

State and School Employees' Health Insurance Plan
Continuation Coverage Election Notice

To: _____
Name of Employee or Qualified Beneficiary(ies) Date Notified

This notice contains important information about your right to continue your health care coverage in the State and School Employees' Health Insurance Plan (Plan). Please read the information contained in this notice very carefully.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. You are receiving this election notice because you experienced a loss of coverage that occurred during the period that begins with September 1, 2008 and ends with December 31, 2009 and you may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the Summary of the COBRA Premium Reduction Provisions under ARRA (page 8) with details regarding eligibility, restrictions, and obligations and the Request for Treatment as an Assistance Eligible Individual (pages 9 - 10). If you believe you meet the criteria for the premium reduction, complete the Request for Treatment as an Assistance Eligible Individual and return it with your completed COBRA Continuation Coverage Election Form (page 3).

To elect COBRA continuation coverage, follow the instructions on the following pages to complete the attached COBRA Continuation Coverage Election Form (page 3) and submit it to Blue Cross & Blue Shield of Mississippi at the address provided at the bottom of the next page (page 2).

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

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

If you believe you meet the criteria for the premium reduction, complete the "Request for Treatment as an Assistance Eligible Individual" (Page 9 -10) and return it along with this page and your completed COBRA Continuation Coverage Election Form (Page 3).

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

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

If elected, COBRA continuation coverage will begin on _____ and can last until _____.

All applicable forms must be completed and returned to Blue Cross & Blue Shield of Mississippi, and must be post-marked no later than _____.

COBRA continuation coverage will cost:

	Select Coverage	Base Coverage
Participant Only	\$368	\$349
Participant and Spouse	\$760	\$695
Participant, Spouse, and Children	\$942	\$877
Participant and Child	\$505	\$440
Participant and Children	\$644	\$579

If you qualify as an "Assistance Eligible Individual", this cost for up to nine months will be:

Select Coverage	Total Premium	Employer Subsidy	Participant Premium
Participant Only	\$368	\$240	\$128
Participant and Spouse	\$760	\$494	\$266
Participant, Spouse, and Children	\$942	\$613	\$329
Participant and Child	\$505	\$329	\$176
Participant and Children	\$644	\$419	\$225

Base Coverage	Total Premium	Employer Subsidy	Participant Premium
Participant Only	\$349	\$227	\$122
Participant and Spouse	\$695	\$452	\$243
Participant, Spouse, and Children	\$877	\$571	\$306
Participant and Child	\$440	\$286	\$154
Participant and Children	\$579	\$377	\$202

Important additional information about payment for COBRA continuation coverage is included in the pages following the *COBRA Continuation Coverage Election Form*.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact:

Blue Cross & Blue Shield of Mississippi
P. O. Box 23734
Jackson, Mississippi 39225

Toll-Free: (800) 709-7881

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this *COBRA Continuation Coverage Election Form* and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed *COBRA Continuation Coverage Election Form* to: **Blue Cross & Blue Shield of Mississippi**

**PO Box 23734
Jackson, MS 39225**

This *COBRA Continuation Coverage Election Form* must be completed and returned by mail. If mailed, it must be post-marked no later than _____.

If you do not submit a completed *COBRA Continuation Coverage Election Form* by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed *COBRA Continuation Coverage Election Form* before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed *COBRA Continuation Coverage Election Form*.

I (We) elect COBRA continuation coverage in the State and School Employees' Health Insurance Plan (Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____
d. _____	_____	_____	_____

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans, including the State and School Employees' Health Insurance Plan (Plan), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of loss of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full and on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Blue Cross & Blue Shield of Mississippi of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that Blue Cross & Blue Shield of Mississippi is

notified of the Social Security Administration's determination within 60 days of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to Blue Cross & Blue Shield of Mississippi, PO Box 23734, Jackson, Mississippi 39225. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify Blue Cross & Blue Shield of Mississippi within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the *COBRA Continuation Coverage Election Form* and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent child(ren). The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the Plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached *Summary of the COBRA Premium Reduction Provisions under ARRA* for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the *COBRA Continuation Coverage Election Form*. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the *COBRA Continuation Election Notice* is post-marked.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Blue Cross & Blue Shield of Mississippi to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction. If you wish to have your monthly premium paid by bank draft, contact Blue Cross & Blue Shield of Mississippi at (800) 709-7881.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. You may instead make payments for continuation coverage for the following coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment, including all back premiums, and all periodic payments for continuation coverage should be sent to:

Blue Cross & Blue Shield of Mississippi
P. O. Box 23734
Jackson, Mississippi 39225

MAKE CHECKS/MONEY ORDERS PAYABLE TO: STATE/SCHOOL INSURANCE FUND

NOTE: Non-sufficient funds and other returned checks will be assessed a \$30 handling fee and must be satisfied immediately to avoid coverage termination.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your *Plan Document*. The *Plan Document* is available online at <http://knowyourbenefits.dfa.state.ms.us>. If you do not have internet access, you may request a paper copy of the *Plan Document* by contacting Blue Cross & Blue Shield of Mississippi at (800) 709-7881. If you have any questions concerning the information in this notice contact Blue Cross & Blue Shield of Mississippi.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov.

Keep Blue Cross & Blue Shield of Mississippi Informed of Address Changes

In order to protect your and your family's rights, you should keep Blue Cross & Blue Shield of Mississippi informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to Blue Cross & Blue Shield of Mississippi.



Summary of the COBRA Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify Blue Cross & Blue Shield of Mississippi in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding the Plan's COBRA coverage you can contact Blue Cross & Blue Shield of Mississippi, P. O. Box 23734, Jackson, Mississippi 39225 Toll-free: (800) 709-7881.

For specific information related to the Plan's administration of the ARRA Premium Reduction or to notify the Plan of your ineligibility to continue paying reduced premiums, contact Blue Cross & Blue Shield of Mississippi at the address provided above.

If you are denied treatment as an "Assistance Eligible Individual", you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272)

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for ARRA Premium Reduction, complete this form and return it to us along with your **COBRA Continuation Coverage Election Form**.

You may also send this form in separately. If you choose to do so, send this completed *Request for Treatment as an Assistance Eligible Individual* to: Blue Cross & Blue Shield of Mississippi, P.O. Box 23734, Jackson, Mississippi 39225.

You may also want to read the important information about your rights included in the *Summary of the COBRA Premium Reduction Provisions Under ARRA*.

State and School Employees' Health Insurance Plan

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

PO Box 23734
Jackson, MS 39225

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number
	E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.*

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage.*	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If you checked NO for statement 3, you may still be eligible. See below for more information.

ADDITIONAL ELECTION PERIOD

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage OR you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. You should receive a new election notice with an *COBRA Continuation Coverage Election Form* which you MUST complete and return. If you believe you should have received this additional notice but have not, contact Blue Cross & Blue Shield of Mississippi, P. O. Box 23734, Jackson, Mississippi 39225 Toll-free: (800) 709-7881.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

FOR PLAN USE ONLY

This application is: Approved Denied Approved for some/denied for others (explain in #4 below)
Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	<input type="checkbox"/>
3. Individual did not elect COBRA coverage.*	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

*If you checked number 3, was individual eligible for, and given, the Additional Election Period described above?

Signature of employer, plan administrator, or other party responsible for COBRA administration for the Plan
→ _____ Date → _____

Type or print name → _____

Telephone number → _____ E-mail address → _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

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

a. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

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

b. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

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

c. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

This form is designed for plans to distribute to COBRA qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

Use this form to notify the State and School Employees' Health Insurance Plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

State and School
Employees' Health
Insurance Plan

Participant Notification

PO Box 23734
Jackson, MS
39225

PERSONAL INFORMATION

Name and mailing address

Telephone number

E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan.
If any dependents are also eligible, include their names below.

Insert date you became eligible _____

I am eligible for Medicare.

Insert date you became eligible _____

IMPORTANT

If you fail to notify the Plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage; However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature → _____ Date → _____

Type or print name → _____

If you and your covered dependents are eligible for coverage under another group health plan, you must also list your covered dependents below:
