entitlement to Medicare, or where a dependent child no longer meets eligibility requirements. Please see the following information or contact human resources to learn more about your COBRA rights.

Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan through Blue Cross Blue Shield of Mississippi. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to Plan Administrator listed below.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notice must be given in writing to Plan Administrator listed below.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Plan Administrator:
Josh Young
301 New Pointe
Ridgeland, MS 39157
Phone: (601) 933-0037
Email: jyoung@southernhealthcare.com

FEDERAL "COBRA"
CONTINUATION COVERAGE FORM

_____
(Date Notified)

To: _____ _____
(Name of Employee or Qualified Beneficiary) (Now covered under I.D. #)

From: _____ _____
(Name of Group) (Group Number)

RE: Right to Continuation Coverage

This is to advise you that you and/or your covered family members have the right to continuation coverage under the employer's group health plan. Each person covered on the day your health plan is terminated can elect continuation coverage. Your group health plan might include other options, such as dental or cancer coverage. Consult the Group Administrator to determine if you are eligible.

You must exercise this right by notifying your employer within 60 days from the date your coverage terminates because of a "qualifying event" or from the date you receive this notice, whichever is later. Your coverage will terminate as a result of a qualifying event. When your election notice is received, your coverage will be reinstated.

As a result of the "qualifying event", your coverage terminates _____. Therefore, continuation coverage will end _____.

You and/or your covered dependents are entitled to continuation coverage for the specified time because of the following qualifying event. If it is for 36 months, a new Enrollment Form and Request for Change Form must be completed.

18 Months

( ) Termination of employment
( ) Loss of coverage due to reduction in work hours

36 Months

( ) Death of employee
( ) Divorce/Separation From Employee
( ) Ineligible dependent child
( ) Medicare-ineligible spouse/children

The monthly premium due for continuation coverage is $ _____ for subscriber only coverage; $_____ for employee and dependent coverage, provided your dependents were previously insured. These applicable rates can include 102 percent of the group premium amount of 150 percent of the group premium amount for disability.

You must submit the monthly premium to our company no later than the _____ of each month. Failure to pay premiums timely will result in cancellation.

Certain disabled qualified beneficiaries can have an 11-month extension from 18 months to 29 months. To qualify, a qualified beneficiary must be determined by the Social Security Administration to be disabled as of the termination or reduction in hours of employment or within sixty (60) days thereafter. In order to qualify for the 11-month extension, the Plan Administrator (employer) must be notified within 60 days after the SSA notice of disability. In addition, that notification to the employer must be made during the initial 18-month coverage period, while Cobra coverage remains in force. In such cases, the qualifying beneficiary may be charged 150 percent of the group fee for the 11-month extended period. The Plan Administrator must forward the award letter to the insurance carrier for an additional 11 months of coverage. The affected individual must also notify the Plan Administrator within thirty (30) days of any final determination that the individual is no longer disabled.

TO BE COMPLETED BY EMPLOYEE/QUALIFIED BENEFICIARY

I acknowledge receipt of the above notice of right to continuation coverage.

For myself and family members, if any, I elect

( ) Not to have continuation coverage

( ) To have continuation coverage, and understand that I am responsible for payment of the entire premium amount/102 percent of the group premium or 150 percent of the group premium for disability.

I understand that continuation of coverage ceases at the expiration of the allowed time period. It can end earlier in case of the following:

1. **All of the employer's health benefit programs are terminated.**
2. **A qualified beneficiary becomes covered under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary.**
3. **A qualified beneficiary becomes entitled to Medicare after the date of the continuation coverage election. [If a qualified beneficiary is already entitled to Medicare before the qualifying event, the qualified beneficiary is entitled to elect COBRA]**
4. **A qualified beneficiary fails to pay a required premium in a timely manner.**
5. **A qualified beneficiary with coverage for up to 29 months due to disability has received a final determination that the individual is no longer disabled.**

Signature:_____
EMPLOYEE/QUALIFIED BENEFICIARY

Date Signed: _____