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 $109.42/week
Employee/Child(ren)$91.49/week
Employee/Family $181.15/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 must 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:
Medical deductible must be met before any benefits are paid. Non-Network not covered
Applies to office visits only **(deductible applies)**
$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 can be viewed under My Benefits towards the end of the page.

Agent Information:
Acuity Group
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 $53.79/week
Employee/Spouse $158.29/week
Employee/Child(ren) $134.54/week
Employee/Family $253.29/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 can be viewed under My Benefits towards the end of the page.

Agent Information:
Acuity Group
327 Main Street Greenville MS
662-378-4470

Blue Cross & Blue Shield of Mississippi: Blue Health Savings

Coverage for: Individual and/or Family | Plan Type: HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at www.bcbsms.com or call 601-664-4590 or 1-800-942-0278. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary on *my*Blue Member or call 601-664-4590 or 1-800-942-0278 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network Providers: $5,000 per Individual / $10,000 per Family For Non-Network Provider: $10,000 per Individual / $20,000 per Family No one covered family member will contribute more than Individual out-of-pocket limit.	Generally, you must pay all of the costs 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 must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network Providers: $6,450 per Individual / $12,900 per Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Balance-billed charges, non-network deductibles, non-network coinsurance, premiums and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsms.com or call 601-664-4590 or 1-800-942-0278 for a list of Network Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 / office visit Deductible applies.	50% Coinsurance	Other Covered Services rendered in the Network Provider's office will be subject to the Network Coinsurance amount. During the COVID-19 Public Health Emergency, medically appropriate COVID-19 diagnostic tests and certain related items/service are covered at no cost share.
	Specialist visit	$50 / office visit Deductible applies.	50% Coinsurance	Other Covered Services rendered in the Network Provider's office will be subject to the Network Coinsurance amount. Routine vision and podiatry are not covered. See Rehabilitation services, below, for additional information. During the COVID-19 Public Health Emergency, cost-sharing is waived for medically appropriate COVID-19 diagnostic tests and certain related items/service.
	Preventive care/screening/ immunization	No charge	Not covered	Covered Services must be rendered by a *Healthy You!* Network Provider in that Provider's setting. Please see www.bcbsms.com/be-healthy/healthy-you-wellness-benefit. You may have to pay for services that aren't preventive. Ask your Provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance	Not covered	Benefits listed are for Independent Labs and Diagnostic Services Facilities. Services provided in the Provider's office may be subject to the amounts listed above for Primary or Specialist care.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsms.com.	Category One Drugs	$15 / prescription	Not covered	Limited to a 30-day retail supply. Certain Prescription drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions. Generic drugs mandatory when available. *See the Prescription Drug Benefits section in Article VIII. During the COVID-19 Public Health Emergency, early refill limits may be waived.
	Category Two Drugs	$35 / prescription	Not covered	
	Category Three Drugs	$75 / prescription	Not covered	
	Category Four Drugs	$100 / prescription	Not covered	
	Category One Maintenance Drugs	$37.50 / Generic prescription; $45 / Brand prescription	Not covered	Limited to a 90-day maintenance supply. Certain drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions. Generic drugs mandatory when available. *See the Prescription Drug Benefits section in Article VIII. During the COVID-19 Public Health Emergency, early refill limits may be waived.
	Category Two Maintenance Drugs	$87.50 / Generic prescription; $105 / Brand prescription	Not covered	
	Category Three Maintenance Drugs	$187.50 / Generic prescription; $225 / Brand prescription	Not covered	
	Category Four Maintenance Drugs	$250 / Generic prescription; $300 / Brand prescription	Not covered	
	Disease Specific Drugs	10% of the Allowed Amount up to $200 Copayment with a minimum of $100 Copayment	Not covered	Disease Specific Drugs must be provided by a Network Disease Specific Pharmacy or a Non-Pharmacy Network Provider, be listed in the Disease Specific Drug Formulary and are subject to Prior Authorization. During the COVID-19 Public Health Emergency, early refill limits may be waived.
	Medical Prescription Drugs	30% Coinsurance	50% Coinsurance or Not Covered	Must be dispensed or administered by a Hospital, Physician or Allied Provider and listed in the Medical Prescription Drug Formulary. Deductible does not apply in Physician's or Allied Provider's office. Non-Network Provider Benefits may vary by place of treatment. No Benefit provided if Non-Network Provider's services are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	Certain Covered Services may be subject to the Specialty Services provisions. *See the Schedule of Benefits-Specialty Services. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See the Ambulatory Surgical Facility Services Article.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	None.
If you need immediate medical attention	Emergency room care	30% Coinsurance	30% Coinsurance	50% Coinsurance for non-emergency services rendered by a Non-Network Provider. During the COVID-19 Public Health Emergency, cost-sharing is waived for medically appropriate COVID-19 diagnostic tests and certain related items/service.
	Emergency medical transportation	30% Coinsurance	50% Coinsurance	None.
	Urgent care	$35 / Primary care or $50 / Specialist office visit Deductible applies.	50% Coinsurance	Other Covered Services rendered in the Network Provider's office will be subject to the Network Coinsurance amount. During the COVID-19 Public Health Emergency, cost-sharing is waived for medically appropriate COVID-19 diagnostic tests and certain related items/service.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	50% Coinsurance	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from Non-Network Provider. Certain Covered Services may be subject to the Specialty Services provisions. *See the Schedule of Benefits-Specialty Services. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See the Hospital Benefits Article.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 / office visit; 30% Coinsurance for Outpatient services.	50% Coinsurance	Deductible applies. For Outpatient services, other Covered Services rendered in the Network Provider's office will be subject to the Network Coinsurance amount after the Deductible. Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	30% Coinsurance	50% Coinsurance	
If you are pregnant	Office visits	$35 / visit Deductible applies.	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a Copayment, Coinsurance, or Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Maternity coverage is not available for dependent children.
	Childbirth/delivery professional services	30% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	30% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	Not covered	Available only through Care Management. *See the Home Health section in Article XIII.
	Rehabilitation services	Inpatient and Outpatient: 30% Coinsurance Physical Medicine: 30% Coinsurance	Inpatient: Not covered Outpatient: 50% Coinsurance Physical Medicine: Not covered	Inpatient Rehabilitation limited to 30 days per year by a Network Provider. Physical medicine limited to 20 combined outpatient visits per year in the home and Provider's office. Outpatient Cardiac Rehab limited to 36 visits per year and must be rendered by a Network Provider. Speech Therapy limited to 20 outpatient visits per year. *See the Inpatient Rehabilitation, Outpatient Cardiac Rehabilitation, Physical Medicine and Speech Therapy sections.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	Not covered	Not covered	Not covered.
	Durable medical equipment	30% Coinsurance	Not covered	Medical Necessity certificate required. *See the Durable Medical Equipment section in Article VIII.
	Hospice services	30% Coinsurance	Not covered	6 month lifetime limitation. *See the Hospice Care section in Article VIII.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Routine dental and eye care are not available.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Habilitation Services
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care
- Routine Foot Care
- Skilled Nursing Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or you can contact the plan at 601-933-0037 . Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan, Blue Cross & Blue Shield of Mississippi at 601-664-4590 or 1-800-942-0278 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more information about limitations and exceptions, see the plan or policy document on the Member page at www.bcbsms.com.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 601-664-4590 or 1-800-942-0278.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 601-664-4590 or 1-800-942-0278.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码601-664-4590 or 1-800-942-0278.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 601-664-4590 or 1-800-942-0278.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Primary Care copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,450
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,510

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,320

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

Blue Cross & Blue Shield of Mississippi: NetworkBlue

Coverage for: Individual and/or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at www.bcbsms.com or call 601-664-4590 or 1-800-942-0278. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary on *my*Blue Member or call 601-664-4590 or 1-800-942-0278 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,500 per Individual / $10,500 per Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and medical services with copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50 per Individual for prescription drug coverage. $250 per admission to non-network hospitals. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For Network Providers: $7,350 per Individual / $22,050 per Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Balance-billed charges, copayments, deductibles, non-network coinsurance, premiums, TMJ benefits and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsms.com or call 601-664-4590 or 1-800-942-0278 for a list of Network Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 / office visit Deductible does not apply.	40% Coinsurance	Other Covered Services rendered in the Network Provider's office will be subject to the Network Coinsurance amount. During the COVID-19 Public Health Emergency, medically appropriate COVID-19 diagnostic tests and certain related items/service are covered at no cost share.
	Specialist visit	$40 / office visit Deductible does not apply.	40% Coinsurance	Other Covered Services rendered in the Network Provider's office will be subject to the Network Coinsurance amount. Routine vision and podiatry are not covered. See Rehabilitation services, below, for additional information. During the COVID-19 Public Health Emergency, cost-sharing is waived for medically appropriate COVID-19 diagnostic tests and certain related items/service.
	Preventive care/screening/ immunization	No charge	Not covered	Covered Services must be rendered by a *Healthy You!* Network Provider in that Provider's setting. Please see www.bcbsms.com/be-healthy/healthy-you-wellness-benefit. You may have to pay for services that aren't preventive. Ask your Provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	Not covered	Benefits listed are for Independent Labs and Diagnostic Services Facilities. Services provided in the Provider's office may be subject to the amounts listed above for Primary or Specialist care.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsms.com.	Category One Drugs	$15 / prescription	Not covered	Limited to a 30-day retail supply. Certain Prescription drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions. Generic drugs mandatory when available. *See the Prescription Drug Benefits section in Article VIII. During the COVID-19 Public Health Emergency, early refill limits may be waived. Prescription Deductible is waived for Category One drugs.
	Category Two Drugs	$35 / prescription	Not covered	
	Category Three Drugs	$75 / prescription	Not covered	
	Category Four Drugs	$100 / prescription	Not covered	
	Category One Maintenance Drugs	$37.50 / Generic prescription; $45 / Brand prescription	Not covered	Limited to a 90-day maintenance supply. Certain drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions. Generic drugs mandatory when available. *See the Prescription Drug Benefits section in Article VIII. During the COVID-19 Public Health Emergency, early refill limits may be waived. Prescription Deductible is waived for Category One drugs.
	Category Two Maintenance Drugs	$87.50 / Generic prescription; $105 / Brand prescription	Not covered	
	Category Three Maintenance Drugs	$187.50 / Generic prescription; $225 / Brand prescription	Not covered	
	Category Four Maintenance Drugs	$250 / Generic prescription; $300 / Brand prescription	Not covered	
	Disease Specific Drugs	10% of the Allowed Amount up to $200 Copayment with a minimum of $100 Copayment, up to $10,000 Disease Specific Drug Out-of-Pocket, then $100 Copayment.	Not covered	Disease Specific Drugs must be provided by a Network Disease Specific Pharmacy or a Non-Pharmacy Network Provider, be listed in the Disease Specific Drug Formulary and are subject to Prior Authorization. During the COVID-19 Public Health Emergency, early refill limits may be waived.
	Medical Prescription Drugs	20% Coinsurance	40% Coinsurance or Not Covered	Must be dispensed or administered by a Hospital, Physician or Allied Provider and listed in the Medical Prescription Drug Formulary. Deductible does not apply in Physician's or Allied Provider's office. Non-Network Provider Benefits may vary by place of treatment. No Benefit provided if Non-Network Provider's services are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Certain Covered Services may be subject to the Specialty Services provisions. *See the Schedule of Benefits-Specialty Services. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See the Ambulatory Surgical Facility Services Article.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	40% Coinsurance for non-emergency services rendered by a Non-Network Provider. During the COVID-19 Public Health Emergency, cost-sharing is waived for medically appropriate COVID-19 diagnostic tests and certain related items/service.
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	None.
	Urgent care	$40 / Primary care or $40 / Specialist office visit; Deductible does not apply.	40% Coinsurance	Other Covered Services rendered in the Network Provider's office will be subject to the Network Coinsurance amount. During the COVID-19 Public Health Emergency, cost-sharing is waived for medically appropriate COVID-19 diagnostic tests and certain related items/service.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from Non-Network Provider. Certain Covered Services may be subject to the Specialty Services provisions. *See the Schedule of Benefits-Specialty Services. Prior Authorization may be required if Covered Services can be provided in a lower place of treatment. *See the Hospital Benefits Article.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / office visit; 20% Coinsurance for Outpatient services.	40% Coinsurance	For Outpatient services, other Covered Services rendered in the Network Provider's office will be subject to the Network Coinsurance amount with the Deductible waived. Subject to Care Management, Medical Necessity, and appropriateness of care.
	Inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	$40 / visit Deductible does not apply.	40% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a Copayment, Coinsurance, or Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Maternity coverage is not available for dependent children.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not covered	Available only through Care Management. *See the Home Health section in Article XIII.
	Rehabilitation services	Inpatient and Outpatient: 20% Coinsurance Physical Medicine: 20% Coinsurance	Inpatient: Not covered Outpatient: 40% Coinsurance Physical Medicine: Not covered	Inpatient Rehabilitation limited to 30 days per year by a Network Provider. Physical medicine limited to 20 combined outpatient visits per year in the home and Provider's office. Outpatient Cardiac Rehab limited to 36 visits per year and must be rendered by a Network Provider. Speech Therapy limited to 20 outpatient visits per year. *See the Inpatient Rehabilitation, Outpatient Cardiac Rehabilitation, Physical Medicine and Speech Therapy sections.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	Not covered	Not covered	Not covered.
	Durable medical equipment	20% Coinsurance	Not covered	Medical Necessity certificate required. *See the Durable Medical Equipment section in Article VIII.
	Hospice services	20% Coinsurance	Not covered	6 month lifetime limitation. *See the Hospice Care section in Article VIII.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Habilitation Services
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care
- Routine Foot Care
- Skilled Nursing Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or you can contact the plan at 601-933-0037. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan, Blue Cross & Blue Shield of Mississippi at 601-664-4590 or 1-800-942-0278 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 601-664-4590 or 1-800-942-0278.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 601-664-4590 or 1-800-942-0278.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码601-664-4590 or 1-800-942-0278.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 601-664-4590 or 1-800-942-0278.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
Primary Care copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$1,770
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,340

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$1,190
Copayments	$830
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,040

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,290
Copayments	$130
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,460

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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: _____