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Introduction

This *Plan Document* contains the official rules and regulations of the State and School Employees' Life and Health Insurance Plan (Plan). This *Plan Document* replaces and supersedes all previously issued *Plan Documents*, *Plan Document Amendments*, *Summary Plan Descriptions* and *Master Plan Documents*. When there are changes in benefits, a notice explaining the details of the changes will be issued. Notices of changes to the health and life insurance coverage may be included in the Plan's *Know Your Benefits* newsletter. This *Plan Document* is a reference guide for questions on life and health benefits. No verbal statements of any person will modify or otherwise affect the benefits or limitations and exclusions of the Plan, nor shall any such statements convey or void any coverage or increase or reduce any benefits under the Plan. This *Plan Document* does not create, nor is it intended to provide an employment contract between the State of Mississippi and any employee.

As provided by Mississippi law, the State and School Employees Health Insurance Management Board (Board) is the Plan Sponsor. The Board has the sole legal authority within the confines of the law to promulgate rules and regulations governing the operations of the Plan. The Department of Finance and Administration (DFA), Office of Insurance (OOI) is authorized by law to provide day-to-day management of the Plan. The Board has provided full discretion to the OOI to determine eligibility status, interpret Plan benefits and rules, and determine whether a claim should be paid or denied according to the provisions of the Plan set forth in this *Plan Document*. The Board reserves the right to amend, reduce, or eliminate any part of the Plan at any time.

The Board consists of the following members: the DFA Executive Director who serves as Chairman; the Chairman of the Workers' Compensation Commission; the Commissioner of Insurance; the Commissioner of Higher Education; the State Superintendent of Education; the Executive Director of the State Personnel Board; the Executive Director of the Mississippi Community College Board; the Executive Director of the Public Employees' Retirement System; two appointees of the Governor whose terms are concurrent with that of the Governor, one of whom has experience in providing actuarial advice to companies that provide health insurance to large groups and one of whom has experience in the day-to-day management and administration of a large self-funded health insurance group; the Chairman of the Senate Insurance Committee or his designee; the Chairman of the House of Representatives Insurance Committee or his designee; the Chairman of the Senate Appropriations Committee or his designee; and the Chairman of the House of Representatives Appropriations Committee or his designee. The legislators, or their designees, serve as ex officio, nonvoting members of the Board.

The Board selects, through a comprehensive request for proposals process, all vendors who provide services under the Plan. These services include claims and provider network administration, pharmacy benefits management, utilization management, health and wellness promotion, data management, Telehealth provider visits, and actuarial and consulting services.

Federal law requires health plans to provide the following notices to their participants: Notice of Election of Exemption from Certain Requirements of HIPPA, Notice of Privacy Practices, Your Prescription Drug Coverage and Medicare, and Summary of Benefits and Coverage (SBC). For easy reference, these notices are printed on colored paper at the back of the *Plan Document.*

How the Plan Works

A Self-Insured Plan

The health insurance component of the Plan is self-insured. When an organization manages a self-insured plan, it means that the organization (in this case, the State of Mississippi) bears the financial responsibility for its own employee benefit plan. The State is responsible for paying claims and other expenses associated with providing participants with health care coverage. No vendor contracted by the Board insures or guarantees these self-insured benefits. The State, through the Board, determines the benefits and establishes the premiums. All Plan costs are paid from the premiums collected and interest earnings. There is no direct State appropriation of funds to the Plan.

Medical Claims Administrator

The medical claims administrator for the Plan is Blue Cross & Blue Shield of Mississippi (BCBSMS). In this role, BCBSMS is responsible for maintaining eligibility, processing medical claims and determining most medical necessity guidelines for the Plan. BCBSMS provides a medical insurance identification card that includes important information and should be presented by the participant when receiving medical services or supplies. For a new or replacement identification card, contact BCBSMS.

Medical Plan Choices

The Plan offers two coverage choices for active employees, COBRA participants and non-Medicare eligible retirees: Base Coverage and Select Coverage. Each coverage type is independent of the other. Throughout this *Plan Document*, the term Plan refers to Base Coverage and Select Coverage unless otherwise noted.

Medicare Primary Coverage

The Plan provides a separate coverage level for Medicare eligible retirees, Medicare eligible surviving spouses and Medicare eligible dependents of retirees and surviving spouses. For these participants, Medicare is deemed to be the primary coverage and the Plan becomes the secondary coverage. If a retired employee, dependent of a retired employee, surviving spouse or dependent of a surviving spouse is eligible for Medicare, and does not elect Medicare Part A and B, benefits will nonetheless be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has both Medicare A and B. **Medicare eligible retirees, Medicare eligible surviving spouses and Medicare eligible dependents of retirees and surviving spouses are not eligible for prescription drug benefits. It is important to enroll in Medicare Parts A, B and D to receive maximum benefits.** Refer to the *Retiree Eligibility and Medical Coverage* section for more information.

Provider Networks

AHS State Network

The AHS State Network (Network) is a network of medical providers and hospitals within the State. The Network is exclusively available only to Plan participants and is responsible for recruiting, credentialing and communicating with providers. Providers participating in the Network agree to accept the allowable charges established by the Network and agree to file claims on behalf of participants receiving their services.

Note: It is important for participants to verify provider participation in the Network before receiving services. While participants may choose to receive services from out-of-network providers, using network providers gives participants the maximum benefits available under the Plan. Participants choosing to use out-of-network providers are responsible for paying any fees charged over the allowable charge, in addition to paying a higher annual deductible (for those participants under Select Coverage) and higher coinsurance amounts for covered services.

BlueCard® Program

BlueCard® is a national program offered through the Blue Cross and Blue Shield Association, an association of independent, locally owned Blue Cross and Blue Shield companies that enables participants to obtain network health care services while traveling or living outside of Mississippi. Through BlueCard®, participants have access to a national network of Blue Cross and Blue Shield contracted health care providers.

Participants have access to the BlueCard® Program across the country. This seamless program affords participants the ability to use any Blue Cross and Blue Shield (BlueCard®) network providers in any location.

Medical Case Management/Utilization Review

Acentra Health (Acentra), formerly known as Keystone Peer Review Organization, Inc. (Kepro) is the medical management administrator for the Plan. Acentra provides medical management, case management and utilization review services. Utilization review is a process to ensure medical services are medically necessary, delivered in the most appropriate setting, reflective of the correct length of stay, and consistent with generally accepted medical standards. Certification requirements may apply, regardless of whether a participant uses a network or out-of-network provider.

Certification is not required for those participants having Medicare for their primary coverage or other primary coverage, unless the primary carrier does not cover the service. For additional information on services requiring certification, participants can reference of the *Medical Case Management and Utilization Review* section of the Plan Document or access the information on the Plan's website at https://www.dfa.ms.gov/insurance.

Health and Wellness Program/Chronic Condition Coaching

ActiveHealth Management, Inc. (ActiveHealth) is the Plan's vendor for health and wellness management. ActiveHealth provides resources to enhance the physical, emotional, and social well-being of Plan participants and provides chronic condition education & coaching designed to support and guide Plan participants on how to lead healthier lives. ActiveHealth provides an engaging, user-friendly, and interactive telehealth portal for managing the Plan's health and wellness program via the Motivating Mississippi – Keys to Living Healthy website and through a smart-phone app available for Apple® and Android cellphones.

Motivating Mississippi – Keys to Living Healthy

Motivating Mississippi – Keys to Living Healthy is the Plan's health and wellness promotion program. It is designed to help participants achieve and maintain a healthy lifestyle and reach their wellness goals. Participants can access this program through the Plan's website at https://www.dfa.ms.gov/insurance.

Participants with certain chronic conditions may enroll in a disease management program administered by ActiveHealth. The program provides help, support and education for participants living with diseases such as cardiac disease, asthma, and/or diabetes. The program is voluntary, completely confidential and provided at no cost to participants.

Special features of the program include:

- Personalized telephonic counseling about the participant's specific health condition.
- Helping the participant achieve health goals.
- An individualized care plan for nutrition, exercise and other lifestyle needs.
- Educational materials.
- Access to community resources.
- Access to health and medical topics.

This program does not replace care rendered by the participant's provider. For information on this program or to stop participation in the program, contact ActiveHealth at 866-939-4721.

ActiveHealth uses its CareEngine® Clinical Decision Support program to identify clinical issues that providers and patients can discuss. ActiveHealth continually monitors medical and pharmacy claims. If the program identifies drug interactions or other medical issues, the participant and his provider will receive a letter called a Care Consideration.

Pharmacy Benefit Manager

CVS Caremark is the pharmacy benefit manager (PBM) for the Plan's prescription drug program. CVS Caremark is responsible for processing prescription claims received from network pharmacies, mail order claims, and paper claims filed directly by participants. To find the most cost-effective place to purchase prescription drugs, participants should visit www.caremark.com. CVS Caremark provides a prescription drug identification card which should be presented when purchasing prescription drugs. For a new or replacement identification card, participants should contact CVS Caremark.

NOTE: Medicare eligible retirees, Medicare eligible surviving spouses and Medicare eligible dependents of retirees and surviving spouses are not eligible for prescription drug benefits.

Telehealth Provider Visits

The University of Mississippi Medical Center (UMMC) is the preferred telehealth provider for the Plan. UMMC provides 24-hour access to providers for participants to receive health care using a smartphone, tablet or webcam-enabled computer to access their UMMC 2 You website at www.umc.edu/Healthcare/Telehealth or through their free UMMC 2 You app. For questions about UMMC 2 You, email Telehealth@umc.edu or call 601-815-2020. Other network providers may be eligible to render telehealth provider visits.

Base Coverage

Base Coverage is a qualifying high deductible health plan that meets the federal government's criteria under Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 in regard to establishing a Health Savings Account (HSA). HSAs are portable, interest-bearing, funded accounts that provide for tax-free savings for medical expenses. HSAs allow individuals to pay for current qualified medical expenses and save for future qualified medical expenses on a tax-free basis. The Plan does not offer or administer HSA accounts. However, participants in Base Coverage may independently secure an HSA.

Summary of Base Coverage Benefits

This is only a summary of the benefits under Base Coverage. It does not provide all details and provisions of the Plan. Some limitations and exclusions apply and can be found within this *Plan Document*. All benefits are subject to the calendar year deductible unless otherwise noted in the *Covered Services* section. There are two tiers of coverage: Individual and Family.

Individual Coverage	**Network**	**Out-of-Network**
Calendar Year Deductible	$1,800	
Preventive Medications Deductible (Other medications are subject to Calendar Year Deductible)	$75	
Coinsurance Maximum	$3,000	$4,000
Out-of-Pocket Limit	$6,500	N/A
Family Coverage	**Network**	**Out-of-Network**
Calendar Year Deductible	$3,200	
Preventive Medications Individual Deductible (Other medications are subject to Calendar Year Deductible)	$75	
Coinsurance Maximum	$5,500	$7,500
Out-of-Pocket Limit (In no event shall any one individual with family coverage exceed $6,500 out-of-pocket expenses for covered network expenses.)	$13,000	N/A
Telehealth Minor Medical Care Visit	You pay $10 copayment subject to deductible	Not Covered
Telehealth Dietitian Services Visit	You pay $10 copayment subject to deductible	Not Covered
Telehealth Mental Health Care Visit	You pay 20%	Not Covered
Specialty Physician/Health Care Professional Services	You pay 20%	You pay 40%
Inpatient Hospital – Services must be certified as medically necessary by Acentra to be covered by the Plan (except for routine maternity delivery).	You pay 20%	You pay 40%
Outpatient Hospital Services	You pay 20%	You pay 40%
Emergency Room – Services are subject to a $50 copayment for the first visit and a $200 copayment for each subsequent visit in addition to the deductible and coinsurance. Copayment is waived if admitted.	You pay 20%	You pay 20%
X-Rays, Laboratory	You pay 20%	You pay 40%

Outpatient MRI/MRA/CAT/CTA Scans	You pay 20%	You pay 40%
Adult Wellness/Preventive Services	Plan pays 100%	Not Covered
Maternity – Specified prenatal care and network routine physician delivery covered at 100% subject to completion of the Maternity Management Program. *Note: Benefits are limited for dependent children.*	You pay 20%	You pay 40%
Maternity – Hospital; Other Services *(Not available for dependent children.)*	You pay 20%	You pay 40%
Well-Newborn Nursery Care	Plan pays 100%	Not Covered
Well-Child Office Visits and Routine Tests	Plan pays 100%	Not Covered
Well-Child Routine Immunizations	Plan pays 100%	Not Covered
Chiropractic Services – Manipulative therapy services - Limited to a maximum of 30 visits per participant per calendar year.	You pay 20%	You pay 40%
Accidental Injury to Natural Teeth and TMJ Services – Coverage is subject to the network coinsurance/copayment maximum. TMJ services are limited to a lifetime maximum of $5,000.	You pay 20%	You pay 20%

Participants in the Base Coverage will be charged the full allowable amount until the applicable deductible is met. Prescription medications are subject to the applicable deductible and the following copayments:

	Retail & Specialty Pharmacies			**Home Delivery**
Prescription Drug Type	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Preferred Generic Drug	$12	$24	$36	$24
Non-preferred Generic Drug	$30	$60	$90	$60
Preferred Brand Drug*	$45	$90	$135	$90
Non-preferred Brand Drug*	$100	$200	$300	$200
Specialty Drug	$100	N/A	N/A	N/A

***Generic mandate applies to brand drugs purchased when a generic is available.** If a participant purchases a covered brand drug for which a generic equivalent is available, the participant will pay the difference in the cost of the brand and the generic drug, plus the applicable brand copayment amount.

Individual Preventive Medications Deductible

Certain preventive medications such as anticoagulants, antiarrhythmics, antihyperlipidemics, antidepressants and diabetes medications are only subject to the preventive medications deductible. If the Base Coverage calendar year deductible is already met, a participant does not also have to meet the preventive medications deductible. Once either deductible is met, participants will pay the standard prescription drug copayments for certain preventive medications, see *Prescription Drug Program*.

Diabetes Related Prescriptions and Supplies Copayments	Retail Pharmacies			Diabetic Management Program
	1-30 Day Supply	31-60 Day Supply	61-90 Day Supply	90 Day Supply (or less)
Testing Supplies:				
Preferred Brand	$12	$24	$36	$24
Non-preferred Brand	$45	$90	$135	$90
Insulin Needles/Syringes	$12	$24	$36	$24
Glucagon	$12	$24	$36	$24
Insulin	$12	$24	$36	$24

Calendar Year Deductible – Individual Base Coverage

The calendar year deductible is the amount of covered expenses a participant must pay each year before the Plan begins to pay its share of covered expenses. Covered medical and prescription drug expenses apply toward the calendar year deductible, unless otherwise indicated. Once the calendar year deductible has been met, the Plan pays its portion of the allowable charge for covered expenses, and the participant pays prescription drug copayments for covered prescription drugs and a percentage of the allowable charge for covered medical expenses.

Calendar Year Deductible – Family Base Coverage

Family coverage applies when an enrollee (active employee, retiree, surviving spouse or COBRA participant) has one or more covered dependents. If an enrollee has family coverage, there is no separate high deductible for each covered individual in the family. Covered medical and prescription drug expenses apply toward the family calendar year deductible, unless otherwise indicated. Medical services and prescription drugs will not be paid for any participants in the family until the family deductible has been satisfied. However, in no event shall an individual's annual out-of-pocket costs exceed $6,500. The family deductible also applies when both husband and wife are covered separately as enrollees, one of the enrollees has dependent coverage, and both are enrolled in Base Coverage.

If both husband and wife are covered employees, one carries dependent coverage, and only one of them elects Base Coverage, calendar year deductibles and coinsurance amounts are not shared. If both husband and wife are covered employees with employee-only coverage, and both elect Base Coverage, the calendar year deductible and coinsurance amounts are not shared.

The following expenses do not count toward the individual or family calendar year deductible:

- Telehealth provider visit copayments
- Emergency room copayments
- Prescription drug copayments
- Utilization review penalties
- Generic drug differential amounts
- Expenses in excess of the allowable charge
- Expenses in excess of Plan maximum limits
- Services not covered by the Plan
- Services not considered medically necessary

Coinsurance – Base Coverage

Once the applicable deductible has been met, the Plan pays a portion of the allowable charge for covered medical expenses. The participant pays the remainder in the form of coinsurance.

Any fees charged by an out-of-network provider that are more than the allowable charge are not part of the coinsurance amount. The Plan will not pay any portion of these charges.

Do these expenses count toward the Coinsurance Maximum?

YES	NO
• Coinsurance paid for hospital inpatient services • Coinsurance paid for other covered medical expenses	• Calendar year deductible • Preventive medications deductible • Telehealth provider visit copayments • Emergency room copayments • Prescription drug copayments • Generic drug differential amounts • Utilization review penalties • Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Services not covered by the Plan • Services not considered medically necessary

Coinsurance Maximum – Individual Base Coverage

The coinsurance maximum is the maximum amount that an enrollee with individual coverage has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100 percent of the allowable charge. The coinsurance maximum provides participants protection against catastrophic health care expenses. The amounts paid toward meeting the calendar year medical deductible, preventive medications deductible, telehealth provider visit copayments, emergency room copayments and prescription drug copayments do not count toward satisfying the coinsurance maximum.

The initial $3,000 of coinsurance is applied to both the network and out-of-network coinsurance maximum. After the initial $3,000 has been met, only the coinsurance amount for services rendered by out-of-network providers will be applied to the additional $1,000 out-of-network coinsurance. Once the annual coinsurance maximum is met, the Plan pays 100 percent of the allowable charge for covered medical expenses for the remainder of that calendar year, except as otherwise specified.

Coinsurance Maximum – Family Base Coverage

The coinsurance maximum is the maximum amount that a family has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100 percent of the allowable charge. If an enrollee has family coverage, there is no separate coinsurance maximum for each individual. The family coinsurance maximum also applies when both husband and wife are covered separately as enrollees, one of the enrollees has family coverage, and both are enrolled in Base Coverage. The amount paid toward meeting the calendar year medical deductible, preventive medications deductible, telehealth provider visit copayments, emergency room copayments, and prescription drug copayments do not count toward satisfying the coinsurance maximum.

The initial $5,500 of coinsurance is applied to both the network and out-of-network coinsurance maximum. After the initial $5,500 has been applied, only the coinsurance amount for services rendered by out-of-network providers will be applied to the additional $2,000 out-of-network coinsurance maximum.

Once the annual coinsurance maximum is met, the Plan pays 100 percent of the allowable charge for covered medical expenses for the remainder of that calendar year, unless otherwise specified. However, in no event shall an individual's annual out-of-pocket costs exceed $6,500 for covered network expenses.

Do these expenses count toward the Coinsurance Maximum?

YES	NO
• Coinsurance paid for hospital inpatient services • Coinsurance paid for other covered medical expenses	• Calendar year deductible • Preventive medications deductible • Telehealth provider visit copayments • Emergency room copayments • Prescription drug copayments • Generic drug differential amounts • Utilization review penalties • Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Services not covered by the Plan • Services not considered medically necessary

Out-of-Pocket Limit – Individual Base Coverage

The out-of-pocket limit is the maximum amount that a participant with individual coverage has to pay for network deductible, coinsurance and copayments for covered medical and prescription drug expenses in a calendar year before benefits will be paid at 100 percent. The out-of-pocket limit protects a participant from having to pay catastrophic medical bills in a given year.

Out-of-Pocket Limit – Family Base Coverage

The out-of-pocket limit is the maximum amount that a family has to pay for network deductible, coinsurance and copayments for covered medical and prescription drug expenses in a calendar year before benefits will be paid at 100 percent. The out-of-pocket maximum protects a family from having to pay catastrophic medical bills in a given year. In no event shall an individual's annual out-of-pocket costs exceed $6,500.

Do these expenses count toward the Out-of-Pocket Limit?

YES	NO
• Network calendar year deductibles • Preventive medications deductible • Prescription drug copayments • Telehealth provider visits copayments • Emergency room copayments • Network coinsurance paid for hospital inpatient services • Network coinsurance paid for other covered medical expenses	• Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Utilization review penalties • Services not covered by the Plan • Generic drug differential amounts • Services not considered medically necessary

Telehealth Provider Visit Copayment

There is a $10 copayment for network telehealth primary care providers and registered dietitians. The copayment applies once the annual deductible has been met. Behavioral health visits are subject to the coinsurance and deductible.

Select Coverage

Summary of Select Coverage Benefits

This is only a summary of the medical benefits under Select Coverage. It does not provide all details and provisions of the Plan. Some limitations and exclusions apply and can be found within this *Plan Document*. All medical benefits are subject to the calendar year deductible unless otherwise noted in the *Covered Services* section.

Individual Coverage	**Network**	**Out-of-Network**
Calendar Year Medical Deductible	$1,800	$2,300
Individual Prescription Drug Deductible	$75	
Medical Coinsurance Maximum	$3,000	$4,000
Out-of-Pocket Limit	$6,500	N/A
Family Coverage	**Network**	**Out-of-Network**
Family Calendar Year Medical Deductible	$3,600	$4,600
Family Out-of-Pocket Limit	$13,000	N/A
Telehealth Minor Medical Care Visit	You pay $10 copayment not subject to deductible	Not Covered
Telehealth Dietitian Services Visit	You pay $10 copayment not subject to deductible	Not Covered
Telehealth Mental Health Care Visit	You pay 20%	Not Covered
Primary Care Office Visit	You pay $25 copayment not subject to deductible	You pay 40%
Other Primary Care Services (labs, x-rays) provided in office	You pay 20% not subject to deductible	You pay 40%
Other Primary Care Services (labs, x-rays) provided outside office	You pay 20%	You pay 40%
Specialty Physician/Health Care Professional Services	You pay 20%	You pay 40%
Inpatient Hospital – Services must be certified as medically necessary by Acentra to be covered by the Plan (except for routine maternity delivery).	You pay 20%	You pay 40%
Outpatient Hospital Services	You pay 20%	You pay 40%
Emergency Room – Services are subject to a $50 copayment for the first visit and a $200 copayment for each subsequent visit in addition to the deductible and coinsurance. The copayment is waived if admitted.	You pay 20%	You pay 20%
Adult Wellness/Preventive Services	Plan pays 100%	Not Covered
Maternity – Specified prenatal care and network routine physician delivery is covered at 100% subject to	You pay 20%	You pay 40%

completion of the Maternity Management Program. *Note: Benefits are limited for dependent children.*		
Maternity – Hospital; Other Services *(Not available for dependent children.)*	You pay 20%	You pay 40%
Well-Newborn Nursery Care	Plan pays 100%	Not Covered
Well-Child Office Visits and Routine Tests	Plan pays 100%	Not Covered
Well-Child Routine Immunizations	Plan pays 100%	Not Covered
Chiropractic Services – Manipulative therapy services limited to a maximum of 30 visits per participant per calendar year.	You pay 20%	You pay 40%
Accidental Injury to Natural Teeth and TMJ Services – Network benefits apply. TMJ services limited to a lifetime maximum of $5,000.	You pay 20%	You pay 20%

Prescription drug copayments for retail pharmacies and home delivery service are as follows:

	Retail and Specialty Pharmacies			**Home Delivery**
Prescription Drug Type	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Preferred Generic Drug	$12	$24	$36	$24
Non-preferred Generic Drug	$30	$60	$90	$60
Preferred Brand Drug*	$45	$90	$135	$90
Non-preferred Brand Drug*	$100	$200	$300	$200
Specialty Drug	$100	N/A	N/A	N/A

***Generic mandate applies to brand drugs purchased when a generic is available.** If a participant purchases a brand drug for which a generic equivalent is available, the participant will pay the difference in the cost of the brand and the generic drug, plus the applicable brand copayment amount.

Diabetes Related Prescriptions and Supplies Copayments	**Retail Pharmacies**			**Diabetic Management Program**
	1-30 Day Supply	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Testing Supplies:				
Preferred Brand	$12	$24	$36	$24
Non-preferred Brand	$45	$90	$135	$90
Insulin Needles/Syringes	$12	$24	$36	$24
Glucagon	$12	$24	$36	$24
Insulin	$12	$24	$36	$24

Individual Prescription Drug Deductible

In most cases, participants must first satisfy a separate prescription drug deductible each calendar year before the Plan will pay any of the cost for prescription drugs. The prescription drug deductible and copayment amounts will not apply toward satisfying the medical calendar year deductible or coinsurance maximum.

Calendar Year Medical Deductible – Individual Select Coverage

The calendar year deductible is the amount of covered medical expense a participant must pay each year before the Plan begins to pay its share of covered expenses. Once the calendar year deductible is met, the Plan pays a percentage of the allowable charge for covered medical expenses.

The initial $1,800 of covered medical expenses will apply to both the network and out-of-network deductible. After the initial $1,800 has been applied, only services rendered by an out-of-network provider will be applied to the additional $500 out-of-network deductible.

Calendar Year Medical Deductible – Family Select Coverage

Once a family has paid the family medical deductible in a calendar year, all covered participants in that family will have satisfied their individual medical deductible for that calendar year.

The family medical deductible also applies when both husband and wife are covered separately as enrollees, and both are enrolled in Select Coverage. No individual family member may contribute more than $1,800 to the network family medical deductible, or more than $2,300 to the out-of-network family medical deductible.

The initial $3,600 of covered expenses will apply to both the network and out-of-network family medical deductible. After the initial $3,600 has been applied, only services rendered by an out-of-network provider will be applied to the additional $1,000 out-of-network family medical deductible.

The following expenses do not count toward the calendar year medical deductible:

- Prescription drug deductible
- Primary care office visit copayments
- Telehealth provider visit copayments
- Emergency room copayments
- Prescription drug copayments
- Generic drug differential amounts
- Utilization review penalties
- Expenses in excess of the allowable charge
- Expenses in excess of Plan maximum limits
- Services not covered by the Plan
- Services not considered medically necessary

Coinsurance – Select Coverage

Once a participant has met the calendar year medical deductible, the Plan pays a portion of the allowable charge for covered medical expenses. The participant pays the remainder in the form of coinsurance.

Any fees charged by an out-of-network provider that are above the allowable charge are not part of the coinsurance amount. The Plan will not pay any portion of these charges.

Coinsurance Maximum – Individual Select Coverage

The individual medical coinsurance maximum is the maximum amount that each participant has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100 percent. The medical coinsurance maximum protects a participant from having to pay catastrophic medical bills in a given year. The amount paid toward meeting the calendar year individual and family medical deductibles does not count toward satisfying the medical coinsurance maximum.

The initial $3,000 of medical coinsurance is applied to both the network and out-of-network medical coinsurance maximums. After the initial $3,000 has been met, only the coinsurance amount for services rendered by out-of-network providers will be applied to the additional $1,000 out-of-network coinsurance. Once the annual medical coinsurance maximum is met, the Plan covers 100 percent of the allowable charge for covered medical expenses for the remainder of that calendar year, unless otherwise specified.

Do these expenses count toward the Coinsurance Maximum?

YES	NO
• Coinsurance paid for hospital inpatient services • Coinsurance paid for other covered medical expenses	• Calendar year deductibles • Family deductibles • Prescription drug deductible • Primary care office visit copayments • Telehealth provider visit copayments • Emergency room copayments • Prescription drug copayments • Generic drug differential amounts • Utilization review penalties • Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Services not covered by the Plan • Services not considered medically necessary

Out-of-Pocket Limit – Individual Select Coverage

The out-of-pocket limit is the maximum amount that a participant with individual coverage has to pay for network deductible, coinsurance, and copayments for covered medical expenses in a calendar year before benefits will be paid at 100 percent. The out-of-pocket limit protects a participant from having to pay catastrophic medical bills in a given year.

Out-of-Pocket Limit – Family Select Coverage

The out-of-pocket limit is the maximum amount that a family has to pay for network deductible, coinsurance and copayments for covered medical expenses in a calendar year before benefits will be paid at 100 percent. The network out-of-pocket maximum protects a family from having to pay catastrophic medical bills in a given year. There is no family out-pocket-limit for out-of-network services.

Do these expenses count toward Out-of-Pocket Limit?

YES	NO
• Network calendar year deductibles • Office visit copayments • Telehealth provider visit copayments • Prescription drug deductible • Prescription drug copayments • Emergency room copayments • Network coinsurance paid for hospital inpatient services • Network coinsurance paid for other covered medical expenses	• Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Utilization review penalties • Services not covered by the Plan including all those found in the *Limitations and Exclusions* section • Generic drug differential amounts • Services not considered medically necessary

Primary Care Office Visit Copayment – Select Coverage

An office visit copayment is available under Select Coverage and only applies to the following network primary care services: Family Practice, General Practice, Gynecology, Internal Medicine, Pediatric Medicine, including Nurse Practitioner, Physician Assistant and Registered Dietitian. Copayments apply to the provider's office visit charge only and are not subject to the deductible or coinsurance requirements. Charges for services rendered in the provider's office such as lab work and x-rays are applied a 20 percent coinsurance, not subject to the deductible. Lab work and other tests performed outside the provider's office are subject to regular Plan benefits. Out-of-network provider office visits are subject to the normal out-of-network deductibles and coinsurance rates.

Helpful Tip: Network providers agree not to charge any amount above the Plan's allowable charge for covered services.

Telehealth Provider Visit Copayment

There is a $10 copayment for network telehealth primary care providers and registered dietitians. Mental health care visits are subject to the coinsurance and deductible.

Medicare Primary Coverage

The Plan provides a separate coverage level for Medicare eligible retirees, Medicare eligible surviving spouses and Medicare eligible dependents of retirees and surviving spouses. For these participants, Medicare is deemed to be the primary coverage, and the Plan becomes the secondary coverage. If a retired employee, dependent of a retired employee, surviving spouse or dependent of a surviving spouse is eligible for Medicare, and does not elect Medicare Part A and B, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has both Medicare A and B. **Medicare eligible retirees, Medicare eligible surviving spouses and Medicare eligible dependents of retirees and surviving spouses are not eligible for prescription drug benefits.**

It is important to enroll in Medicare Parts A, B and D to receive maximum benefits.

Benefits for Medicare primary participants will be provided as follows:

- The Plan will pay 100 percent of the remaining balance after Medicare processes the claim based on the Medicare allowance for covered services. If Medicare does not cover a service and it is a covered service under the Plan, the Plan will pay at 100 percent of the Plan's allowance.
- Regular Plan benefits will apply for dependents who are not eligible for Medicare.
- Wellness benefits for Medicare primary participants will pay at 100 percent of the Plan allowance for covered services if Medicare denies the service. If Medicare pays for the service, the Plan will pay 100 percent of the balance remaining after the Medicare payment. Wellness benefits are not subject to network or out-of-network differentials for Medicare primary participants.
- Emergency room and telehealth provider visit copayments will not apply to participants who are Medicare primary.
- Medicare eligible participants are not required to pre-certify medical services through Acentra unless Medicare does not cover the service.

Covered Services

Benefits are provided for the services listed in this section deemed to be medically necessary. All benefits are subject to the calendar year deductibles and the allowable charges, unless otherwise noted. Participants should refer to the *Summary of Base Coverage Benefits* or *Summary of Select Coverage Benefits* within this *Plan Document* for coinsurance amounts. Benefits are provided for covered expenses incurred by a participant as a result of a non-occupational injury or non-occupational illness, only as expressly provided in this *Plan Document*.

Ambulance

Benefits will be available for the following covered ambulance services and when determined to be medically necessary by the medical claims administrator:

Medically necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured under the following circumstances:

- From the place where the participant is injured or stricken by illness to the nearest appropriate facility where treatment is to be given when deemed medically necessary.
- From a hospital where the participant is an inpatient to another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the hospital of origin and back to the hospital of origin after such services have been rendered.
- From a hospital to another hospital when the discharging hospital has inadequate treatment facilities and the receiving hospital has appropriate treatment facilities.

Ambulance service also includes transportation by air ambulance when, as determined by the medical claims administrator, the participant's condition or urgency of needed medical care precludes travel by surface transportation. Air ambulance service is helicopter transportation to the nearest institution with appropriate facilities for treatment of the participant's injury or illness. Fixed wing air transportation is for long distance travel only and is not ordinarily considered to be an air ambulance service.

Ambulance service benefits will not be provided exclusively for a participant's comfort or convenience.

Ambulatory Surgical Facility

Ambulatory surgical facility services include:

- Pre-operative laboratory procedures directly related to a surgical procedure.
- Pre-operative preparation.
- Use of facility (operating rooms, recovery rooms and surgical equipment).
- Anesthesia, drugs and surgical supplies.

Bariatric Surgical Services

Benefits for bariatric surgery are only provided for participants 18 years or older and are limited to one surgery per lifetime paid for by the Plan, and must be authorized by Acentra. Benefits for these services are provided only when the facility is an American Society for Metabolic and Bariatric Surgery Center of Excellence (BSCOE). Participants must agree to participate in a medically supervised treatment plan for at least one-year post surgery. Bariatric surgery for morbid obesity will only be considered medically necessary when **ALL** of the following are met:

- Consent to a multidisciplinary health evaluation at a BSCOE.

- Must meet **one or more** of the following clinical criteria: Presence of severe obesity that has persisted for at least the last two years (24 months) as documented in clinical records, defined as **one or more** of the following:
    - Body mass index (BMI) exceeding 40; or
    - BMI greater than 35 in conjunction with any **one or more** of the following severe comorbidities:

    - Clinically significant obstructive sleep apnea
    - Coronary heart disease
    - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management)
    - Type 2 Diabetes Mellitus
- Participant must meet one or more of the following criteria:
    - Medically-supervised nutrition and exercise program
    - Multidisciplinary surgical preparatory regimen

Medically supervised nutrition and exercise program

Participant must have participated in two or more medically-supervised nutrition and exercise programs (including dietitian consultation, low calorie diet, increased physical activity and behavior modification, Weight Watchers®, the Atkins Diet®, the South Beach Diet®, or Sugar Busters®), documented in the medical record at each visit.

This medically-supervised nutrition and exercise program must meet **ALL** of the following criteria:

- Participation must be documented in the medical record. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other provider. ***Note: A physician's summary letter is not sufficient documentation.*** Documentation should include medical records of clinician's contemporaneous assessment of patient's progress throughout the course of the nutrition and exercise program. For participants who participate in a medically administered nutrition and exercise program (e.g., MediFast®, OptiFast®), program records documenting the participant's participation and progress may substitute for provider medical records.
- Nutrition and exercise program must be supervised and monitored by a clinician working in cooperation with dietitians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote).
- Nutrition and exercise program(s) must be for a cumulative total of six months (180 days) or longer in duration and occur within two years before surgery, with participation in one program of at least three consecutive months. Precertification may be made before completion of nutrition and exercise program as long as six months of cumulative participation in nutrition and exercise program(s) is completed before the date of surgery.

Multidisciplinary surgical preparatory regimen

Within six months before surgery, the participant must participate in an organized multidisciplinary surgical preparatory regimen of at least three months (90 days) duration meeting **ALL** of the following criteria, in order to improve surgical outcomes, reduce the potential for surgical complications, and establish the participant's ability to comply with postoperative medical care and dietary restrictions:

- Behavior modification program supervised by qualified professional.
- Consultation with a dietitian or nutritionist.

- Documentation in the medical record of the participant's participation in the multidisciplinary surgical preparatory regimen at each visit. (A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant's progress at the completion of the multidisciplinary surgical preparatory regimen.)
- Exercise regimen (unless contraindicated) to improve pulmonary reserve before surgery, supervised by exercise therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely).
- Reduced-calorie diet program supervised by dietitian or nutritionist.

For participants who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, clearance must be provided via formal psychiatric or doctorate level psychology evaluation by an individual with experience in the evaluation of bariatric surgery patients.

Note: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery.

Breast-feeding Support, Supplies and Counseling

Benefits are provided for breast-feeding support, supplies and counseling in conjunction with each childbirth. This includes comprehensive lactation support and counseling by a trained provider during pregnancy and/or postpartum. The purchase of a manual breast-feeding pump is covered at 100 percent, not subject to the calendar year deductible. The purchase or rental of an electronic breast-feeding pump is covered up to $100, not subject to the calendar year deductible. Breast-feeding pumps and pump supplies may be purchased through a durable medical equipment (DME) company or at a retail store. In most cases, the participant will be required to pre-pay for the equipment and file a claim for reimbursement. Participants must submit a copy of the receipt with a claim form to be reimbursed, at the Plan allowance, for these supplies.

Cardiac Rehabilitation – Outpatient

Benefits for outpatient cardiac rehabilitation are provided for patients with a clear medical need and referred by the attending provider. Prior approval must be obtained from BCBSMS. The attending provider must submit a formal treatment plan to BCBSMS including the number of visits, the duration of therapy, and the expected outcomes. Maintenance or exercise therapy is not covered.

Participants must use a cardiac rehabilitation program that is certified by the American Association of Cardiovascular and Pulmonary Rehabilitation. Participants can contact BCBSMS to locate a certified provider at the telephone number listed in the front inside cover of this *Plan Document*.

Chiropractic Services

Manipulative chiropractic therapy services are limited to a maximum of 30 visits per participant per calendar year.

Clinical Trial

Benefits for medically necessary routine services associated with an approved clinical trial may be available as defined by the Affordable Care Act (ACA).

Routine services generally include all items and services consistent with the coverage provided under the Plan for a qualified individual who is not enrolled in a clinical trial.

All of the following limitations apply to benefits for routine patient costs associated with an approved clinical trial:

1. All applicable Plan limitations for coverage of out-of-network care will apply to routine services in clinical trials; *and*
2. All utilization management rules and coverage policies that apply to routine care for participants not in clinical trials will also apply to routine patient care for participants in clinical trials; *and*
3. Participants must meet all applicable Plan requirements for precertification, registration, and referrals.

Routine services do not include the following:

1. The cost of the investigational item, device or service.
2. The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management.
3. The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a diagnosis.
4. The cost for travel, lodging and meals.

An approved clinical trial is defined as a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. A federally funded or approved trial.
2. A clinical trial conducted under an FDA investigational new drug application.
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Contraceptives

Coverage is provided to female participants for prescription contraceptives and other U.S. Food and Drug Administration (FDA) approved contraceptive methods. A prescription is required. Benefits for certain generic contraceptives will be provided at 100 percent not subject to the calendar year deductible. Refer to the CVS Caremark ACA Drug list at www.caremark.com for specific covered drugs. Brand contraceptives are subject to the calendar year deductible and the applicable copayment except in situations where there is no generic available within that specific method as identified by the FDA, or in situations where the generic within that specific method is not medically appropriate as determined by the participant's provider. In this situation, a medical necessity copayment waiver request must be approved by CVS Caremark.

Dental Services

Dental services are not covered under the Plan, except for the following:

- Coverage is provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) caused solely through external means.
- The accidental injury must have occurred while the participant is covered under the Plan or as a direct result of a disease covered by the Plan. Injury to teeth as a result of chewing or biting is not considered an accidental injury.
- Coverage is provided for inpatient hospital services/supplies and associated anesthesia services for dental care and treatment and dental or oral surgery if the hospital stay is determined to be medically necessary by Acentra.
- Coverage is provided for outpatient hospital or ambulatory surgical facility services and/or supplies and associated anesthesia services for dental care if it is determined to be medically necessary by BCBSMS.

Except as indicated above, benefits are not provided for dental services including, but not limited to, the following:

- In-mouth appliances, crowns, bridgework, dentures, implants, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of such services or supplies is to relieve pain.
- Extraction of wisdom teeth.
- Removal, repair, replacement, restoration, or reposition of teeth lost or damaged while biting or chewing.
- Repair, replacement or restoration of fillings, crowns, dentures, or bridgework.
- Periodontal treatment (i.e., gum disease).
- Dental cleaning, in-mouth scaling, planing or scraping.
- Myofunctional therapy (muscle training therapy or training to correct or control harmful habits).
- Root canal therapy.
- Routine tooth removal.
- Any dental service or treatment not associated with an accidental injury or as a direct result of a disease covered by the Plan.
- TMJ, except to the extent coverage is specifically provided in this *Plan Document.*

Diabetic Management Program

To help meet the needs of participants with diabetes, CVS Caremark offers the Diabetic Management Program. Some of the benefits of the Diabetic Management Program are:

- Free blood glucose meters are provided through CVS Caremark in partnership with select manufacturers.
- Participants receive a 90-day supply of diabetic supplies for two generic copayments through mail.
- Educational materials.

Diabetic Self-Management Education and Support

Benefits are provided for Diabetic Self-Management Education and Support (DSMES) at 100 percent of the allowable charge (not subject to the calendar year deductible) for participants approved by Acentra.

Diagnostic Services – X-rays and Laboratory Services

Medically necessary diagnostic services, such as x-rays and laboratory examinations, are covered. Refer to the *Medical Case Management and Utilization Review* section for certification requirements for specified outpatient diagnostic tests.

Dietitian Services

Nutritional counseling services are covered when provided by a registered dietitian. One dietitian visit per year is provided at no cost to the participant under wellness/preventive benefits when a network dietitian renders services.

For Select Coverage, additional visits are covered subject to the primary care office visit copayment when a network dietitian renders services. For Base Coverage, additional visits are subject to regular Plan benefits. These services may also be available via telehealth provider visits with a lower copayment.

Durable Medical Equipment

In order to be covered, durable medical equipment (DME) must be prescribed by the attending provider and determined by BCBSMS to be medically necessary for treatment of the illness or injury or to prevent the participant's further deterioration. Prior approval by BCBSMS is recommended. DME must be made to withstand

repeated use; primarily used to serve a medical purpose rather than for comfort or convenience; generally, not useful to a person in the absence of illness, injury or disease; and appropriate for use in the participant's home. Benefits for DME are based on the allowable charge for basic equipment. Benefits for any deluxe item will be limited to the allowable charge for the basic version of the item. If special features are medically necessary to maintain or promote patient mobility or function, BCBSMS may approve those features. DME may be rented or purchased, based on the determination of BCBSMS. Rental fees cannot exceed the cost of buying an item. A DME claim must include a letter from the provider explaining medical necessity.

Emergency Care

Emergency care received from an out-of-network provider will be paid at the network benefit level (for example, deductibles and coinsurance will be the same for visits to a hospital emergency room whether the hospital is a network or out-of-network facility). However, the participant is still responsible for amounts charged by the out-of-network provider that exceed the allowable charge.

Emergency Room Services

Benefits are provided for treatment in a hospital emergency room. A $50 emergency room copayment will be applied to the first emergency room visit in a calendar year. A $200 copayment will be applied to any subsequent emergency room visit during the year. The emergency room copayment is in addition to the deductible and coinsurance amount. The emergency room copayment is waived if admitted. Emergency room services should only be used in an emergency situation.

Home Infusion Therapy

Benefits are provided for home infusion therapy services approved by Acentra for treatment in the patient's home. Acentra must certify services as medically necessary before beginning the therapy. Covered expenses for home infusion therapy are limited to the following:

- Prescription drugs
- Intravenous solutions
- Durable medical equipment
- Pharmacy compounding and dispensing services
- Fees associated with drawing blood for the purpose of monitoring response to therapy
- Therapist services
- Ancillary medical supplies
- Nursing visits – including initiation of home infusion therapy, intravenous restarts, and emergency care when medically necessary to provide home infusion therapy

Hospice Care

Benefits are provided for inpatient and home hospice services for up to six months, subject to certification of medical necessity by Acentra.

Hospital Services

Covered inpatient and outpatient hospital services and supplies include the following:

- Hospital room and board (including dietary and general nursing services)
- Operating or treatment rooms
- Anesthetics and their administration

- Intravenous injections and solutions
- Physical, occupational, speech therapy
- Radiation therapy
- Oxygen and its administration
- Diagnostic services
- Intensive, coronary and burn care unit services
- Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization, including charges for take-home drugs
- Dressings and supplies
- Blood transfusions, including the cost of whole blood, blood plasma and expanders
- Psychological testing

All inpatient admissions except routine maternity admissions require certification by Acentra. Inpatient rehabilitative services are limited to acute short-term care in a hospital or rehabilitation hospital, as approved by Acentra. Refer to the *Medical Management and Utilization Review* section for certification requirements.

Long-Term Acute Care Facility

All admissions to a long-term acute care facility must be certified as medically necessary by Acentra.

Mastectomy

The following services related to medically necessary mastectomies are covered.

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and care of physical complications of mastectomy, including lymphedema.

Maternity

Maternity benefits are provided to covered participants or covered spouses. Other female dependents are eligible for limited maternity benefits as indicated in this section. See the *Medical Management and Utilization Review* section for more information.

Benefits for the following prenatal laboratory and diagnostic procedures will be provided at 100 percent of the allowable charge, not subject to the calendar year deductible, when services are provided by a network provider:

Prenatal Laboratory and Diagnostic Procedures	Limit Per Pregnancy
Hemoglobin/Hematocrit/CBC	2
Antibody Test for Rh-Negative (if unsensitized)	1
Gestational Diabetes Screening – at 24 weeks of gestation or after	1
Cervical Cytology (PAP)	1
HIV Screening	1
Gonorrhea Screening	1
Syphilis Screening	1
Chlamydia Screening	1
Bacteriuria Screening	1
Hepatitis B Screening	1

Note: For covered participants or covered spouses, other prenatal laboratory and diagnostic procedures, inpatient hospital delivery and other covered services are subject to the deductible and coinsurance. For covered female dependents, no benefits will be provided for any other prenatal laboratory and diagnostic procedures, delivery and other services beyond those listed above.

Maternity Management Program

Employees and covered spouses are encouraged to participate in the Maternity Management Program provided by ActiveHealth as early in the pregnancy as possible. This program is voluntary and offered at no charge. The program provides an ActiveHealth maternity nurse that will assist participants throughout the pregnancy and help with early identification of any risk factors, and provide educational materials and support during and after delivery.

As part of the program, participants will have access to a robust online library created specifically for expectant mothers and the questions that may arise during a pregnancy. The participants or covered spouse must complete three program activities. This can be a combination of calls with an ActiveHealth maternity nurse and digital coaching, but the participant must have a minimum of one call with an ActiveHealth maternity nurse.

Subject to successful completion of the Maternity Management Program, routine physician's delivery charges and the following prenatal services will be provided at 100 percent when rendered by a network provider:

Prenatal Laboratory and Diagnostic Procedures	Limit Per Pregnancy
Ultrasound	4
Alpha-fetoprotein	1
Group B Strep	1
Urinalysis, screening dipstick	3
Urinalysis, spun	1

Note: Other prenatal laboratory and diagnostic procedures, inpatient hospital delivery charges, anesthesia and other covered services are subject to the deductible and coinsurance.

Special Note: Adding a Newborn

In order for a newborn to be covered from date of birth, an Application for Coverage form must be submitted to your Human Resources office within 60 days of the date of birth (see Special Enrollment Periods) with the appropriate premiums. ***Simply reporting the baby's birth by phone to ActiveHealth, Acentra or BCBSMS <u>does not</u> add the baby to the participant's coverage****.*

Medical Prescription Drugs

Medical prescription drugs are not dispensed by a Network Pharmacy. These benefits will be subject to (a) the applicable cost-sharing for medical benefits as outlined in the Covered Benefits; (b) the Prescription Drug Benefits outlined in the Prescription Drug Program section; (c) Medical Policy; (d) the Medical Prescription Drug Formulary; and (e) the Prescription Drug Benefits provisions in the Limitations and Exclusions section.

Medical Supplies

Medical supplies such as splints, casts, trusses and braces, syringes and needles, catheters and colostomy bags and supplies are covered, based on medical necessity.

Mental Health Services

Benefits are provided for inpatient, residential treatment facility, day treatment/partial hospitalization, outpatient, and telehealth mental health services. All inpatient hospital and residential treatment facility admissions for mental health services must be certified as medically necessary by Acentra. Refer to the *Medical Management and Utilization Review* section for certification requirements.

Multiple Surgical Procedures

Special rules apply to multiple surgical procedures performed by the same provider during the same operation. If more than one surgical procedure is performed during the same operation through one or more routes of access, the allowable charge is the amount payable for the primary procedure plus 50 percent of the allowable charge that would be allowed for each of the additional procedures had those procedures been performed alone. Any of the costs associated with additional procedures (incidental procedures) not essential to the purpose of the primary procedure are not covered.

Nursing Services – Private Duty and Home Health

Nursing services of a registered nurse (RN) or licensed practical nurse (LPN) are covered when those services meet the following criteria:

- Ordered and supervised by a provider
- Require the technical skills of an RN or LPN
- Certified by Acentra to be provided in the home
- Certified by Acentra as medically necessary before initiation

No nursing benefits will be provided for:

- Services of a nurse who ordinarily lives in the patient's home or is a member of the patient's family
- Services of an aide, orderly, companion or sitter
- Nursing services provided in a nursing facility or a personal care facility

Occupational Therapy

Occupational therapy services are covered when prescribed by the participant's provider and specified in a treatment plan. BCBSMS may require proof of medical necessity. Services must be provided by a licensed occupational therapist.

Out-of-Network Review Services

If a participant needs any covered medical services that are not available from network providers, he should call Acentra and request a review of the availability of the needed services. This is called an "out-of-network review" and must be requested **before** receiving medical services.

If Acentra certifies that the covered service is not available in the Network, then that service is covered at the network benefit level, even if provided by an out-of-network provider. Services approved through an out-of-network review are subject to the appropriate network calendar year deductible and coinsurance. Although approval to use an out-of-network provider may be granted, the participant is responsible for amounts charged by the provider that exceed the Plan's allowable charge.

Out-of-network approval does not guarantee that services will be covered. Benefits are subject to the patient's eligibility at the time charges are actually incurred, and to all other terms, conditions and exclusions of the Plan.

Physical Therapy

Physical therapy services are covered when prescribed by the participant's provider and specified in a treatment plan. BCBSMS may require proof of medical necessity.

Provider Services

The following provider services are covered:

- In-hospital medical care
- Medical care in the provider's office, patient's home or elsewhere
- Surgery and assistant at surgery (when appropriate and provided by a provider practicing within the scope of his license)
- Consultations
- Administration of anesthesia
- Radiation therapy
- Obstetrical care
- X-rays and laboratory tests performed in a provider's office, except when performed during routine examinations, unless applied to the wellness benefit
- Psychiatric and psychological services for mental health treatment
- Allergy testing
- Covered dental care
- Dialysis treatment

Prosthetic or Orthotic Devices

Covered services include the purchase and initial placement of prosthetic or orthotic devices, and the fitting, repair or replacement when medically necessary. No shoe buildup, shoe orthotic, shoe brace or shoe support is covered unless the shoe is attached to a brace.

Pulmonary Rehabilitation Programs

Benefits are provided for medically necessary pulmonary rehabilitation programs.

Residential Treatment Facility

All admissions and continued stays in a residential treatment facility must be certified as medically necessary by Acentra. Refer to the *Medical Management and Utilization Review* section for certification requirements.

Skilled Nursing Facility

All admissions and continued stays in a skilled nursing facility must be certified as medically necessary by Acentra. Refer to the *Medical Management and Utilization Review* section for certification requirements.

Sleep Disorders

Unattended home sleep studies are covered subject to medical necessity and only when provided by a network sleep center which has met the American Academy of Sleep Medicine (AASM) Standards for Accreditation.

Speech Therapy

Speech therapy services are covered if needed as the result of an illness or injury, there is a reasonable expectation that the therapy will achieve measurable improvement within a reasonable and predictable period, and services are prescribed by a provider and performed by a licensed speech therapist. Speech therapy services for delayed language development are limited to a lifetime maximum of 15 visits. Speech therapy is not covered for maintenance speech, articulation disorders, learning disabilities, attention disorders, psychosocial speech delay, behavioral problems, conceptual handicap, mental retardation, stammering or stuttering.

Sterilization Procedures

Benefits are provided at 100 percent for sterilization procedures for all women with reproductive capacity when services are rendered by a network provider. No coinsurance or calendar year deductible may be applied to sterilization procedures for all women with reproductive capacity. Sterilization procedures for male participants are provided at regular benefits.

Substance Abuse

Benefits are provided for inpatient, partial hospitalization, residential treatment facility, intensified outpatient program and outpatient substance abuse treatment. All inpatient hospital and residential treatment facility admissions for substance abuse treatment must be certified as medically necessary by Acentra Refer to the *Medical Management and Utilization Review* section for certification requirements.

Telehealth Provider Visit

Telehealth provider visit benefits are provided for the HIPAA-compliant delivery of health care services such as diagnosis, consultation, or treatment through the use of interactive audio, video or other electronic media. Services must be "real-time" consultations and do not include the use of audio-only telephone, email or fax. In order to qualify for benefits under the Plan, such services must be rendered by a network provider or approved vendor. Telehealth provider visits are available for primary care physicians, nurse practitioners, registered dietitians and mental health therapists. Benefits are subject to copayments and may be subject to deductibles depending upon the participant's coverage option (Base or Select). Refer to *Base Coverage* and *Select Coverage* sections for cost-sharing and related coverage limitation information.

Temporomandibular Joint Syndrome (TMJ)

Benefits for surgery and diagnostic services of the temporomandibular/craniomandibular joint are provided, up to a lifetime maximum benefit of $5,000. Benefits are not provided for physical therapy, orthodontics, dentures, occlusal reconstruction, or for crowns or inlays.

Tobacco Cessation

The Plan offers a tobacco cessation program available to all participants at no charge through ActiveHealth. Participants who regularly use tobacco in any form have the opportunity to participate in the cessation program in an effort to help them to become tobacco free. Covered spouses and other covered dependents age 18 and over are also eligible to participate in the Plan's tobacco cessation program at no charge. ActiveHealth's program provides tobacco cessation counseling and up to eight weeks of over-the-counter nicotine replacement medication. For more information regarding the Plan's free tobacco cessation program including nicotine replacement therapy drugs, visit https://www.dfa.ms.gov/insurance. *Note: 180 days of smoking cessation medication is also available under the Plan's pharmacy benefits with a prescription from your health care provider at no cost for generics or brand-only medications.*

Transplants

All solid human organ and bone marrow or stem cell transplants must be certified as medically necessary by Acentra and are subject to the following provisions:

- The condition requiring the transplant is life-threatening.
- The transplant for the condition is the subject of an ongoing phase III clinical trial or has been approved by FDA.
- The procedure follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise.

- The participant is a suitable candidate for the transplant under the medical protocols used by Acentra.

Organ Acquisition Coverage

Benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or bone marrow/stem cell used in a covered transplant procedure. If any organ or bone marrow/stem cell is sold rather than donated to the participant, no benefits will be payable for the purchase price. Costs related to evaluation and procurement are covered.

Travel Expenses Related to Transplant

Transportation costs of the transplant recipient and one other person to and from the surgery site, as well as reasonable and necessary costs of meals and lodging for the accompanying person, are covered. If the recipient is a minor, reasonable and necessary expenses for the transportation, meals, and lodging of two other accompanying persons are covered. Only those travel expenses incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of preoperative and postoperative services are not eligible for reimbursement. The Plan will only reimburse actual travel expenses supported by dated receipts. The amount of reimbursement will not exceed $10,000 for any single transplant episode. Dated receipts must be submitted to BCBSMS to qualify for reimbursement.

Living Donor Coverage

The following chart summarizes when benefits are available for an organ or bone marrow/stem cell transplant from a living donor:

If…	Then…
Both the recipient and the donor are participants…	Covered benefits provided to the donor will be applied to the recipient's Plan benefit.
Only the recipient is a participant…	The donor is entitled to Plan benefits, but only to the extent coverage is not provided by another health care plan. Covered benefits provided to the donor will be applied to the recipient's Plan benefit.
When only the donor is a participant…	No benefits are provided.

Benefits for the following services are provided to the donor:

- Search for matching bone marrow, or organ.
- Transportation to and from the surgery site.
- Organ or bone marrow/stem cell removal, withdrawal and preservation and hospitalization.

Travel Outside the United States

Benefits are provided for covered services rendered outside the United States through the BlueCard® Worldwide Program. If using a provider that does not participate in this program, claims must be translated to English and converted to U.S. dollars before submission to the Plan.

Weight Management Program

The *Weight Management Program* through ActiveHealth is provided for participants with a Body Mass Index (BMI) of 30 or greater. This 12-month program provides individual counseling over the phone with dietitians, nurses and fitness experts. This confidential program is available to participants at no cost.

Well-Child Care

Benefits are provided for well-child care services for covered dependents up to age 18 at 100 percent. These services are not subject to the calendar year deductible. **Benefits are only provided when a network provider renders the service and the wellness services are filed with a wellness diagnosis**.

Well-newborn nursery care while a newborn is hospital-confined after birth is covered at 100 percent. Well-newborn nursery care includes room, board and other normal care provided for which a network hospital or provider makes a charge. Also, well-child office visits, certain diagnostic tests and immunizations are covered at 100 percent.

Wellness/Preventive Coverage for Adults

Benefits are provided at 100 percent of the allowable charge for up to two office visits per calendar year and certain diagnostic tests and immunizations. Certain diagnostic tests and immunizations are based on the participant's age and gender. These services are not subject to the calendar year deductible.

Wellness and preventive care benefits are only provided when a network provider renders the service and the wellness services are filed with a wellness diagnosis. Go to https://www.dfa.ms.gov/insurance for a list of covered preventive services.

Wellness/Preventive Prescriptions

In accordance with health care reform, benefits for the items listed are provided at 100 percent of the allowable charge and not subject to the calendar year or prescription drug deductible. A prescription is required for all preventive medications that are provided at 100 percent of the allowable charge.

- Low-dose aspirin (81mg/day) after 12 weeks of gestation for women who are at high risk for preeclampsia, 12-59 years of age.
- Fluoride Supplements for children 5 years of age or younger.
- Folic Acid Supplements for female participants 55 years of age or younger.
- Iron Supplements for children ages 6 – 12 months old.
- Generic statins (Lovastatin/pravastatin) for participants without a history of cardiovascular disease (CVD), 40 - 75 years of age with one or more CVD risk factors with a 10-year cardiovascular event risk factor of 10 percent or greater.
- Generic bowel prep medications for colonoscopy procedures in participants 45-75 years of age.
- Infant Eye Ointment for the prevention of gonococcal eye infections (for newborns) up to age 3 months.
- HIV Pre-Exposure Prophylaxis
- Certain preventive medications for women 35 years of age and older who are at an increased risk for breast cancer.

A complete list of the covered preventive prescriptions can be found at www.caremark.com or can be obtained by calling CVS Caremark Customer Care at 888-996-0050.

Wound Vacuum Assisted Closure

Benefits are provided for wound vacuum assisted closure services when medically necessary and prescribed by the attending provider.

Prescription Drug Program

To be considered for coverage under the Plan, prescription drugs must first be:

- Available on the formulary managed by the Plan's pharmacy benefit manager;
- Prescribed by a licensed provider;
- Dispensed by a licensed pharmacist;
- Found to be medically necessary for the treatment of the participant's illness or injury;
- Food and Drug Administration (FDA) approved; and
- Not otherwise excluded from coverage under the Plan.

Participants may purchase medically necessary prescription drugs at participating retail pharmacies or by mail through the Plan's pharmacy benefit manager (PBM), CVS Caremark. (See *Diabetic Management Program* and *Pharmacy Mail Order Program* sections for more detail.) Specialty medications must be purchased through participating specialty drug providers. Coverage for prescription drugs purchased at a retail pharmacy is limited to a 90-day supply. Coverage for prescription drugs purchased through the pharmacy mail order program is limited to a minimum 60-day supply and a maximum 90-day supply. Coverage for prescription drugs purchased through the specialty pharmacy program is limited to a 30-day supply.

When a covered prescription drug is purchased at a network retail pharmacy, the participant is only required to pay the appropriate copayment amount (after the applicable deductible is met) or the cost of the drug, whichever is less. There is no claim form to file. When a prescription drug is purchased at an out-of-network pharmacy, the participant must file a claim with CVS Caremark. The prescription drug claim form is available to be downloaded and submitted online at www.caremark.com or the paper claim can be returned to CVS Caremark. Payment of the claim will be made based upon the Plan's allowable charge. The participant is responsible for any amount in excess of the allowable charge, plus the applicable deductible and/or copayment.

In most instances, when a generic drug is available and the participant purchases the brand name drug instead, the participant will pay the difference in the cost of the brand name drug and the generic drug, plus the brand copayment amount.

CVS Caremark Customer Care

CVS Caremark is available 24/7 to provide assistance to participants. If a participant should experience a problem having a prescription filled or have a question regarding coverage, he may contact CVS Caremark at 888-996-0050.

Copayments

The copayment amount of certain covered prescription drugs may be reduced, increased or eliminated to assist in controlling prescription drug costs.

Coordination of Benefits

When a participant has other health insurance coverage that is primary, a prescription drug claim may be filed for secondary coverage under the Plan. To file a claim, a copy of the explanation of benefits from the primary insurance carrier along with a copy of the receipt from the pharmacy must be attached to a prescription drug claim form. This form is available at www.caremark.com. The claim is processed by CVS Caremark and reimbursement is made to the participant based upon the Plan's allowable charge, less the amount paid by the primary carrier, less the applicable copayment for that prescription drug.

Formulary

The formulary is a list of medications covered by the Plan. The formulary consists of both brand and generic drugs. Sometimes, several drugs can treat the same condition, and the Plan may choose some drugs over others. Covered drugs are chosen based on their clinical appropriateness and cost effectiveness. While the formulary may be modified at any time, changes are typically made quarterly. A copy of the Plan's drug formulary may be obtained through the Plan's website at https://www.dfa.ms.gov/insurance or by contacting CVS Caremark directly.

Generic Drugs

Typically, generic drugs cost less than equivalent brand drugs. Because the generic drug copayments are less, participants save money when purchasing generic drugs. Participants are encouraged to use generic drugs whenever possible. To be covered by the Plan, a generic drug must:

- Contain the same active ingredients as the brand drug (inactive ingredients may vary).
- Be identical in strength, form of dosage and the way it is taken.
- Demonstrate bioequivalence with the brand drug.
- Have the same indications, dosage recommendations and other label instructions (unless protected by patent or otherwise exclusive to the brand).

Vaccine Program

Benefits will be provided at 100 percent of the allowable charge for annual influenza (flu), pneumococcal infection (pneumonia), Haemophilus influenza type b (Hib), Hepatitis A and B, HPV, measles, mumps, rubella, varicella, meningococcal, polio, rabies, respiratory syncytial virus (RSV), rotavirus, tetanus, diphtheria, Covid-19 and acellular pertussis (whooping cough) vaccines administered by an immunization-certified pharmacist at a network pharmacy. In addition, based on the Centers for Disease Control and Prevention (CDC) recommendations, benefits will be provided at 100 percent of the allowable charge for non-Medicare participants age 50 and over for the appropriate herpes zoster (shingles) vaccine. Participants must use a pharmacy that participates in the CVS Caremark Vaccine Network in order to receive benefits. A trained clinician administers the vaccine on-site according to state regulations. A prescription may be required. Participating vaccine network pharmacies may be found using the CVS Caremark Vaccine Network tab on www.caremark.com or by contacting CVS Caremark Customer Care at 888-996-0050.

Pharmacy Mail Order Program

Participants can utilize the convenience of receiving medication(s) by mail by using the CVS Caremark Mail Order Pharmacy program. To get started, register at www.caremark.com or contact CVS Caremark Customer Care at 888-996-0050.

Please note: Participants should allow 7-10 days for delivery and plan accordingly.

A prescription submitted to CVS Caremark Mail Order Pharmacy for less than a 90-day supply will be charged the same copayment as for an entire 90-day supply. Coverage for prescription drugs purchased through the mail order pharmacy is limited to a minimum of 60 days and a maximum of 90 days. CVS Caremark Mail Order Pharmacy may suspend service if participants carry an unpaid balance.

Prior Authorization

Certain prescription drugs require prior approval. The prescribing provider must contact CVS Caremark at 800-294-5979 for prior authorization. The provider must provide appropriate documentation of medical necessity.

Only the provider can request prior authorization approval. Examples of prescription drugs requiring prior authorization include, but are not limited to, medications for treating acne, androgens and anabolic steroids, growth hormones, and medications for treating Hepatitis B and C. The quantity of some prescription drugs may be limited based on drug indications or medical necessity. If the quantity of a covered prescription drug, as prescribed by the provider, is not approved by CVS Caremark, the provider must contact CVS Caremark for prior approval of additional quantities. Approval will require appropriate documentation of medical necessity. The fact that a provider has prescribed, ordered, recommended or approved a prescription drug, does not, in itself, make the prescription drug medically necessary for purposes of coverage under the Plan.

Step Therapy

Some prescription drugs require step therapy. Step therapy is a process that optimizes rational drug therapy while controlling costs by defining how and when a particular drug or drug class should be used based on a patient's drug history. Step therapy requires the use of one or more prerequisite drugs that meet specific conditions before the use of another drug or drugs.

Quantity Limits

Quantity limits have been established by CVS Caremark for certain drugs based on the approved dosing limits established during the FDA approval process. Your provider must submit a prior authorization request form to CVS Caremark for approval of amounts that exceed the established quantity limit.

Early Refills

There are some circumstances when a participant will be allowed to obtain an early refill of a prescription drug for purposes such as going on vacation, for a dosage change during the course of a treatment, or for lost or destroyed medication. The participant's pharmacist may contact CVS Caremark to obtain authorization for an early refill or advance supply of a medication. Early refills are limited to two refills per medication per 12 months.

Specialty Drug Management Program

The Specialty Drug Management Program provides access to specialty medications with the convenience of express mail delivery. Specialty medications are limited to a 30-day supply and must be purchased through an approved network specialty pharmacy. Participants have access to a Specialty Care Team staffed by experienced pharmacists specially trained in complex health conditions and the latest medication therapies. Participants can call CVS Specialty at 800-237-2767 for more information on the Specialty Drug Management Program, or for information on other approved specialty network pharmacies.

Specialty pharmacies provide medications for many chronic conditions, such as:

- Multiple Sclerosis
- Rheumatoid arthritis
- Gaucher's Disease
- Cystic Fibrosis
- Hemophilia
- Hepatitis C
- Anemia
- Pulmonary Hypertension
- Respiratory Syncytial Virus
- Growth Hormone Deficiency
- Crohn's Disease
- Neutropenia

Limited Distribution Drugs

Limited distribution drugs are only available through select specialty providers as determined by the drug manufacturer. Access to limited distribution drugs is available through other specialty providers in the Specialty Drug Management Program. For assistance with obtaining a limited distribution drug and with locating an approved distributor, contact CVS Caremark Customer Care at 888-996-0050.

Caremark Cost Saver

As a CVS Caremark® member, we know that keeping your out-of-pocket costs low is important to you and your family. That's why we are working with industry leading prescription discount suppliers to offer Caremark Cost Saver™, helping you save on commonly dispensed generic medications. Caremark Cost Saver makes sure you automatically get the lowest available cost for medications covered under your plan. All you have to do is present your member ID card when you pick up your prescriptions.

Wegovy

The U.S. Food and Drug Administration (FDA) approved Wegovy (semaglutide) to reduce the risk of major adverse cardiovascular (CV) events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight.

Your provider must submit a prior authorization request form to CVS Caremark to determine if you meet the requirements of coverage for this indication. Wegovy consideration for coverage will be limited to this indication alone. Wegovy and other drugs used for weight loss and/or obesity are a plan exclusion.

Limitations and Exclusions

In addition to the benefit limitations and exclusions discussed elsewhere in this *Plan Document*, the following are either limited or not covered by the Plan.

Medical Service	Limitations and Exclusions
Abortion	Not covered, unless documented to be medically necessary to preserve the life or physical health of the mother.
Acupuncture/Biofeedback	Not covered
Allowable charge	Charges exceeding the allowable charge are not covered.
Assistant at surgery	Not covered, unless services are medically necessary and are rendered by a physician, physician assistant or first nurse assistant.
Cardiac Rehabilitation – Outpatient	Not covered unless determined to be medically necessary by BCBSMS.
Canceled or missed appointments	Not covered
Charity Hospital, Public Mental Institution, Public Health Institution, Sanatorium	Services for which the participant has no legal obligation to pay or for which no charge would be made if the participant had no health insurance coverage are not covered.
Chelation Therapy	Not covered, except for treatment of acute heavy metal poisoning.
Coding	Charges resulting from inappropriate coding, as determined by BCBSMS are not covered.
Convalescent, custodial or domiciliary care	Not covered, including companions and sitters.
Copayments, coinsurance, deductibles	Not covered
Cosmetic services	Not covered, except for correction of defects incurred by a participant while covered under the Plan through traumatic injury or disease requiring surgery.
Counseling	Sex therapy and marriage or family counseling are not covered.
Coverage effective dates	Services or supplies provided before coverage becomes effective or after coverage ends are not covered.
Dental services	Not covered, except when services are provided due to an accidental injury to sound natural teeth which occurs while the participant is covered by the Plan, or as a direct result of a disease covered by the Plan.

Medical Service	Limitations and Exclusions
Dental services (hospital or ambulatory surgical facility services and anesthesia)	Hospital services and supplies for covered dental care and treatment, and covered dental or oral surgery are not covered unless the inpatient hospital stay is determined medically necessary by Acentra. Outpatient hospital, ambulatory surgical facility, or anesthesia services are not covered unless determined medically necessary by BCBSMS.
Diabetic Self-Management Education and Support	Outpatient Diabetic Self-Management Education and Support is not covered, except as approved by Acentra.
Dietary/Nutritional supplements, breast milk	Not covered
Educational training	Educational training is not covered unless otherwise specified in this *Plan Document* or covered under *Wellness/Preventive Services*.
Equipment	Equipment that has a nontherapeutic use (i.e., humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, etc.) is not covered.
Experimental/Investigational	Experimental/investigational treatments, procedures, facilities, equipment and supplies are not covered, as determined by BCBSMS or Acentra.
Eye examinations	Routine eye examinations (except as provided through well-child care), eyeglasses, or contact lenses or fittings for them are not covered.
Foot care	Palliative or cosmetic foot care is not covered.
Gene manipulation therapy	Not covered
Genetic testing or counseling	Not covered unless provided under *Wellness/Preventive Services* and when determined to be medically necessary by BCBSMS.
Government agency	Services or supplies provided by the U.S. or any other government agency, at no charge to the patient, are not covered.
Hair loss	Services and supplies for the treatment of hair loss are not covered.
Hearing examinations and hearing aids	Routine hearing examinations are not covered except for newborn screening. Hearing Aids are not covered.
Holistic therapies	Not covered
Hypnosis	Not covered
Infertility treatment, artificial insemination, intrauterine insemination, In-vitro fertilization or reversal of sterilization	Not covered

Medical Service	Limitations and Exclusions
Luxury, deluxe or convenience items	Not covered
Massage therapy	Not covered
Maternity benefits	Charges or expenses related to the pregnancy of a dependent, other than the spouse, are not covered unless otherwise specified in this *Plan Document*.
Medical records	Fees for medical records and claim filing are not covered.
Medical Prescription Drug Benefits	Not covered, unless included in the Medical Prescription Drug Formulary or determined to be medically necessary. These Medical Prescription Drugs include but are not limited to the following: those where an equivalent product is available over the counter; where Prior Authorization is required in order for benefits to be provided and Prior Authorization is not obtained; those for which benefits are sought by the participant when the participant has failed to comply with the Plan's Medical Policy requirements with regard to Prescription Drugs and/or Medical Prescription Drugs; or those not provide in the appropriate place of service. See other limitations and exclusions related to the Prescription Drug Program specified in this *Plan Document*.
Medicare covered services	Not covered to the extent that charges for such services or supplies are paid or payable under Medicare, whether or not the participant has such Medicare coverage, whether or not Medicare benefits are claimed or received, or whether or not the participant has elected to obtain such Medicare coverage, if eligible.
Military Service connected injury/illness	Not covered, except in those cases where enforcement would be prohibited by law.
Nursing home, extended care or personal care facility	Not covered
Obesity treatment or weight loss therapies, prescriptions	Not covered, regardless of any claim of medical necessity, degree of obesity or clinical diagnosis, unless otherwise specified in this *Plan Document* or covered under wellness/preventive services. Nutritional and behavioral counseling services are covered when performed by a network provider.
Prescription Digital Therapeutics	Software programs or applications intended to prevent, manage or treat a medical disorder or disease.
Pulmonary rehabilitation	Not covered unless determined to be medically necessary by BCBSMS.
Refractive eye surgery	Not covered
Rehabilitation services	Not covered, unless otherwise specified in this *Plan Document.*

Medical Service	Limitations and Exclusions
Related provider	Services rendered by a provider (physician or other provider) who is related to the participant by blood or marriage or who regularly resides in the participant's household are not covered.
Retainer fees	Fees paid for the purpose of retaining the services of a health care provider are not covered.
Scope of license	Services rendered by a physician or other provider not practicing within the scope of his license at the time and place service is rendered are not covered.
Services not specifically included as benefits	Not covered
Services deemed not medically necessary	Not covered
Sex transformations	Not covered, Puberty-blocking drugs are not covered
Smoking cessation programs	Not covered, unless specified as a *Wellness/Preventive Service* for Adults.
Speech therapy	Not covered when services are provided for maintenance speech, articulation disorders, learning disabilities, attention disorders, psychosocial speech delay, behavioral problems, conceptual handicap, intellectual disability, stammering or stuttering.
Telehealth visit	Telehealth visits must be a "real-time" consultation and does not include the use of audio-only telephone, email or fax. These services must be provided by a network provider or approved vendor.
Telephone consultations	Not covered
Therapy services	Primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, aromatherapy, colonic irrigation, reflexology, vision perception training, carbon dioxide therapy, and related therapies are not covered.
Third party liability	Services related to an injury or illness which occurs due to the wrongful act or omission of another party for which that party or some other party makes settlement or is legally responsible is not covered. However, if the participant is unable to recover from the responsible party, benefits of this Plan will be provided.
Travel expenses such as transportation, meals and lodging	Not covered, except as provided under transplant benefits.
Visual or orthoptic training	Not covered

Medical Service	Limitations and Exclusions
War	Services rendered for diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war are not covered.
Workers' compensation/ employer liability law	Services related to any injury or illness arising out of or in the course of employment entitling the participant to benefits under any workers' compensation or employer liability law are not covered.

The following drugs and medical items are not covered under the prescription drug program:	
Anabolic steroids for muscle enhancement	Hematinics
Anorectics (any drug used for the purpose of weight loss)	Immunizations for prevention of infectious diseases (e.g., measles, polio, etc.) except as provided through the Vaccine Program.
Anti-wrinkle agents	Infertility medications
Any medication not proven effective in general medical practice	Investigative drugs and drugs used other than for the FDA approved diagnosis.
Breast milk	Medications for the termination of pregnancy (abortifacients)
Certain drugs that are considered similar in nature to currently available medications	Medications for the treatment of alopecia
Charges for administration or injection of any drug, except as provided through the Vaccine Program	Medications listed on a Drug Exclusion List
Compound medications containing bulk chemicals	Minerals (except for iron supplements for children ages 6 to 12 months, prescription required)
Compound medications exceeding $200 unless approved by the PBM	More than the recommended daily dosage.
Dietary/nutritional supplements	Non-FDA approved medications
Drugs considered not medically necessary	Non-legend drugs other than those listed as covered.
Drugs furnished at no cost to the patient by the local, state or federal government	Pigmenting/depigmenting agents
Drugs paid by workers' compensation coverage	Prescription drugs that have a chemically equivalent product available over the counter.

Drugs prescribed by a provider not acting within the scope of his license	Refills in excess of the number specified by the provider or any refills dispensed more than one year after the date of provider's original prescription.
Drugs that have been on the market for less than 6 months and/or have not been approved by the PBM	Therapeutic devices or appliances, including needles, syringes, support garments and other nonmedicinal substances, regardless of intended use, except those listed as covered above (some of these items may be covered under the Plan's medical benefits).
Drugs that, by FDA guidelines, do not require a written prescription (except as otherwise noted)	Vision Enhancement Agents: prescription ophthalmic products used to improve field of vision (e.g., blepharoptosis, drug-eluting contact lenses etc.)
Drugs used for cosmetic purposes	Vitamins, singly or in combination (except legend prenatal vitamins and folic acid for women up to age 55)
Fluoride supplements (except for children up to age 5, prescription required)	

Health Insurance Eligibility and Enrollment

Enrollee Eligibility

The following persons are eligible for coverage:

- A full-time employee who:
  - Receives compensation directly from one of the following Mississippi public entities:
    - Department, agency or institution of State Government
    - Public school district
    - Community college
    - Institution of higher learning
    - Public library
- A full-time employee who works for the:
  - State's judicial branch
  - State's legislative branch
  - University-based program authorized under state law for deaf, aphasic and emotionally disturbed children
- A full-time employee who works as a:
  - Full-time salaried Judge
  - Full-time salaried district attorney, or is a member of his staff
  - Full-time compulsory school attendance officer
- A regular nonstudent school bus driver
- A COBRA participant
- A retired employee
- A surviving spouse

An employee making contributions to a retirement plan approved by the Mississippi Public Employees' Retirement System (PERS) is considered a full-time employee.

Additionally, certain W-2 contract employees of participating State agencies will be deemed "ACA full-time employees." These employees will be eligible for coverage under the Base Plan option only. However, ACA full-time employees will be responsible for 100% of the cost of such coverage. ACA full-time employees are determined based upon the State's official Look-Back Stability Rule Policy for identifying full-time employees in accordance with Section 4980H of the Internal Revenue Code. To determine if you qualify as an ACA full-time employee under this policy please contact your State agency.

Eligibility under the Plan does not extend to the spouse of ACA full-time employees.

Note: Any employee participating in the Plan who continues coverage as a retiree and receives retirement benefits from PERS must be covered as a retiree and not as an active employee. This does not include retirees from the Mississippi Highway Safety Patrol Retirement System.

Dependent Eligibility

Eligible dependents include the following:

- The enrollee's lawful spouse, unless the spouse is eligible as a full-time employee as defined above
- The enrollee's child to age 26 (Coverage ends at the end of the month in which the child reaches age 26.) The term "child" includes the following:
    - Natural child or stepchild or legally adopted child
    - Foster child
    - Child placed in the enrollee's home in anticipation of adoption
    - Child for whom the enrollee is legal guardian
    - Child for whom the enrollee has legal custody
    - Child of the enrollee who is required to be covered by reason of a Qualified Medical Child Support Order (QMCSO)

The enrollee may be required to provide proof of dependent eligibility.

Initial Enrollment for New Employees

Initial enrollment applies to newly eligible active employees. An employee is required to complete an *Application for Coverage* form to apply for or waive coverage within the first 31 days of employment. The employee's Social Security Number must be provided on the *Application for Coverage* form in order for an employee to enroll in the Plan. Dependent information on the *Application for Coverage* form must include birth date, Social Security Number and mailing address, if different from the enrollee.

Legacy Employee

- An employee who was initially employed before January 1, 2006.
- An employee employed on or after January 1, 2006, who was ever a full-time employee of a Mississippi public community college, public library, public school district, State agency or institution for higher learning before January 1, 2006.

Horizon Employee

- An employee initially employed on or after January 1, 2006.

An employee may choose Base Coverage or Select Coverage at initial enrollment. If timely application is made and appropriate premiums are paid, the effective date of coverage for the employee and any eligible dependent(s) will be the first day of employment. If an employee does not enroll or if he waives coverage within 31 days of employment, application may be made only during an open enrollment or special enrollment period. Enrollment periods are discussed later in this section.

Disabled Dependent

The enrollee's dependent child is eligible for coverage at any age provided the dependent is permanently mentally or physically disabled, so incapacitated as to be incapable of self-sustaining employment, and depends upon the enrollee for 50 percent or more support. The disabling condition must have occurred before the dependent's 26th birthday. The enrollee must provide written proof of the incapacity including documentation from a provider. Neither a reduction in work capacity nor an inability to find employment is, of itself, evidence of incapacitation. Coverage may continue for as long as the incapacitation exists and the enrollee remains covered under the Plan.

Proof of disability must be provided to BCBSMS **31 days before the date a child would cease to be covered** because of age. The Plan reserves the right to request proof of continuous disability.

New employees who wish to enroll a permanently disabled dependent over age 26 must submit a *Request for Coverage for a Mentally or Physically Disabled Dependent* form along with the *Application for Coverage* form. This form can be obtained from BCBSMS, who will make final determination of disability. The disabling condition must have occurred before the dependent's 26th birthday.

Right to Request Documentation

If requested, documentation of dependent relationship, such as marriage license or birth certificate, must be provided. To enroll a child due to adoption, placement in anticipation of adoption, legal guardianship, legal custody or placement for foster care, a copy of the applicable court order must be submitted with the *Application for Coverage* form.

Paying for Coverage

The employer pays the cost of Base Coverage for all active employees. Employees may enroll in Select Coverage and pay a portion of the premium. The cost for dependent coverage is the employee's responsibility under both coverage types. Premiums for the active employee's cost of Select Coverage and dependent coverage are paid through payroll deductions. Premium rates may be found at https://www.dfa.ms.gov/insurance.

Special Rules when Family Members are also Employees

If both husband and wife are eligible employees, each may be covered by the Plan as employees but not as a dependent of the spouse. In addition, if a dependent child is an active employee, he may be covered by the Plan as an employee or as a dependent of his parent up to age 26. Dependent children may be covered as dependents of only one of the parents/stepparents. At no time may a dependent be covered under more than one contract under this Plan. An employee must indicate on the *Application for Coverage* form if his spouse is also an active employee.

If one spouse terminates employment, he may be added as a dependent under the remaining employee's coverage. In order for the terminated spouse to be added as a dependent, the remaining employee must complete an *Application for Coverage* form within 60 days of the spouse losing coverage under the Plan.

Active Employee Eligibility and Coverage

The following Plan guidelines apply to active employees. Enrollment periods for retirees and surviving spouses can be found in the *Retiree Eligibility Coverage* section.

Coverage and Maintenance

Active employees enroll and maintain coverage through their employer unit. It is important that a participant's address be kept up to date to ensure that he receives all communications regarding life and health insurance coverage. Active employees must submit address changes to their employer unit. Upon separation from employment, a COBRA notification will be electronically distributed to the email address on file with BCBSMS's *my*Blue system or mailed to the address on file. (See *Continuing Coverage Under the Plan* for additional detail.)

Open Enrollment for Active Employees

Each October during the annual open enrollment period, an employee may choose to elect health insurance coverage for himself and/or any eligible dependents. The coverage elected during open enrollment takes effect January 1 of the following calendar year. An employee may choose Base Coverage or Select Coverage during open enrollment.

Special Enrollment Periods Resulting from Loss of Coverage

An employee, dependent of a covered employee, or dependent of a COBRA participant who loses coverage under another health plan will be eligible to enroll for coverage in the Plan if the following apply:

- The employee initially declined coverage for himself or his dependents because he or the dependents were covered by other health insurance coverage; or the COBRA participant declined coverage for his dependent when first eligible because the dependent was covered by other health insurance coverage.
- The employee or dependent lost other coverage as a result of any of the following qualifying events:
    - Divorce
    - The employee or dependent is no longer eligible for coverage. Loss of coverage due to nonpayment of premiums does not qualify.
    - The employer unit ceased to contribute toward the cost of the other health plan, and it was terminated.
    - The employee's or dependent's COBRA continuation coverage eligibility has expired.

To enroll for coverage under these circumstances, an *Application for Coverage* form must be submitted within 60 days of losing coverage under the other plan and appropriate premiums must be paid. As part of the application process, proof of loss of coverage must be provided.

If these requirements are met, coverage under the Plan will take effect the first day following the loss of other coverage. An enrollee adding coverage due to a special enrollment event may change coverage types (Base to Select, or Select to Base). There is no deductible or out-of-pocket credit if an enrollee changes coverage types during a calendar year.

Special Enrollment Period as a Result of Gaining a New Dependent

An enrollee may enroll a new dependent for coverage if the new dependent was acquired as a result of any of the following qualifying events:

- Marriage
- Birth
- Placement for foster care
- Adoption
- Legal custody
- Legal guardianship
- Qualified Medical Child Support Order
- Placement in anticipation of adoption

To enroll for coverage under these circumstances, an *Application for Coverage* form must be submitted to the employer unit within 60 days of the event, and appropriate premium payments must be made. As part of the application process, the enrollee may be required to provide proof of the qualifying event. If these requirements are met, coverage under the Plan will take effect as of the date of the qualifying event. (In the case of a QMCSO, the coverage will be effective the first day of the month following the date of the order.)

An enrollee adding coverage due to a special enrollment event may change coverage types (Base to Select, or Select to Base). There is no deductible or out-of-pocket credit if an enrollee changes coverage types during a calendar year.

If an enrollee is applying for coverage for a newborn, the *Application for Coverage* form must be submitted to the employer unit within 60 days of the child's date of birth even if a Social Security number for the newborn is not available at the time. The Social Security number should be provided by the enrollee when received from the Social Security Administration.

Note: If the enrollee does not apply for coverage for himself or his eligible dependents during any of the special enrollment periods described herein, application cannot be made until an open enrollment period.

Transferring Within the Plan

If an employee transfers between employer units, begins full-time employment with the new employer unit at any time during the following month, and completes an *Application for Coverage* form within 31 days of his date of employment, there will be no break in coverage. The employee may choose Base Coverage or Select Coverage at this time. There is no deductible or out-of-pocket credit if an employee changes coverage types when transferring to a new employer unit during the year. The employee may also add eligible dependents at this time. The employee must complete an *Application for Coverage* form with the new employer unit within 31 days of his date of employment.

When Coverage Ends

An active employee's coverage under the Plan ends at the end of the month in which he terminates from full-time employment. Coverage will also end if any required contributions are not paid, or if the Plan is terminated for some reason. Dependent coverage ends at the same time or at the end of the month in which the Plan is made aware that a dependent is no longer eligible. Coverage ends at the end of the month in which the employee or dependent loses eligibility or contributions cease. Termination of coverage ends all rights of the participant to benefits under the Plan as of the effective date of coverage termination.

Transitional Coverage for School Districts

- **If a school employee** terminates employment at the end of a school year and does not return to covered employment with either the same or a new district or college, the coverage end date is dependent on receipt of the employee's final check. If the final check is received June 30, coverage will end June 30. If the final check is received July 31, coverage ends July 31.
- **If a school employee** terminates employment at the end of the school year, but returns to work (with either the same or new district or college) no later than September 1 of the following school year, coverage in the Plan will be reinstated. Reimbursement will be made for any COBRA premiums paid.

- **If a school employee** does not terminate employment at the end of the school year but does not return to work for the fall semester, coverage will terminate at the end of the month in which the school begins fall semester.

Terminating Dependent Coverage

To terminate coverage for a dependent, an enrollee must complete an *Application for Coverage* form, except when termination occurs as a result of employee's termination of employment or when a dependent becomes ineligible due to age. Coverage will be terminated at the end of the month in which the *Application for Coverage* is received. Retroactive terminations are not allowed. Termination of coverage ends all rights of the participant to benefits under the Plan as of the date coverage ends.

Note: Some limitations may apply for participants of cafeteria (IRS Section 125) plans.

Retiree Eligibility and Coverage

NOTE: MEDICARE ELIGIBLE RETIREES, MEDICARE ELIGIBLE SURVIVING SPOUSES AND MEDICARE ELIGIBLE DEPENDENTS OF RETIREES AND SURVIVING SPOUSES ARE NOT ELIGIBLE FOR PRESCRIPTION DRUG BENEFITS.

Coverage and Maintenance

Active employees who want to continue coverage under the Plan upon their retirement must initially apply through their employer unit. Once a former employee has enrolled as a retiree, he must submit all requested coverage changes directly to BCBSMS. It is important that a retiree's address be kept up to date to ensure that he receives all communications regarding life and health insurance coverage. Any change in enrollment status, such as death, divorce, entitlement to Medicare, etc., should be reported to BCBSMS as soon as possible. The change can be made on an *Application for Coverage* form. This form may be obtained from BCBSMS; however, the change can be completed as long as the request is submitted in writing.

Retiree Eligibility

To be eligible for retiree health coverage under the Plan, the active employee must:

- Have been participating in the Plan on the day before the effective date of retirement; and
- Have participated in the Plan for four years or more (unless retiring due to work-related disability); and
- Participate in a retirement plan approved by the Mississippi Public Employees' Retirement System (PERS); and
    - Qualify for service retirement under the applicable PERS regulations; or
    - Be approved for disability retirement benefits by PERS; or
    - Be an elected state or district official who does not run for re-election or who is defeated.

Note: Refer to the Group Term Life Insurance section for information on applying for life insurance coverage as a retiring employee or totally disabled employee.

Retiree Enrollment

An employee should apply for retiree coverage at least 31 days before his retirement date to avoid a temporary lapse in coverage. A health insurance *Application for Coverage* form must be received by the employee's Human Resources Office within 31 days of losing coverage as an employee. If the forms are received more than 31 days after coverage as an active employee has terminated, the right to continue coverage as a retiree is forfeited. The effective date of the new coverage will be the first day of the month following termination as an active employee. Retirement is <u>not</u> considered a qualifying event, and coverage type changes cannot be made at that time.

Reminder: If you or your spouse is eligible for Medicare, contact your local Social Security office to enroll in Medicare Parts A and B, and Part D for drug coverage. It is important to enroll in Medicare to receive maximum benefits. Even if Medicare is not elected, benefits under the Plan will be reduced as though Medicare is the primary payer.

In the event an employee does not elect retiree coverage within 31 days of leaving employment, he may still choose to continue coverage through COBRA any time during the balance of the COBRA election period. However, once the COBRA election period expires, the retiree has no option for coverage under the Plan. See specific details regarding COBRA continuation coverage under *Continuing Coverage Under the Plan.*

If an employee applies for disability retirement through PERS and is not eligible for service retirement, the employee may elect to continue coverage under COBRA until disability retirement is approved. However, disability retirement must be approved by PERS **prior** to the termination of aforementioned COBRA coverage.

If disability retirement is approved by PERS, an enrollee must complete an *Application for Coverage* form within 31 days of approval and submit an appropriate premium amount. If the employee experiences more than a 31-day lapse in coverage, he forfeits his right to continue coverage as a retiree.

Surviving Spouse Eligibility

If a covered retiree or a covered active employee who is eligible to retire dies, his covered surviving spouse and any covered dependent children may continue coverage under the Plan. The surviving spouse can be covered for their lifetime, and dependent children may be covered under the surviving spouse's coverage until the end of the month they reach age 26. If the retiree or active employee has covered dependent children but not a covered spouse, the dependent children can continue coverage for up to 36 months under COBRA continuation coverage. See specific details regarding COBRA continuation coverage and the election period under *Continuing Coverage Under the Plan.*

Surviving Spouse Enrollment

To continue coverage under the Plan, the surviving spouse must apply within 60 days of the end of the month following the employee's (or retiree's) date of death. An *Application for Coverage* form can be obtained by contacting BCBSMS. The surviving spouse must return the *Application for Coverage* form to the Department of Finance and Administration, Office of Insurance along with all premiums due for the coverage period beginning at the first of the month following the employee's (or retiree's) death. Any *Application for Coverage* form received by the Department of Finance and Administration, Office of Insurance more than 60 days after the employee's (or retiree's) date of death will be returned, and coverage will not be available.

Cost of Retiree/Surviving Spouse Coverage

The retiree (or surviving spouse) is responsible for paying 100 percent of the premium for the coverage selected for himself and any covered dependents. Premiums will be deducted from the retiree's monthly PERS retirement benefit, the surviving spouse's monthly PERS survivor benefit, or the retiree (or surviving spouse) will be direct billed by BCBSMS if the monthly PERS benefit is insufficient to cover the cost of the premium. For direct bill participants, premium payments are due on the first of each month. Automatic bank drafts are also available.

Open Enrollment

Retirees cannot add dependents during open enrollment. A non-Medicare eligible retiree or surviving spouse may choose either Base Coverage or Select Coverage during open enrollment.

Special Enrollment Periods Resulting from Loss of Coverage

A dependent of a covered retiree (or surviving spouse) who loses coverage under another health plan will be eligible to enroll for coverage in the Plan if the following apply:

- The retiree (or surviving spouse) declined coverage for his dependents when first eligible because the dependent was covered by other health insurance coverage.
- The dependent lost other coverage as a result of any of the following qualifying events:
    - Divorce;
    - The dependent is no longer eligible for coverage. Loss of coverage due to nonpayment of premiums does not qualify;

- The employer unit ceased to contribute toward the cost of the other health plan and it was terminated;
- The dependent's COBRA continuation coverage has expired.

To enroll for coverage under these circumstances, an *Application for Coverage* form must be submitted within 60 days of losing coverage under the other plan and appropriate premium payments must be made. As part of the application process, proof of loss of coverage must be provided. If these requirements are met, coverage under the Plan will take effect the first day following the loss of other coverage.

Special Enrollment Period as a Result of Gaining a New Dependent

A retiree (or surviving spouse) may enroll a new dependent if the new dependent was acquired as a result of any of the following qualifying events:

- Marriage
- Birth
- Adoption
- Placement in anticipation of adoption
- Legal guardianship
- Legal custody
- Qualified Medical Child Support Order
- Placement for foster care

To enroll the new dependent, an *Application for Coverage* form must be submitted to BCBSMS within 60 days of the date of the qualifying event and the appropriate premiums must be paid. Any *Application for Coverage* form received by BCBSMS more than 60 days from the date of the qualifying event will be returned, and coverage will not be available.

As part of the application process, proof of the qualifying event may be required. If these requirements are met, coverage under the Plan will take effect on the date of the qualifying event. In the case of a QMCSO, the coverage will be effective the first day of the month following the date of the Order.

Right to Request Documentation

If requested, documentation of dependent relationship, such as marriage license or birth certificate, must be provided. To enroll a child due to adoption, placement in anticipation of adoption, placement for foster care, legal guardianship or legal custody, a copy of the applicable court order must be submitted with the *Application for Coverage* form.

Transferring Dependent Coverage

A retiree may transfer dependent coverage from another contract under the Plan. For example: A retiree's spouse has coverage under the Plan as an active employee, and the spouse terminates employment and is not eligible to retire. The retiree can add the spouse and any other dependents covered under the spouse's contract. The retiree must complete an *Application for Coverage* form within 60 days of the spouse leaving employment and pay the appropriate premiums. Any *Application for Coverage* form received by BCBSMS more than 60 days from the date the spouse loses coverage due to termination of employment will be returned, and coverage will not be available.

Retiree Re-employment

A covered retiree who returns to work (other than full-time) with a covered employer unit and continues to receive retirement benefits from PERS may remain covered as a retired employee, but will not be eligible for employer-paid coverage as an active employee under the Plan. A covered retiree who returns to full-time employment with a covered employer unit and terminates retirement benefits is eligible for employer-paid coverage as an active employee.

A retired Mississippi Highway Safety Patrol officer receiving benefits under the Mississippi Safety Patrol Retirement System who is re-employed as a full-time active employee by a covered employer unit, may continue to receive retirement benefits and be eligible for employer-paid coverage under the Plan.

Special note on Medicare Eligibility:
It is a retiree's (or surviving spouse's) responsibility to contact BCBSMS when the retiree or a covered dependent becomes entitled to Medicare (upon reaching age 65 or eligibility through Social Security disability).

Medical Coverage: Non-Medicare Eligible Retirees, Surviving Spouses and Dependents

The Plan is the primary payer for a retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is under age 65, is not on Social Security disability, and is not covered as an active employee under another plan.

Medical Coverage: Medicare Retirees, Surviving Spouses and Dependents

The Plan provides a separate coverage level for Medicare eligible retirees and surviving spouses and/or dependents. Medicare is the primary payer for a retired employee, surviving spouse, or dependent of a retired employee, or surviving spouse who is:

- Age 65 or older.
- Under age 65 with Social Security disability.
- Under age 65 with end-stage renal disease after the first 30 months of Medicare eligibility.

Medicare coordination provisions are subject to change in accordance with changes in the Medicare program.

When Medicare is primary, the Plan will provide 100 percent toward the Medicare deductible and coinsurance amounts not covered by Medicare. The Plan only provides benefits for covered expenses outlined in this *Plan Document*. Benefits are paid at 100 percent for a covered expense that is not covered by Medicare.

Benefits are allowed based on the difference between the Medicare maximum allowable charge and the amount Medicare paid (or the difference between the Medicare allowed amount and the amount Medicare paid if assignment is accepted by the provider). This provision applies regardless of whether or not the provider participates in Medicare or contracts directly with the participant.

If a retired employee, dependent of a retired employee, surviving spouse, or dependent of a surviving spouse is eligible for Medicare and does not elect Medicare Part A and B, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has both Medicare A and B.

It is important to enroll in Medicare Parts A, B and D to receive maximum benefits. Participants should contact the local Social Security office for information on medical coverage.

Retirees should notify BCBSMS immediately upon being approved for Medicare due to Social Security disability by submitting a copy of their Medicare ID card. The Plan will update their records to reflect Medicare as the primary coverage effective the date of Medicare eligibility. The Plan will also refund any overpayment of premiums and reprocess claims not to exceed a two-year limit to calculate benefits as secondary to Medicare retroactive to the effective date of Medicare.

Prescription Drug Program – Medicare

The Plan does not provide prescription drug coverage for Medicare eligible retirees, Medicare eligible surviving spouses, or Medicare eligible dependents of retirees and surviving spouses.

Limitations and Exclusions

The limitations and exclusions are the same for all participants, regardless of how Medicare pays.

Canceling Coverage

A retiree wanting to terminate his coverage in the Plan must send a written request to BCBSMS to cancel coverage under the Plan, including the requested effective date of termination. Coverage terminations are effective at the end of the month following or coincident with the requested termination date, so long as it is not retroactive. Coverage will also end if any required contributions are not paid, or if the Plan is terminated for some reason. Dependent coverage ends at the same time the retiree coverage ends or at the end of the month in which the Plan is made aware that a dependent is no longer eligible. Requests for retroactive cancellation are not allowed.

Becoming entitled to Medicare does NOT automatically terminate your coverage under the Plan. If you wish to terminate your coverage under the Plan, as secondary to Medicare, when you become eligible for Medicare, you MUST submit a request in writing to terminate your coverage.

Termination of coverage ends all rights of the enrollee to benefits under the Plan as of the date coverage ends. Retirees are not eligible to subsequently reapply for coverage once it has been terminated.

Continuing Coverage Under the Plan

Continuing Coverage Under the Plan (other than continuing coverage as a Retiree)

In certain situations, coverage may be extended for an employee and covered eligible dependents with the employee being responsible for all applicable premiums. For information on continuing coverage as a retiree, refer to the *Retiree Eligibility* section. The following chart summarizes the circumstances in which coverage may be continued under the Plan.

If…	Coverage May Be Extended…
An employee is no longer receiving pay from his employer and has been approved for a leave of absence without pay…	For up to 12 months for both the employee and his covered dependents. The employee can contact his Human Resources office for more details.
An employee is placed on involuntary furlough without pay…	Until the employee returns from furlough to full-time employment. The employee can contact his Human Resources office for more details.
An active employee is called to active military duty…	For up to 24 months under COBRA
An employee dies while not yet eligible to retire, dependents may be eligible to extend coverage…	For up to 36 months under COBRA for any covered dependents. See below for exceptions.
An employee dies while eligible to retire and his spouse and children are covered as dependents…	For the rest of the covered spouse's lifetime and until the end of the month for any covered dependent child who reaches age 26. See *Surviving Spouse Eligibility* and *Surviving Spouse Enrollment* in this section.
An employee dies while eligible to retire and his children are covered as dependents…	For up to 36 months under COBRA for any covered dependent children.

Exceptions for a surviving spouse of an employee who dies while not yet eligible to retire:

- If a covered surviving spouse is on Medicare at the time of the employee's death, he will be eligible to continue coverage for up to 36 months under COBRA. Medicare will be the primary payer.
- If a covered surviving spouse enrolls in Medicare at any time after COBRA continuation has begun, coverage will terminate.

Active Military Duty

If an employee is called to active military duty and elects not to continue coverage under the Plan while on active duty, the employee may re-enroll for coverage upon return from active duty. The employee must apply for coverage within 31 days from the date he returns from active duty. If the employee returns within the same calendar year and applies for coverage within the 31-day period, the employee and any covered dependents will not be required to satisfy a new calendar year deductible.

What are COBRA Benefits?

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) is a federal law that allows for continuation of coverage under an employer's group health plan to covered persons (called "qualified beneficiaries") following a qualifying event.

Who is a Qualified Beneficiary?

A qualified beneficiary is an individual who, on the day before the qualifying event, is covered under the Plan either as an employee, enrollee's dependent spouse or enrollee's dependent child. A qualified beneficiary is also a child born to the employee, or who is placed for adoption with the employee during a period of COBRA continuation coverage.

What is a Qualifying Event?

A qualifying event is an occurrence which, but for the continuation coverage available under the Plan, would result in the loss of coverage for a qualified beneficiary.

Under COBRA, qualifying events include the loss of coverage that otherwise would result due to:

- Termination of employment for reasons other than gross misconduct.
- Reduction in hours of employment.
- Death of the enrollee.
- Divorce or legal separation.
- Entitlement to Medicare.
- Loss of dependent eligibility

If the qualifying event is divorce, legal separation, or ineligibility of a dependent child, the employee or qualified beneficiary must notify the employee's employer unit no later than 60 days after the qualifying event occurs; otherwise, continuation coverage may not be made available. Any other enrollee or his qualified beneficiary must notify BCBSMS no later than 60 days after the qualifying event occurs; otherwise, continuation coverage may not be made available.

An active employee covered by the Plan is eligible for COBRA as follows:

If an employee loses coverage under the Plan due to…	Continuation of coverage under COBRA may extend for…
A reduction in hours of employment… Termination of employment (for reasons other than gross misconduct)…	Up to 18 months
Being called to active military duty…	Up to 24 months

A spouse is eligible for COBRA as follows:

If a spouse loses coverage under the Plan due to…	Continuation of coverage under COBRA may extend for…
The death of the enrollee…	Up to 36 months unless enrollee was retired or eligible to retire
Termination of employee's employment (for reasons other than gross misconduct) … Reduction in employee's hours…	Up to 18 months
Employee being called to active military duty…	Up to 24 months
Divorce or legal separation… COBRA participant becomes entitled to Medicare…	Up to 36 months

Dependent children are eligible for COBRA as follows:

If a dependent child loses coverage under the Plan because of…	Continuation of coverage under COBRA may extend for…
The death of the enrollee…	Up to 36 months, unless eligible for coverage as a dependent of a surviving spouse
Termination of employee's employment (for reasons other than gross misconduct) … Reduction in employee's hours…	Up to 18 months
A parent being called to active military duty…	Up to 24 months
A parent's divorce or legal separation… COBRA participant becomes entitled to Medicare… No longer being an eligible dependent under the Plan…	Up to 36 months

If another qualifying event occurs during an 18-month continuation coverage period, then the period of continuation coverage can be extended, but not to exceed 36 months from the date of employment termination or reduction of hours of the employee.

Disability Extension

An 11-month coverage extension, in addition to the initial 18 months, may be granted to qualified beneficiaries who were disabled (as defined and determined under the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage. BCBSMS must receive a copy of the Social Security Administration's disability determination notice within 60 days of the qualified beneficiary receiving the notice and before the end of the initial 18-month period of continuation coverage to be eligible for this extension.

Cost for COBRA Continuation Coverage

The qualified beneficiary is responsible for the entire cost for his COBRA continuation coverage. The premiums charged for the initial 18-month COBRA coverage period are limited by law to 102 percent of the regular Plan premiums. If there is an 11-month coverage extension, the premiums charged for coverage during the extended period are limited by law to 150 percent of the regular Plan premiums.

COBRA Continuation Coverage Checklist

- Election of COBRA coverage can be made through the COBRA Self-Enrollment portal in *my*Blue or by completing a COBRA election form and returning to BCBSMS within 60 days of the date coverage ended or the date of the notice, whichever is later.
- The first premium payment must be made within 45 days from the date of election to continue coverage.
- The first payment must include all premiums due for the coverage period beginning with the COBRA coverage effective date through the current month.

Qualified beneficiaries will have continuous coverage through the COBRA election period as long as the applicable premiums are paid. If the required premium payment is not received within the 45-day period, coverage will terminate retroactively to the date of the qualifying event.

COBRA Benefits and Premium Changes

Benefits provided under COBRA continuation coverage are the same that the Plan provides to other participants under the Plan who are not receiving COBRA continuation coverage. Benefits and premiums under the Plan are subject to change at the discretion of the State and School Employees Health Insurance Management Board.

Dependent Coverage for COBRA Participants

A qualified beneficiary who has elected COBRA continuation coverage can choose to cover a newborn child, adopted child, or a new spouse who joins the family of the qualified beneficiary on or after the date of the qualifying event, subject to Plan enrollment period provisions as to when an eligible dependent may be enrolled. Coverage for a new family member ceases at the same time as the continuation coverage of the qualified beneficiary. New family members, except for children born to the covered employee or placed for adoption with the covered employee, do not become qualified beneficiaries.

Coverage Maintenance and Open Enrollment for COBRA Participants

It is important that an enrollee's address be kept up to date to ensure that he receives all communications regarding health insurance coverage. Updates and coverage changes should be submitted directly to BCBSMS.

Each October during the annual open enrollment period, a COBRA participant may choose to elect coverage for his eligible dependent(s). The coverage elected during open enrollment takes effect January 1 of the following calendar year. A COBRA participant may choose either Base Coverage or Select Coverage during open enrollment.

Coordination of Benefits

If a participant is covered by another employer's benefit plan or another group type health benefit plan, there may be some duplication of benefit coverage between this Plan and the other plan. The Plan coordinates benefits with other plans to prevent duplication of payments for the same services. This section describes how Coordination of Benefits (COB) works under the Plan. To determine how plans coordinate benefits, one plan is considered "primary" and the other is considered "secondary." The primary plan pays benefits first up to that plan's limits. The secondary plan will not pay benefits until the primary plan pays or denies a claim. In no instance will the primary and secondary plans pay, in total, more than the actual cost of the health care services. If the other plan does not include a coordination of benefits or non-duplication provision that plan will be primary. The following are the provisions for determining which plan will be "primary":

Description	Primary Plan	Secondary Plan
Active employee *Note: If employee is covered as an "employee" under two plans, the plan covering the employee for the longest period of time is considered the primary plan.*	Plan that has been in effect the longest	
Active employee with COBRA from previous employer	State and School Employees' Health Insurance Plan	COBRA
Dependent spouse with other coverage as "active employee"	Other health plan	State and School Employees' Health Insurance Plan
Active employee and spouse with children: both parents' health plans cover children	Follow birthday rule*	Follow birthday rule*
Active employee, divorced or separated, both parents' health plans cover children with court order	Follow court decree**	Follow court decree**

*Under the birthday rule, the plan of the parent whose birthday falls earliest in the calendar year is the child's primary plan. If both parents have the same birthday, the parent who has been covered longer has the primary plan. If the non-MSSEHIP plan does not have the birthday rule, then the rule in the non-MSSEHIP plan will determine *which is primary.*

**If parents are divorced or separated, and both parents' plans cover a dependent child, and there is no court decree, benefits for the child are determined in this order:

- First, the plan of the parent with custody;
- Then, the plan of the stepparent (spouse of the parent with custody of the child);
- Finally, the plan of the parent not having custody of the child.

Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine which plan is primary. Where the determination cannot be made in accordance with other provisions in this section, the plan that has covered the participant for the longer period of time will be primary. The term "plan" as used in this section means any of the following that provide benefits for services, for or by reason of, medical or dental care or treatment:

- Any health plan which provides services, supplies or equipment for hospital, surgical, medical, or dental care or treatment, or prescription drug coverage, including, but not limited to, coverage under group or individual insurance policies, nonprofit health service plans, health maintenance organizations, self-insured group plans, pre-payment plans, and Medicare as permitted by federal law. This does not include hospital daily indemnity plans, specified diseases-only policies, or limited occurrence policies that provide only for intensive care or coronary care in the hospital.
- Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under SCHIP Title XXI or Medicaid Title XIX (grants to States for Medical Assistance Programs of the United States Social Security Act as amended). It also does not include any law or plan when, by law, its benefits are in excess to those of any private insurance program or other nongovernmental program.
- Any individual automobile no-fault insurance plan.
- Any labor-management trusted plan, union welfare plan, employer organization plan, or employee benefit organization plan.

Each plan or other arrangement for coverage outlined immediately above is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan. For the purpose of this provision, BCBSMS may, without consent or notice to any person, release to or obtain from any insurance company or other organization or person any information that may be necessary regarding coverage, expenses and benefits. Participants claiming benefits under the Plan must furnish BCBSMS such information as may be necessary for the purpose of administering this provision. Where any medical payment sums are applicable under any coverage, including but not limited to, automobile and premises liability policies, the limits of any such coverage must be applied to related claims before any benefits will be provided under this Plan.

Medicare Coordination

The Plan is the primary payer for an active employee, active employee's spouse, and active employee's dependent child that is also covered by Medicare. Medicare is the primary payer for a retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is:

- Age 65 or older; or
- Under age 65 with Social Security disability; or
- Under age 65 with end-stage renal disease (ESRD) after the first 30 months of Medicare eligibility.

If the participant does not elect Medicare Part A and B, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has Medicare A and B.

Medicare Primary/Secondary Rules

Medicare Coordination Rules			
Employee Status	**Medicare Entitlement**	**Primary Plan**	**Secondary Plan**
Active Employee age 65 or older	Medicare due to age	State and School Employees' Health Insurance Plan	Medicare
Spouse (age 65 or older) of Active Employee	Spouse has Medicare due to age	State and School Employees' Health Insurance Plan	Medicare
Retired Employee age 65 or older	Medicare due to age	Medicare	State and School Employees' Health Insurance Plan
Disabled Retired Employee under age 65	Medicare due to disability	Medicare	State and School Employees' Health Insurance Plan
Active Employee any age	Medicare due to ESRD	State and School Employees' Health Insurance Plan (1st 30 months)	Medicare (Primary after 30 months)
COBRA participant under age 65	Medicare due to ESRD	State and School Employees' Health Insurance Plan (1st 30 months)	Medicare (Primary after 30 months)
COBRA participant over 65 or disabled	Medicare due to age or disability	Medicare	COBRA

If you have COBRA when you become Medicare-eligible, your COBRA coverage ends on the date you enroll into Medicare. If you have Medicare before you are eligible for COBRA, you are allowed to keep the COBRA benefits.

If the Plan is primary at the time the 30-month coordination for ESRD begins, the participant must serve the entire 30 months before Medicare will be primary regardless if they become Medicare eligible for any other reason.

A surviving spouse or dependent of a retired employee or surviving spouse age 65 or older is assumed to have Medicare Part A and B regardless of that participant's Medicare eligibility. The Plan will calculate benefits assuming the participant has Medicare A and B.

If a retiree is retroactively approved for Medicare due to Social Security disability, the Plan will update their records to reflect Medicare as the primary coverage effective the date of Medicare eligibility. Subject to any federal restrictions and/or Plan conditions, the Plan will also refund any overpayment of premiums and reprocess claims to calculate benefits as secondary to Medicare not to exceed two years.

Medicare Coordination – End-Stage Renal Disease (ESRD)

The Plan is the primary payer for:

- An active employee or employee's dependent spouse or child with ESRD during the first 30 months of Medicare eligibility solely by reason of ESRD (Medicare is primary after the first 30 months).
- A retiree, surviving spouse, or retiree's or surviving spouse's dependent spouse or child under age 65 with ESRD during the first 30 months of Medicare eligibility.

Medicare is the primary payer for:

- An active employee or employee's dependent spouse or child with ESRD after the first 30 months of Medicare eligibility solely by reason of ESRD.
- A retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is under age 65 with ESRD after the first 30 months of Medicare eligibility.

If the participant does not elect Medicare Part A and B, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has Medicare Part A and B.

Medicare Part D Coordination

Medicare eligible retirees, Medicare eligible surviving spouses and Medicare eligible dependents of retirees and surviving spouses are not eligible for prescription drug benefits

The Plan is primary for prescription drug coverage for COBRA participants unless the participant obtains Part D. In this case, the Plan will coordinate prescription drug coverage and apply prescription drug secondary coordination of benefit rules. The claim is processed by the pharmacy benefit manager and reimbursement is made to the participant based upon the Plan's allowable charge, less the amount paid by the primary carrier, less the applicable copayment for that prescription drug.

Medical Case Management and Utilization Review

Acentra provides medical case management and utilization review for the Plan. Utilization review is a process to make sure that the care participants receive is medically necessary, delivered in the most appropriate location, and follows generally accepted medical standards. Utilization review provides clinical review and certification of the medical necessity of care. **Certification of medical necessity does not guarantee that services are covered**. Benefits are subject to the patient's eligibility at the time charges are actually incurred, and to all other terms, conditions and exclusions of the Plan.

Notification Requirements

It is the participant's responsibility to make sure that Acentra is notified in advance of certain types of medical services. The notification requirements that apply to inpatient hospital admissions and specified outpatient diagnostic tests are detailed within this section.

The following services require certification and must be certified as medically necessary by Acentra:

- Inpatient hospital admission – except routine maternity admissions
- Inpatient rehabilitation
- Residential treatment facility
- Inpatient bariatric surgical procedures
- Outpatient bariatric surgical procedures
- Private duty and home health nursing
- Solid organ and bone marrow/stem cell transplants
- Home infusion therapy
- Skilled nursing facility
- Long term acute care facility
- Hospice care
- Diabetic self-management training/education

Acentra must be contacted in advance of any anticipated nonemergency hospital admission and immediately following an emergency admission by calling 888-801-1910. Failure to comply with notification requirements may result in financial penalties, reduction of benefits or even denial of benefits.

Note: Certification is not required for those participants having Medicare or other primary coverage, unless the service is not covered by Medicare or other primary coverage. In this case, the service will be subject to the certification process through Acentra.

Certifying a Hospital Admission

For certification review of nonemergency admissions to a hospital, psychiatric facility or chemical dependency facility, the participant should call Acentra as soon as he is advised that he may need to be hospitalized. In all cases, the call should be made as soon as possible but at least five days before the admission date. It is the participant's responsibility to ensure that notification requirements are met.

Certifying Maternity Hospitalization

For routine deliveries, Acentra must be notified if the hospital maternity stay exceeds 48 hours. In the case of a cesarean section, Acentra must be notified if the stay exceeds four days. Acentra should also be notified if the

newborn requires additional hospital days beyond the mother's length of stay, or if the mother is not a participant, but the child will be enrolled in the Plan.

Certifying an Emergency Hospital Admission

Acentra must be notified within 48 hours of an emergency admission to a hospital. If the participant is unable to make the call, another party can make the call on the participant's behalf. However, it is the participant's responsibility to ensure that notification requirements are met.

Notification Requirements for Inpatient Hospital Admissions

Type of Admission	Notification Requirement
Nonemergency	As soon as possible, but at least five days before admission.
Emergency	Within 48 hours of admission.

Note: Weekend and holiday admissions must also be reported within these timeframes.

If the notification requirements are not met and the inpatient admission is later found to be medically necessary by Acentra, penalties will be imposed.

Inpatient Financial Penalties

Notification	Definition	Penalty
No Notification	Notification that occurs after discharge	A $500 penalty will be imposed
Late Notification	Notification that occurs: • Less than five days before the admission date, but before discharge for a nonemergency admission; or • More than 48 hours after admission, but before discharge for an emergency admission.	A $250 penalty will be imposed

Notification Requirements for Outpatient Diagnostic Tests

Type of Admission	Notification Requirement
Nonemergency	As soon as possible, but at least 48 hours before test being performed
Emergency	Within 48 hours of test being performed

If the participant fails to meet the notification requirements, penalties will be imposed if the test is later found to be medically necessary by Acentra.

Outpatient Financial Penalty

Notification	Definition	Penalty
No Notification	Notification that occurs any time notice is given to Acentra more than 48 hours after an emergency test	A $100 penalty will be imposed

	is performed or any time after a nonemergency test is performed.	

Non-certification of Medical Necessity

If Acentra determines services are not medically necessary, or are being provided at a level of care inconsistent with the standard form of managed care environments, Acentra will advise the participant and/or the treating provider that coverage cannot be guaranteed.

No benefits will be provided for any service related to an inpatient hospital admission or specified outpatient diagnostic test that is determined by Acentra (either before or after the admission) not to be medically necessary.

Retrospective Review

If Acentra is not notified of an inpatient admission or outpatient diagnostic test, a retrospective review may be performed. A retrospective review may be performed when Acentra is contacted ***after*** discharge from an inpatient admission or more than 48 hours after a specified outpatient diagnostic test was performed. Even if Acentra determines that services are medically necessary, financial penalties will apply.

Medical Case Management

Acentra may perform medical case management for those participants who have a complicated, catastrophic or chronic condition. Through medical case management, Acentra may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies that are not otherwise covered under the Plan. The decision to provide extended or alternative benefits is made on a case-by-case basis for participants who meet Acentra criteria.

Chronic Condition Coaching Program

Participants with certain chronic conditions may enroll in a coaching program administered by ActiveHealth. The program provides help, support and education for participants living with conditions such as cardiac disease, asthma, and/or diabetes. The program is voluntary, completely confidential and provided at no cost to participants.

Special features of the program include:

- Personalized telephonic counseling about the participant's specific health condition.
- Helping the participant achieve health goals.
- An individualized care plan for nutrition, exercise and other lifestyle needs.
- Educational materials.
- Access to community resources.
- Access to health and medical topics.

This program does not replace care rendered by the participant's provider. For information on this program or to stop participation in the program, contact ActiveHealth at 866-939-4721.

Clinical Decision Support Program

ActiveHealth uses its CareEngine® Clinical Decision Support program to identify clinical issues that providers and patients can discuss. ActiveHealth continually monitors medical and pharmacy claims. If the program identifies drug interactions or other medical issues, the participant and his provider will receive a letter called a Care Consideration.

Pre-Admission and Post-Discharge Call Services

Acentra provides pre-admission educational calls for elective inpatient surgical patients as well as outreach calls to participants after discharge. The purpose of this service is to assess the participant's level of understanding of the surgery to be performed, pre-operative testing and preparation requirements, post-surgical limitations, expected care needs and to evaluate the participant's support system and preparation in relation to post-discharge care. Acentra will follow up telephonically with the participant after a hospital discharge to confirm any home care and/or durable medical equipment needs, ensure the participant has scheduled post-acute visits with surgeon, specialist(s), and primary care provider, confirm participant has filled required prescriptions and has resumed pre-operative medications as directed by the provider, and determine if the participant has adequate support to allow him to adhere to the prescribed plan of care.

Solid Organ and Bone Marrow/Stem Cell Transplant Services

Acentra reviews and evaluates all requests for transplant services and makes a recommendation concerning the medical necessity of the transplant services based on the clinical data provided by the attending provider. All participants meeting certification requirements for a transplant will be immediately placed in the medical case management program. Case management of transplant services includes all management necessary to coordinate pre-transplant services for the patient and family such as supportive care required for the patient while awaiting a transplant, alternative living arrangements for the patient and/or family once the transplant has been scheduled and performed, and all necessary post-transplant services to coordinate and transition care for the patient from the transplant facility to the patient's home based medical care providers.

Claims Administration

Verifying Coverage of a Service

To have a procedure or service reviewed for medical necessity before the service is performed, the participant's provider may write a pre-determination letter describing the condition and treatment. The provider's letter must include the enrollee's name and identification number, the patient's name and pertinent medical information. The letter should be sent to BCBSMS. For all inpatient hospital services and any specified diagnostic tests listed in the *Medical Case Management and Utilization Review* section, contact Acentra at 888-801-1910.

How to File a Medical Claim

A claim must be filed before benefits can be determined. The claim must contain all of the information needed by BCBSMS to process the claim. Network providers have agreed to file claims for participants. See *Time Limit for Claims Filing*.

For care received from an out-of-network provider, a participant must receive the proper itemized bills from the provider and file a claim. A participant can get a medical claim form by calling BCBSMS at 800-709-7881. The form must be completed in its entirety to avoid delays in processing. Completed medical claim forms must be mailed to BCBSMS.

- ***If another plan is primary,*** the claim must be filed with that plan first. Once an explanation of benefits (EOB) from the other plan has been received, the claim must be filed with BCBSMS. The claim must be filed with a copy of the other plan's EOB. If the other plan's EOB is not attached, the claim will be denied until the information is received.
- ***If Medicare is primary***, the claim must be filed with Medicare first. Once an explanation of Medicare benefits has been received, the claim must be filed with BCBSMS. The claim must be filed with a copy of the explanation of Medicare benefits. If the explanation of Medicare benefits is not attached, the claim will be denied until the information is received.

How to File a Prescription Drug Claim

If a participant uses a pharmacy that participates in the prescription drug program, there is no claim to file. The participant will pay the applicable deductible and copayment at the time of purchase. The prescription drug deductible and copayment are the participant's responsibility and will not be reimbursed under the prescription drug program or the medical program. See *Time Limit for Claims Filing.*

- ***If a participant uses a pharmacy that does not participate in the prescription drug program***, a paper claim must be filed. A participant can get a prescription drug claim form online at www.caremark.com or by contacting CVS Caremark Customer Care. The claim form must be completed in its entirety to avoid delays in processing. Pharmacy receipts must be attached to the claim form. The completed form can be mailed to CVS Caremark or completed online at www.caremark.com .
- The participant will be reimbursed the difference between the Plan's allowable charge and the copayment amount, once the applicable deductible has been met. Any charge for a prescription drug that exceeds the Plan's allowable charge will be the participant's responsibility and will not be applied toward meeting the deductible or copayment.
- ***If another plan is primary***, the claim must be filed with that plan first. When an EOB from the other plan has been received, the claim must be filed with CVS Caremark. The claim must be filed with a copy of the other plan's EOB and the pharmacy receipts. If the other plan's EOB is not received, the claim will be denied until the information is received.

Time Limit for Claims Filing

A claim should be filed as soon as possible after receiving care.

- **Deadline for Filing Medical Claims:** All claims and any additional information requested must be filed with BCBSMS within 12 months of the day you received services or supplies.
    - **A Special Note about Medical Claims:** BCBSMS does not consider a claim to be received for processing until the claim is actually received in the proper form, with all of the necessary information provided. Ensure all necessary information is filed with the claim and forms are completed appropriately. It is the participant's responsibility to ensure that claims are filed within the time limits. Claims filed after the time limits have expired are not eligible for benefits and will be denied.

- **Deadline for Filing Prescription Drug Claims:** All claims and any additional information requested must be filed with CVS Caremark within 12 months of the day you received services or supplies.

Tips for Filing Claims

- Keep all receipts from out-of-network pharmacies and providers.
- File claims promptly.
- Use the correct form. (There are separate claim forms for medical and prescription drug benefits.)
- Complete the entire form.
- Keep a copy of all claims filed.
- Mail the claim to the correct address.

General Claims Process Information

There are different categories of claims that can be made under the Plan.

- A claim is a pre-service claim if it requires certification of medical necessity in advance of obtaining the medical care.
- An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment when the time periods that otherwise apply to pre-service claims could seriously jeopardize the participant's life or health or ability to regain maximum function or would, in the opinion of a provider with knowledge of the participant's medical condition, subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim or an urgent care claim.

The Plan will decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the certification request. The Plan will decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the certification request. The Plan will decide an initial post-service claim within a reasonable time but no later than 30 days after receipt of the claim.

Despite the specified timeframes, nothing prevents the participant from voluntarily agreeing to extend the above timeframes. In addition, if the Plan is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the participant is notified in writing before the expiration of the initial timeframe applicable to the claim. The extension notice will include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

In the case of an incorrectly filed pre-service claim, the participant will be notified as soon as possible but no later than five days following receipt by the Plan of the incorrectly filed claim; and in the case of an incorrectly filed urgent care claim, the participant will be notified as soon as possible but no later than 24 hours following receipt by the Plan of the incorrectly filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the participant.

If an urgent care claim is incomplete, the Plan will notify the participant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the participant, unless the participant requests written notice, and it will describe the information necessary to complete the claim and will specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Plan will decide the claim as soon as possible but not later than 48 hours after the earlier of receipt of the specified information; or the end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the Plan may deny the claim or may take an extension of time, as described above. If the Plan takes an extension of time, the extension notice will include a description of the missing information and will specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the claim will be suspended from the date the extension notice is received by the participant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan will decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Appeals

A participant has the right to appeal any decision that denies payment of a claim or a request for coverage of a health care service or treatment.

Medical Appeals

If a participant believes that BCBSMS incorrectly denied all or part of a claim, he has the right to obtain a full and fair review. A request for a review must be made in writing to BCBSMS.

The participant has 180 days to request a review after receiving notice of denial from BCBSMS. The participant may provide additional information that relates to the denied claim. If the participant fails to request a review within this timeframe, the right to review is forfeited.

After the claim has been reviewed, if benefits are again denied, the decision will be sent to the participant in writing. The letter will include the reason(s) why benefits are denied, with reference to the Plan provisions on which the decision is based.

If, after following the appeal procedure described above, the participant still disagrees with the determination, a final internal appeal may be submitted in writing to the Department of Finance and Administration, Office of Insurance within 180 days after receiving the second denial from BCBSMS. The request to the Office of Insurance must include a copy of the BCBSMS review decision and all information pertinent to the claim.

The decision of the State Insurance Administrator with the Department of Finance and Administration, Office of Insurance is final and concludes all internal levels of appeal.

Within four months after the date of receipt of a final internal denial of a claim, the participant may file a request for an external review. An external review is available when the final denial involves an issue of medical judgement (including, but not limited to, medical necessity, appropriateness, health care setting, level of care, effectiveness, or whether a treatment is experimental or investigational), or rescission. The participant will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. The request must be made through the Office of Insurance and must include all information pertinent to the denied claim. An external review decision is binding on the participant except to the extent the participant has other remedies available under applicable federal or State law.

Failure to request a review within the above referenced time frames and in accordance with the procedures will result in the participant's right to an appeal and rights to sue being forfeited. *Note: A participant may request an External Review during any part of the Appeal Process.*

Prescription Drug Appeals

If a participant believes that CVS Caremark incorrectly denied all or part of a prescription drug claim, he has the right to obtain a full and fair review. A request for review must be made in writing to CVS Caremark.

The participant has 180 days from receiving notice of denial from CVS Caremark to request a review. The participant may provide additional information that relates to the denied claim. If the participant fails to request a review within this timeframe, the right to review is forfeited.

After the claim has been reviewed, if benefits are again denied, the decision will be sent to the participant in writing. The letter will include the reason(s) why benefits are denied, with reference to the Plan provisions on which the decision is based.

If, after following the appeal procedure, the participant still disagrees with the determination, a second level appeal may be submitted in writing to CVS Caremark within 180 days after receiving the initial denial from CVS Caremark. The second level appeal decision will conclude all appeals with CVS Caremark.

Within four months after the date of receipt of a final internal denial of a claim, the participant may file a request for an independent review. An independent review is available when the final denial involves an issue of medical judgement (including, but not limited to, medical necessity, appropriateness, health care setting, level of care, effectiveness, or whether a treatment is experimental or investigational), or rescission. The participant will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. The request must be made by contacting CVS Caremark and must include all information pertinent to the denied claim. An external review decision is binding on the participant except to the extent the participant has other remedies available under applicable federal or State law.

Failure to request a review within the above referenced time frame and in accordance with the procedures will result in the participant's right to an appeal and rights to sue being forfeited. *Note: A participant may request an independent review during any part of the Appeal Process.*

Utilization Review Appeals

If a participant or provider believes that Acentra incorrectly denied all or part of a medical service, he may initiate the appeals process. The attending provider may contact Acentra to discuss any findings of "not medically necessary" with the physician who initially made the determination. If the physician is not available, another physician will be made available. Based on that discussion, the Acentra staff physician will determine whether the original decision should be affirmed or amended. The enrollee and attending physician will be notified in writing of the results of this review.

When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone on an expedited basis, within one working day.

The attending provider or participant may submit a request for appeal, outlining the reason for the request, within 180 days of the initial denial decision. A thorough review and discussion of medical records and other supporting documentation will be undertaken by a specialist with experience in the condition or procedure requested.
Based on this review, a decision affirming or amending the original decision will be rendered and provided in writing to the enrollee and the attending provider. The provider may also request an expedited internal appeal at the same time as an expedited external review if the provider believes that the patient's life could be in jeopardy waiting the timeframe to complete a standard internal appeal.

Within four months after the date of receipt of an adverse determination or a final internal denial of a claim, the participant may file a request for an external review. An external review is available when the final denial involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The participant will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. The request must be made through Acentra. An external review decision is binding on the participant except to the extent the participant has other remedies available under applicable federal or state law. Failure to request a review in accordance with the procedures above will result in the participant's right to an appeal and rights to sue being forfeited.

Out-of-Network Review Appeals

Out-of-network reviews are not subject to the utilization review appeals process. A denial of an out-of-network approval may be appealed directly to the Department of Finance and Administration, Office of Insurance.

Other Complaints

If a participant has a complaint regarding any services provided under Mississippi's State and School Employees' Life and Health Insurance Plan, he may write to the Office of Insurance. The letter should contain specific information about the complaint.

General Internal Appeals Process Information

The person who reviews and decides an appeal will be a different individual than the person who initially processed the claim. The review will take into account all information submitted by the participant, whether or not presented or available when the claim was processed. No deference will be given to the initial benefit decision.

In the case of a claim denied on the grounds of a medical judgment, the Plan will consult with a health care professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual. Upon request and at no cost, a participant will be given reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. If advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each expert will be provided on request to the participant, regardless of whether the advice was relied on by the Plan.

The Plan will decide the outcome of an appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of the appeal request or 15 days if there are two levels of internal appeals. The Plan will decide the appeal of an urgent care claim as soon as possible, taking into account the medical emergency, but no later than 72 hours after receipt by the Plan of the appeal request. The Plan will decide the outcome of an appeal of a post-service claim within a reasonable period, but no later than 60 days of receipt by the Plan, or 30 days if there are two levels of internal appeals.

Refund of Overpayments and Subrogation

Refund to the Plan of Overpayment of Benefits

If Plan benefits are paid in error to any participant or provider of service, the Plan reserves the right to have the overpayment refunded. If any participant or provider of service does not promptly refund an overpayment to the Plan upon request, the Plan reserves the right to reduce any future benefit payments until the full amount of the overpayment is recovered.

Subrogation – Third Party Liability

As a condition to receiving medical benefits under the Plan, participants agree to transfer to the Plan their rights to recover damages in full for such benefits when an injury or illness occurs through the act or omission of another person. The participant agrees to execute or cause to be executed any and all documents required by the Plan, including a Subrogation Reimbursement Agreement and Accident Questionnaire, within thirty (30) days of receipt of the same, and to execute or cause to be executed any documents on behalf of minor dependents covered by the Plan. In the event the dependent is a minor, Chancery Court approval of such Subrogation Reimbursement Agreement may be required.

Alternatively, if a participant receives any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the participant agrees to reimburse the Plan in full, in first priority, for any medical expenses paid by it (i.e., the Plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the participant).

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the settlement or judgment specifically designates the recovery, or a portion thereof, as including medical expenses.

The Plan's right of full recovery, either by way of subrogation or right of reimbursement, may be from funds the participant or legal representative of the participant receives or is entitled to receive from any third party or the insured's own uninsured/underinsured or medical payment motorist insurance.

The Plan may enforce reimbursement or subrogation rights by requiring the participant or legal representative of the participant to assert a claim to any of the foregoing coverage to which he may be entitled.

The Plan will not contribute to any attorney fees or costs associated with the participant's recovery efforts.

In the event any hospital, medical, and related service or benefit is provided for, or any payment is made or credit is extended to a participant for injuries or illnesses resulting from an act or omission of another party, the Plan will be subrogated and will succeed to the right of the participant to recovery against any person, organization or other carrier. The acceptance of such benefits hereunder will constitute such subrogation. The participant must remit to the Department of Finance and Administration, for the Plan, all sums recovered by suit, settlement or otherwise, on account of such hospital, medical, and related service or benefit, and must take such action to furnish such information and assistance, and execute such assignments and other instruments as may be required to facilitate enforcement of rights hereunder, and must take no action prejudicing the rights and interests of the Department of Finance and Administration hereunder.

Failure by the participant to execute such evidence of subrogation as may be required will make the participant liable for all costs and expenses incurred under the Plan in his behalf because of such hospital, medical and related services. Nothing contained in this provision will be deemed to change, modify, or vary the terms of the *Coordination of Benefits* section of this *Plan Document.*

Subrogation – Work-Related

Benefits for work-related injuries or illnesses may be extended by the Plan where liability is being controverted by the employer in a proceeding before the particular workers' compensation agency with jurisdiction and participant's related claims are unpaid; or claims payments were made before notification to the Plan of their work-related nature.

Where the Plan does extend benefits for a work-related injury or illness, the Plan will be entitled to reimbursement where the employer acknowledges or the respective workers' compensation agency determines that the injury or illness is work-related. The Plan will be entitled to reimbursement even if a settlement does not specifically include payments for health care expenses. Reimbursement may be sought from the participant or directly from the employer or its workers' compensation liability carrier. The participant agrees to provide the Plan with prior notice of and opportunity to participate in any settlement proceedings.

The participant will take such action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of its rights and will take no action prejudicing the rights and interests of the Plan and/or the Department of Finance and Administration.

The participant must immediately notify the Plan of any injury, illness, or condition for which a claim has been or will be pursued under any applicable workers' compensation laws.

General Conditions

Breach or Default

Whenever any condition or requirement of the Plan has been breached by the participant or he is in default as to any term or condition hereof, failure of the Plan Sponsor, BCBSMS, Acentra, ActiveHealth, or CVS Caremark to avail of any right stemming from such breach or default, or indulgences granted, will not be construed as a waiver of the right of the Plan Sponsor, BCBSMS, Acentra, ActiveHealth, or CVS Caremark on account of existing or subsequent breach or default.

Covered Expense

Covered expense is incurred on the date the service is received or rendered. Benefits for covered expenses will be provided only to the extent that the provider can render such service, and payment therefore to the provider by BCBSMS or CVS Caremark as herein provided will constitute a complete discharge of the obligation of the Plan hereunder.

The Plan does not insure against any condition, disease, ailment or injury (including pregnancy and conditions arising from it), but only provides benefits for covered expenses incurred by a participant during his effective dates of coverage under the Plan.

Disclosure

The State and School Employees' Health Insurance Plan may disclose summary health information to the Plan Sponsor for the administrative functions of the Plan to include payment, treatment, and operations as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 C.F.R. Parts 160-64).

Liability

Neither the Plan Sponsor nor its contractors, their agents, or their employees will be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance, or malpractice on the part of any hospital or other institution, any agent or employee thereof, or on the part of any provider, health care professional, pharmacist, or other person participating in or having to do with the care or treatment of the participant.

Notices

Any notice required to be given by a contractor of the Plan Sponsor to an enrollee hereunder will be deemed to be given and delivered when deposited in the United States mail, postage prepaid, addressed to the enrollee at his address as the same appears on the records of BCBSMS.

Proof of Loss

Upon failure of the participant to notify BCBSMS or CVS Caremark or furnish proof of loss, payment may be refused or a percentage of the regular payment may be paid at the option of the Plan; provided, however, failure to give notice of proof of loss within the time provided will not invalidate a claim if it can be shown that compliance with this provision was not reasonably possible and that notice of claim was given as soon as reasonably possible.

Terms

The terms *pay*, *paid*, *payment* and *payable*, as well as similar terms, are found throughout this *Plan Document*. When the aforementioned terms are used with respect to the provision of benefits, the terms are referencing the benefits provided under the Plan, rather than the actual amount paid by the Plan, unless otherwise indicated.

Privacy of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) as updated under the American Recovery and Reinvestment Act (ARRA) gives participants certain rights and imposes certain obligations on the Plan with respect to health information. The following sections describe protections afforded a participant's health information as it relates to coverage under the Plan. This information is referred to as "protected health information."

The State and School Employees Health Insurance Management Board is the Plan Sponsor. The Plan will disclose protected health information (PHI) to the Plan Sponsor only upon receipt of certification by the Plan Sponsor that the *Plan Document* has been amended to incorporate the following provisions. The Plan Sponsor agrees to abide by the following requirements:

1. The Plan Sponsor will use or disclose PHI only to carry out Plan administration functions for the Plan not inconsistent with the requirements of the HIPAA (45 C.F.R. Parts 160-64), updated in the ARRA as permitted or required by the *Plan Document* or as required by law.
2. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the same restrictions and conditions included in the *Plan Document* with respect to PHI.
3. The Plan Sponsor will not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under the *Plan Document* of which it becomes aware.
5. The Plan Sponsor will make any PHI solely available to it available in accordance with 45 Code of Federal Regulations § 164.524.
6. The Plan Sponsor will make PHI solely available to it for amendment in accordance with 45 Code of Federal Regulations § 164.526.
7. The Plan Sponsor will track disclosures it may make of PHI solely available to it so that it can make available the information required for the Plan or its business associates to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
8. If the Plan Sponsor uses or maintains electronic health records with respect to PHI, if requested, the Plan Sponsor will provide a copy of such information in "electronic format."
9. The Plan Sponsor will make available its internal practices, books and records, relating to its use and disclosure of PHI, if any, to the HHS to determine compliance with 45 Code of Federal Regulations Parts 160-64.
10. The Plan Sponsor will, if feasible, return or destroy all PHI in any form received from the Plan, when PHI is no longer needed for the Plan administration purposes for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

The following employees or classes of employees or other workforce members under the control of the Plan Sponsor may be given access to PHI received from the Plan or a health insurance issuer or business associate servicing the Plan:

Employees of the Department of Finance and Administration, Office of Insurance:

1. This list includes every employee or class of employees or other workforce members under the control of the Plan Sponsor who may receive PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.
2. The employees, classes of employees, or other workforce members identified above will have access to PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Plan.

3. The employees, classes of employees, or other workforce members identified above will be subject to disciplinary action and sanctions, including if appropriate, termination of employment or affiliation with Plan Sponsor, for any use or disclosure of PHI in noncompliance with the provisions of the *Plan Document*. The Plan Sponsor will impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the noncompliance and will work to mitigate any deleterious effect of the noncompliance on any participant or beneficiary.

Security of Electronic Protected Health Information

HIPAA also imposes certain obligations on the Plan Sponsor to secure protected health information when it is in an electronic format (called "ePHI"). In order for the Plan to disclose any ePHI to the Plan Sponsor, the Plan Sponsor must amend the *Plan Document* to incorporate certain provisions required under HIPAA. The Plan Sponsor hereby amends the *Plan Document* and agrees to be bound by the following requirements:

1. The Plan Sponsor implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the Plan in accordance with 45 C.F.R. Parts 160, 162 and 164.
2. The Plan Sponsor will make certain that the HIPAA privacy requirements, applicable to its employees and other workforce members under the control of the Plan Sponsor who are not allowed access to ePHI as part of their role in performing Plan administrative functions, are also supported by reasonable and appropriate security measures.
3. The Plan Sponsor will make certain that any third-party administrators or other entities providing services to the Plan (called business associates) and their subcontractors agree to implement reasonable and appropriate security measures to safeguard the ePHI in their possession or control.
4. The Plan Sponsor will report any incident involving the security of ePHI to the Plan's Security Official as soon as reasonably possible.
5. In the event of a breach of "unsecured" PHI, the Plan Sponsor will provide notification of the breach of unsecured PHI without unreasonable delay, and in no case later than 60 days, after discovery of the breach. Unsecured PHI is defined as PHI that is not secured using Secretary of Health and Human Services-approved standards.

Glossary

Accidental Injury: A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happened involuntarily or, if the result of a voluntary act, entails unforeseen consequences.

Acute Care: Short-term diagnostic and therapeutic services provided in a hospital for a patient who is ill from a disease or injury of an acute nature. The period of acute care continues until the patient is stable enough to be transferred to a long-term care facility or bed for rehabilitation or maintenance care, or until the patient can be discharged to home care.

Allowable Charge: The lesser of the submitted charge or the amount established by the Plan as the maximum amount allowed for covered expenses.

Ambulatory Surgical Facility: An institution licensed as such by the appropriate state agency or certified by Medicare as an Ambulatory Surgical Facility whose primary purpose is performing elective or nonemergency surgical procedures on an outpatient basis.

Brand Name Drug: A drug with a trademark name protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the drug by other companies without consent of the innovator, as long as the patent remains in effect.

Calendar Year: A 12-month period beginning each January 1.

Certification: A review by the Plan's Utilization Review Vendor to determine if an admission or health care service is medically necessary as well as meets the notification requirements of the Plan.

Child: Any natural child, stepchild, child placed in anticipation of adoption, child placed in foster care, legally adopted child, child for whom the enrollee is legal guardian, child for whom the enrollee has legal custody, or child of the enrollee who is required to be covered by reason of a Qualified Medical Child Support Order.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986): Federal regulations that provide participants the option to pay for continued coverage under the Plan in the event that the participant no longer meets the Plan eligibility requirements.

COBRA Participant: A qualified beneficiary who elects to continue coverage under the Plan due to a qualifying event.

Coinsurance: The amount (usually a percentage of costs) of a covered health care service that a participant will pay after the deductible has been applied.

Coinsurance Maximum: The maximum amount of coinsurance a participant is responsible for before benefits are paid at 100 percent of the allowable charge for the remainder of the calendar year. Certain expenses cannot be used to the meet the coinsurance maximum.

Convalescent Facility: An institution (or distinct part thereof) that meets each of the following tests:

- It is primarily engaged in and licensed to provide, for compensation, skilled nursing services or intermediate care services and physical restoration services to convalescing patients on an inpatient basis.
- It provides these services on a 24-hour daily basis and under the full-time supervision of a provider or a registered nurse, with licensed nursing personnel on duty at all times.

- It maintains a complete medical record on each patient and has a utilization review plan for all of its patients.
- It is not, other than incidentally, a place for rest, custodial care, educational care, the care of mental disorders, or a place for the aged. Mental disorders include, but are not limited to, drug addiction, alcoholism, chronic brain syndrome and mental retardation.

Skilled nursing services and intermediate care services means services rendered by a registered nurse or by a licensed practical nurse under the direction of a registered nurse; physical restoration services means services which assist the patient to achieve a sufficient degree of body functioning to permit self-care in the essential activities of daily living; custodial care means care primarily to aid the patient with bathing, dressing, eating, and other activities of daily living; and, chronic brain syndrome means a condition of mental deterioration involving some irreversible brain damage due to a variety of causes ranging from alcohol abuse to senile dementia of unknown cause.

Coordination of Benefits (COB): The process that determines the order of benefits payable when an enrollee and/or his eligible dependent(s) are covered under more than one insurance plan.

Copayment: A fixed amount you pay for covered health care services that can vary depending on the type of services. A deductible may or may not apply depending on the services provided.

Covered Expense: The expense incurred for eligible services, supplies, and prescription drugs subject to the allowable charge, received on or after the effective date of the participant's coverage. The expense incurred, or portion of such expense, for medical care, services, supplies, or prescription drugs that are prescribed by a health care professional and are necessary in conjunction with the therapeutic treatment of the injury or illness involved, are not excluded from payment of benefits by the provisions of a particular coverage or by the exclusions and limitations, and are not in excess of the allowable charges for the same or similar medical care, services, supplies or prescription drugs.

Covered Provider or Provider: Health care professionals or facilities (as defined in this *Plan Document*) providing services within the scope of their license under state law. No other practitioners are considered covered providers.

Custodial Care: Services and supplies furnished primarily to assist an individual in the activities of daily living, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care, or supervisory care by a provider for a participant who is mentally or physically disabled. Such services and supplies are custodial care without regard to whom they are prescribed, by whom they are recommended, or by whom or by which they are performed. This term also includes convalescent or domiciliary care.

Deductibles (Base Coverage):

- **Individual Calendar Year Deductible:** A specific dollar amount that a participant must meet for covered expenses before the Plan will pay benefits in a calendar year.
- **Family Calendar Year Deductible:** A cumulative dollar amount that, when met, satisfies the calendar year deductible for covered expenses for all family members.
- **Individual Calendar Year Preventive Medications Deductible:** A specific dollar amount that a participant must meet before the Plan will pay benefits for certain preventive medications in a calendar year. Once either the calendar year deductible or the calendar year preventive medications deductible is met, participants will pay the standard prescription drug copayments for certain preventive medications.

Deductibles (Select Coverage):

- **Calendar Year Deductible:** A specific dollar amount that a participant must meet for covered medical expenses before the Plan will pay benefits in a calendar year.

- **Family Deductible:** A cumulative dollar amount that, when met, satisfies the calendar year deductible for covered medical expenses for all family members.
- **Prescription Drug Deductible:** A specific dollar amount that a participant must meet for covered prescription drugs before the copayment amount is applied in a calendar year.

Disabled dependent: A child who is:

- Permanently mentally or physically disabled or incapacitated.
- So incapacitated as to be incapable of self-sustaining employment.
- Dependent upon the enrollee for 50 percent or more support.
- Otherwise eligible for coverage as a dependent except for age.

The disabling condition must have occurred before the dependent's 26th birthday.

Durable Medical Equipment: Equipment prescribed by the attending provider and determined by the medical claims administrator to be medically necessary for treatment of an illness or injury, or to prevent the participant's further deterioration. The equipment must be made to withstand repeated use. DMEs are primarily used to serve a medical purpose rather than for comfort or convenience and generally not useful to a person in the absence of illness, injury or disease. DMEs are appropriate for use in the home care setting.

Emergency Care: Care as the result of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical care could reasonably severe injury or even death.

Determination of emergency care is based on presenting symptoms rather than final diagnosis. This means the treatment given in a hospital's or urgent care's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Permanently placing the participant's health in jeopardy.
- Serious impairment of bodily functions.
- Serious and/or permanent dysfunction of any bodily organ, or part or other serious medical consequences.
- Serious jeopardy to the health of the mother and/or fetus, in the case of a pregnant woman.

Employee: An active full-time employee who has satisfied the specifications in the *Health Insurance Eligibility and Enrollment* section of this *Plan Document*.

Employer Unit: Any of the following Mississippi public employers whose employees are eligible to participate in the Plan:

- State Agency
- Institution of Higher Learning
- Public School District
- Community College
- Public Library

Enrollee: An employee, a retired employee, a COBRA participant, or a surviving spouse who is enrolled in the Plan.

Explanation of Benefits (EOB): An itemized statement from Plan's medical claims administrator or pharmacy benefit manager that lists charges made and the benefits allowed or denied as the result of a claim.

Facility: A hospital or other entity licensed or certified by the appropriate state or federal agency and approved by the Plan and BCBSMS as a specific type of institution to provide a specific level of care.

Formulary: A specific list of covered drugs maintained by pharmacy benefit manager (PBM), which can assist practitioners and pharmacies in selecting clinically appropriate and cost-effective drugs. The formulary represents the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health.

Generic Drug: A drug that is therapeutically equivalent (identical in strength, concentration and dosage form) to a brand name drug and that generally is made available after the expiration of the brand name patent.

Health Care Provider: A physician or other medical practitioner who is licensed to perform specified health services consistent with State law.

Health Savings Account (HSA): Portable, interest-bearing, funded accounts that provide for tax-free savings for medical expenses as provided by Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, including all amendments.

Home Infusion Therapy: Services and supplies required for the administration of home infusion therapy regimen.

Horizon Employee: An employee initially hired on or after January 1, 2006, who, before January 1, 2006, was never a full-time employee of a Mississippi State agency, public school district, public community college, public library or State institution of higher learning.

Hospice Care: A program in which emphasis is placed upon palliative and supportive care, either on an inpatient or outpatient basis, to meet the special needs of patients and their families during the final stages of illness. Full scope health services are provided by an organized interdisciplinary team, available on a 24/7 basis.

Hospital: An institution which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of providers who are duly licensed to practice medicine in the state where the institution is located; which continuously provides 24-hour a day nursing service by a Registered Nurse (RN); and which is duly licensed as a hospital in such state.

The term hospital may also include an institution that primarily provides psychiatric or chemical dependency care, if licensed as such by the state in which the hospital is located.

Benefits are not provided for treatment in a facility that is primarily a place for rest, rehabilitation or the aged, including custodial and convalescent, except as otherwise provided by the Plan.

Illness: An accidental injury, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one illness.

Intensified Outpatient Program: As provided for the treatment of substance abuse, intensified outpatient program refers to a program provided as a continuation of inpatient substance abuse treatment prescribed by a provider, under the management of a substance abuse provider, which is licensed or certified by the appropriate state or federal agency and is approved by the Plan.

Investigative or Experimental: Use of a procedure, facility, equipment, drug, device, or supply not recognized at the time of treatment as accepted medical practice within the United States for the condition being treated. A drug, device, medical treatment, or procedure will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
- It cannot be lawfully marketed without the approval of the FDA or other governmental agency and such approval has not been granted at the time of its use or proposed use.
- It is the subject of a current investigational new drug or new device application on file with the FDA.
- A recognized national medical or dental society or regulatory agency has determined, in writing that it is experimental, investigational or for research purposes.
- A written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational or for research purposes.
- It is being provided pursuant to:
    - A Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.
    - A written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives.
    - Is being delivered, or should be delivered, subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the FDA or the Department of Health and Human Services (HHS).
- In the predominant opinion among experts:
    - As expressed in the published, authoritative literature, is substantially confined to use in research setting; or
    - Is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives.
    - Is experimental, investigational, unproven, or is not a generally acceptable medical practice.
    - Is not a covered service under Medicare because it is considered investigational or experimental as determined by the Centers for Medicare and Medicaid (CMS) of HHS.
    - Is provided concomitantly to a treatment, procedure, device or drug which is experimental, investigational or unproven treatment.

The Plan may, at its discretion, determine that a drug, device, medical treatment or procedure, which is deemed experimental or investigational under the above criteria, should nonetheless not be deemed experimental or investigational.

Legacy Employee: An employee who is an active employee as of January 1, 2006, or an employee hired on or after January 1, 2006, who was ever a full-time employee with a Mississippi State agency, public school district, public community college, public library, or State institution of higher learning before January 1, 2006.

Legal Custody: The permanent legal status created by a court order which gives the legal custodian the responsibilities of physical possession of the child and the duty to provide him with food, shelter, education and reasonable medical care.

Legal Custodian: A court appointed custodian of a child.

Legal Guardian: A court appointed guardian of a child.

Legal Guardianship: The permanent legal status created by a court order which gives the guardian of a child the same responsibilities as though he was the child's natural parent. This includes the duty to feed, clothe, house the child, and make decisions concerning the child's education and health care.

Long Term Acute Care Facility: A facility specializing in treating patients with serious and often complex medical conditions requiring a longer length of stay than is usually provided by traditional acute care hospitals.

Maintenance Drug: A prescription drug taken for an extended period of time for a chronic health condition.

Maintenance or Exercise Therapy: Consists of activities that preserve the Participant's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

Manipulative Therapy: All services preparatory to or complementary to an adjustment of the articulations of the vertebral column and its immediate articulations.

Medical Claims Administrator: The organization under contract with the State and School Employees Health Insurance Management Board to maintain eligibility and process medical claims for the Plan.

Medical Management Administrator: The organization under contract with the State and School Employees Health Insurance Management Board to provide inpatient and outpatient utilization review and case management services.

Medical Policy: Formal written guidelines developed by the medical claims administrator regarding new and existing medical and surgical procedures, products, drugs, technology and tests. These guidelines are determined by review of currently available peer reviewed scientific literature as well as input from practicing professionals. The medical claims administrator relies on Medical Policy for reaching decisions on matters of: 1) Medical Necessity, 2) Covered Services under this Plan Document, and 3) appropriate adjudication of claims. The specific guidelines found in the Medical Policy are not set out in their entirety in this Plan Document.

Medical Prescription Drugs: Prescription Drugs dispensed or administered by a Hospital, Physician, Allied Provider or in other healthcare/clinical settings rather than by a participating retail Pharmacy, or participating mail order Pharmacy. Drugs that under federal law may be dispensed only by written prescription and that the FDA has approved for general use. Prescription drugs must be medically necessary, must not be experimental/investigative, and must not otherwise be excluded in order to be covered by the Plan.

Medical Prescription Drug Formulary: A list of Drugs covered by the Plan when administered and billed through the medical setting. The Medical Prescription Drug Formulary provides medical policy, coverage and clinical comparator information to providers servicing the Plan's Members.

Medical Supplies or Supplies: Supplies which are medically necessary disposable items, primarily serving a medical purpose, (and generally not useful to a person in the absence of illness, injury or disease) having therapeutic or diagnostic characteristics essential in enabling a participant to effectively carry out a provider's prescribed treatment for illness, injury or disease, and are appropriate for use in the participant's home.

Medically Necessary: A service or supply furnished by a particular provider is medically necessary if it is determined by the Plan that it is appropriate for the diagnosis, the care, or the treatment of the disease or injury involved. To be appropriate, the service or supply must be:

- Care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- A diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative

outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and

- No costlier (taking into account all health expense incurred in connection with the service or supply) as to diagnosis, care and treatment, than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the following will be taken into consideration:

- Information provided on the affected person's health status.
- Reports in peer reviewed medical literature.
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data.
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment.
- The opinion of health professionals in the generally recognized health specialty involved.
- Any other relevant information.

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, a mental health or a dental professional.
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider, or health care facility.
- Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined.
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a provider's office or other less costly setting.

Medically necessary services or supplies must be:

- Prescribed by a provider to be necessary and appropriate.
- Non-experimental or non-investigational.
- Not in conflict with accepted medical or surgical practices prevailing in the geographic area where, and at the time when, the service or supply is ordered.
- Not associated with an occupational injury or disease.
- Reasonable.

Medical necessity does not include any service or supply that is for the psychological support, education, or vocational training of the participant. Medical necessity does not include implant of any artificial organ for any reason whatsoever.

Network (Medical): A group of providers under contract with the network administrator to participate in the Plan's AHS State Network.

Network Administrator: The organization under contract with the State and School Employees Health Insurance Management Board to contract with providers and negotiate discounts in a defined geographic area. The network administrator is responsible for the selection of and ongoing contracting with covered providers.

Network Pharmacy: A pharmacy that has a contractual relationship with the Plan's PBM to provide prescription drugs to participants.

Network Provider: A provider that has a contractual relationship with the Plan's Network Administrator to deliver services and supplies to participants.

Non-occupational Injury or Disease: An injury or disease that does not:

- Arise out of (or in the course of) any work for pay or profit.
- Result in any way from an injury or disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person is covered under any type of workers' compensation law and is not covered for that disease under such law.

Orthotic Device: An orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

Out-of-Network Pharmacy: A pharmacy that has not contracted with the Plan's PBM to be a network provider of prescription drugs to participants.

Out-of-Network Provider: A provider who has not contracted with the Plan's network administrator to deliver medical services or supplies to participants.

Out-of-Network Review: The process by which the Plan's medical management administrator determines if the Plan will allow network level benefits for services provided by a non-participating provider.

Out-of-Pocket Limit: The maximum amount an individual or family pays for network deductibles, coinsurance, and copayments in a calendar year before benefits will be paid at 100 percent.

Partial Hospitalization: Inpatient psychiatric and substance abuse treatment, other than full 24-hour programs, in a treatment facility licensed or certified by the state in which services are rendered. The term includes day, night and weekend treatment programs.

Participant: An individual who is enrolled in the Plan and is eligible to receive health care services for which payment may be sought under the terms of this *Plan Document*.

PERS: The Public Employees' Retirement System of Mississippi.

Pharmacy Benefit Manager (PBM): The organization under contract with the State and School Employees Health Insurance Management Board to administer the prescription drug program.

Provider: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Surgical Chiropody (D.S.C.), Doctor of Podiatry (D.P.M. or Pod. D.), Optometrist (O.D.), Chiropractor (D.C.), Certified Registered Nurse Anesthetist (CRNA), Physician Assistant (PA), Nurse Midwife, Nurse Practitioner (N.P.), Registered Dietitian, Physical Therapist, Occupational Therapist, Speech Pathologist, Clinical Psychologist (doctoral level), Professional Counselor, Clinical Social Worker, and Marriage and Family Therapist is deemed to be a provider for purposes of this *Plan Document*.

Plan: The self-insured Plan administered by the State and School Employees Health Insurance Management Board consisting of the Mississippi State and School Employees' Life and Health Insurance Plan as defined in § 25-15-1 et seq. of the Mississippi Code.

Plan Document: The statement of terms and conditions of the Plan as adopted by the Plan Sponsor.

Plan Sponsor: The State and School Employees Health Insurance Management Board, acting administratively through the Department of Finance and Administration, Office of Insurance.

Prescription Drug: Drugs that under federal law may be dispensed only by written prescription and that the FDA has approved for general use. Prescription drugs must be dispensed by a licensed pharmacist upon the

prescription order from a licensed prescriber, usually a physician, must be medically necessary, must not be experimental/investigative, and must not otherwise be excluded in order to be covered under the Plan.

Proof of Loss: Written evidence of expenses incurred or payable for services or supplies covered under the terms of this Plan.

Prosthetic Device: An artificial device that replaces all or part of an absent body part, or replaces all or part of the function of a permanently inoperable or malfunctioning body part.

Rehabilitative Care: Coordinated use of medical, social, educational or vocational services, beyond the acute care stage of disease or injury, for the purpose of upgrading the physical and functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

Residential Facility: A licensed facility providing an inpatient rehabilitation program for the treatment of alcohol or drug abuse or mental or nervous conditions.

Retired Employee: A covered employee who has left employment and qualifies for retirement benefits under a retirement plan approved by the Mississippi Public Employees' Retirement System (PERS).

Skilled Nursing Facility: A health institution planned, organized, operated, and maintained to provide facilities and health services with related social care to patients requiring medical care and 24-hour nursing services for illness, injury or disability. Each patient shall be under the care of a licensed provider. The nursing services shall be organized and maintained to provide 24-hour nursing services under direction of a registered professional nurse employed full-time.

Surviving Spouse: The covered spouse of a deceased employee who was eligible to retire or the covered spouse of a deceased retiree who was covered under the Plan at death.

Utilization Review: Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures and facilities.

Group Term Life Insurance

The State and School Employees Health Insurance Management Board is authorized by state law to provide certain specified group life insurance benefits for active employees and retirees. The Board's coverage is underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. Minnesota Life provides a fully insured group term life insurance policy for eligible employees and retirees of State agencies, State universities, public libraries and certain public community colleges and public school districts. Those public community colleges and public school districts that are not covered under the Board's policy with Minnesota Life have elected to opt out of the State and School Employees' Life Insurance Plan and instead purchase similar coverage through an alternative policy from a private carrier. The following information pertains primarily to coverage under the Minnesota Life contractual policy between the Board and Minnesota Life in the State and School Employees' Life Insurance Plan only. Questions relative to the aforementioned alternative policy should be directed to the respective public community college or public school district, or to the private carrier.

The State of Mississippi offers group term life insurance coverage for active full-time employees. Life insurance coverage can be continued when a covered employee retires or becomes totally disabled (as determined by Minnesota Life). The following is a summary of the pertinent information relative to the State and School Employees' Life Insurance Plan. Participants should refer to the *Certificate of Insurance* booklet for a comprehensive description of the benefits and policy provisions. The *Certificate of Insurance* booklet may be accessed on the Plan's website at https://www.dfa.ms.gov/insurance. Active employees who do not have access to the internet should contact their employer unit for a paper copy of the *Certificate of Insurance* booklet, while participating retirees and totally disabled employees without internet access should contact the Department of Finance and Administration, Office of Insurance.

State Group Term Life Insurance at a Glance

Minnesota Life Insurance Company	Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc. is the underwriter of your group coverage for the State and School Employees' Life Insurance Plan.
Amount of Life Insurance	**Active Employees:** The amount of life insurance is equal to 2 times the annual salary, raised to the next higher thousand. Minimum - $30,000, maximum - $100,000. **Retirees** may continue their term life insurance coverage at a reduced benefit level of $5,000, $10,000, or $20,000. Participating employees who retired before 7/1/1999 are limited to benefit levels of $2,000, $4,000, or $10,000. **Totally disabled employees** approved for continued coverage by Minnesota Life can continue group term life insurance coverage under limited conditions with the same amount of term life insurance coverage they had as an active employee. **Dependents** are not eligible for life insurance coverage under the Plan.
Beneficiary	The individual(s) one designates to receive benefits. Minnesota Life receives and maintains all beneficiary information.

Premiums	An **active employee** and his employer shares equally in the cost of the monthly premium for life insurance. A **retiree** is solely responsible for paying his monthly premium. A **totally disabled employee** pays an initial nine-month's premium, after which the premium is waived to age 65, subject to continuation of his disability.
Accidental Death & Dismemberment	The policy also provides accidental death and loss of use coverage to active employees at no additional cost.
Conversion/Portability	A covered active employee may convert or port some or all of his life insurance coverage to an individual policy with Minnesota Life after leaving employment. This provision also includes coverage amounts lost or reduced due to retirement.
Blue Cross & Blue Shield of Mississippi (BCBSMS)	BCBSMS maintains life insurance coverage information and administers the premium billing.
Filing a Claim	Claims for active employee coverage should be filed initially with the employee's Human Resources office. Claims for retiree and/or totally disabled employee coverage should be filed directly with the Mississippi Department of Finance and Administration, Office of Insurance, at the address provided inside the front cover of this *Plan Document*.

Who Is Eligible?

The following persons are eligible for group term life insurance coverage:

- A full-time employee who:
    - Receives compensation directly from one of the following Mississippi public entities:
        - Department, agency or institution of State Government
        - Public school district
        - Community college
        - Institution of Higher Learning
        - Public library
- A full-time employee who works for the:
    - State's judicial branch
    - State's legislative branch
    - University-based program authorized under state law for deaf, aphasic and emotionally disturbed children
- A full-time employee who works as a:
    - Full-time salaried Judge
    - Full-time salaried district attorney, or is a member of his staff
    - Full-time compulsory school attendance officer
- A regular nonstudent school bus driver
- A retired employee

Enrolling in Life Insurance

An eligible employee must either enroll in life insurance coverage or waive coverage when he begins covered employment. If the employee enrolls in the life insurance coverage, the effective date of coverage is his date of employment; however, a life insurance ***Enrollment/Change Request Form*** **must be completed, signed and forwarded to their employer unit within the first 31 days of employment.**

Late Enrollees

If an employee applies for life insurance after the first 31 days of employment or initially waives coverage when first eligible and subsequently elects to participate, he will be considered a "late enrollee" applicant. As a late enrollee, he will be required to complete an *Evidence of Insurability Statement* in addition to the life insurance *Enrollment/Change Request Form*. Coverage may be denied to late enrollees/applicants based on Minnesota Life's underwriting guidelines.

Forms can be found on the Plan's website at https://www.dfa.ms.gov/insurance, or are available from the employee's Human Resources office. The employee must return the *Enrollment/Change Request Form* to his employer unit. The employee may submit the completed *Evidence of Insurability Statement* confidentially directly to Minnesota Life or return the form to his employer for submission. Minnesota Life will be responsible for evaluating the late enrollment request, along with any follow-up documentation they may request from the applicant to determine if coverage will be approved. Upon completion of their review and determination process, Minnesota Life will notify the employee and the employer of their decision. Minnesota Life is the sole authority for evaluating late enrollment applications. If a late enrollee application is approved, the effective date of coverage will be the first of the month following or coincident with the date of Minnesota Life's approval.

How Much Coverage Can an Employee Have?

An active employee's life insurance amount is two times their annual salary, rounded up to the next higher thousand. The minimum amount of life insurance under the Plan for employees is $30,000, and the maximum amount is $100,000.

If an employee's salary changes (increases or decreases), the amount of life insurance coverage may also change. Any change in the amount of the employee's life insurance will be effective on the first day of the month following or coinciding with the change in salary.

Cost of Coverage for Employees

The employee shares with his employer in the cost of his life insurance premiums. The employee pays half of the monthly premium cost through payroll deduction, and his employer pays the other half.

Accidental Death and Dismemberment Benefits

The group term life insurance coverage provides an accidental death and dismemberment and loss of use (AD&D) benefit to covered employees at no additional cost. The amount of the AD&D benefit is based on the employee's term life insurance amount, and varies depending upon the specific loss. Refer to *Continuation of Coverage* for a complete schedule of AD&D benefits.

AD&D benefits may be paid for losses due to an accidental bodily injury while insured. In other words, AD&D benefits are generally available when death or a covered bodily injury is the direct result of an accident and independent of all other causes. AD&D coverage is provided to an employee so long as he maintains his term life insurance coverage. Totally disabled employees and retirees are not eligible for AD&D coverage.

Retiring Employees

A retiring employee must be participating in the life insurance plan as an active employee at the time of his retirement in order to continue coverage as a retiree. A retiring employee may continue term life insurance coverage in the amount of $5,000, $10,000 or $20,000. To ensure coverage is continued, the retiring employee should apply at least 31 days before retirement, but no later than 31 days after losing coverage as an employee, and must make the appropriate premium contributions to continue coverage. This will be the retiring employee's only opportunity to continue coverage, as late retiree applications will not be accepted. Employees should contact their Human Resources office for forms and application instructions.

Note: Retiring employees may also be eligible to port or convert some or all of the coverage they had as an active employee. Please refer to the Portability to a Term Life Policy section.

Cost of Coverage for Retired Employees

A retiree must pay the full premium cost for his coverage. Similar to retiree health insurance coverage provisions, the premiums for term life insurance must be deducted from the retiree's monthly Public Employees Retirement System (PERS) retirement benefit if the benefit amount is sufficient. Otherwise, the retiree will be billed the appropriate premium amount each month. The premium cost is actuarially determined and will vary based on the retiree's age and the benefit level selected. Refer to the Plan's website at https://www.dfa.ms.gov/insurance for current life insurance rates.

Totally Disabled Employees

If a covered employee becomes totally disabled, he may be eligible to retain the same amount of term life insurance coverage he has as an active employee. The employee should apply at least 31 days before leaving employment as an active employee. If application is made more than 31 days after coverage as an employee has terminated, the right to apply for coverage as a totally disabled employee will be forfeited. To apply for continuation of coverage, the employee must complete a life insurance *Enrollment/Change Request Form*, a *Group Disability* claim form, and have his doctor complete an *Attending Physician's Statement*. Forms are available on the Plan's website at https://www.dfa.ms.gov/insurance, or may be obtained from the employee's Human Resources office. The employee should submit all three forms to his Human Resources office, which is responsible for providing additional information on the forms before sending them to the Mississippi Department of Finance and Administration, Office of Insurance.

The Office of Insurance will likewise provide additional information and forward these documents to Minnesota Life for evaluation and a determination of disability. Additional medical information supporting the disability claim may be requested from the employee by Minnesota Life. Minnesota Life will notify the employee, the employer, and the Office of Insurance of their decision.

If the employee is approved by Minnesota Life for continuation of coverage as a totally disabled employee, the Office of Insurance will contact him with instructions on how to initiate his coverage. He will be required to make a one-time premium payment equivalent to nine times the applicable monthly premium based on the amount of life insurance coverage currently in force as an active. After that, his premiums will be waived until he is deemed by Minnesota Life to be no longer disabled or reaches age 65, whichever comes first. Minnesota Life is the sole authority for evaluating disability continuation of term life insurance coverage applications.

Naming a Beneficiary

Employee group term life insurance beneficiary designation is accomplished by the participant accessing Minnesota Life's online beneficiary management tool through the *my*Blue website. Follow the instructions below to designate a beneficiary with Minnesota Life:

- Log in to the Mississippi Blue Cross & Blue Shield of Mississippi website, http://bcbsms.com, and click on the My Benefits tab.
- Click the Life Benefits section. This section provides the effective date and amount of life insurance coverage.
- Click the link in the Life Benefits section and follow the instructions on Minnesota Life's site to submit a beneficiary designation.

Once the beneficiary information is submitted, a confirmation statement will be mailed to the participant's home address. Beneficiary information may be viewed or updated anytime by accessing Minnesota Life's website through the *my*Blue portal. Questions about designating a life insurance beneficiary or to obtain a paper beneficiary change request form should be directed to Minnesota Life at the number provided in the front inside cover of this *Plan Document*.

Note: You can elect or change a beneficiary only through Minnesota Life or the BCBSMS secure website portal described above.

If more than one beneficiary is named, the insured should indicate how to divide the benefit among them in whole number increments to total 100 percent. If it is not indicated on the form how the benefit would be divided and the insured dies, the benefit will be divided equally among the named beneficiaries. Contingent beneficiaries may also be named if so desired. Benefits are payable to a contingent beneficiary if the primary beneficiary dies before the insured's date of death. If a beneficiary is not named as of the insured's date of death, Minnesota Life will pay the benefits in accordance with the policy's terms and conditions, in the following order:

- Your lawful spouse, if living; otherwise
- Your natural and legally adopted children in equal shares, if living; otherwise
- Your parents in equal shares, if living; otherwise
- Your estate.

Termination of Life Insurance Coverage

Life insurance coverage will terminate on the earliest of the following:

- The date the life insurance plan and/or group term policy with Minnesota Life terminates;
- The end of the month for which premiums have been paid;
- The end of the month in which the employee ceases to be employed or loses eligibility; or
- The end of the month following the date the insured elects in writing to terminate coverage.

Note: Retroactive termination requests are not permitted.

Portability to a Term Life Policy

Active employees participating in the group term life policy who subsequently terminate their employment have the option to continue some or all of their term life insurance coverage through Minnesota Life. This provision allows qualified terminating employees to "port" to a term life insurance coverage, with no evidence of insurability requirements. To qualify, the participant must be under age 70, and his coverage termination in the group term life insurance coverage must be due to his employment termination, retirement, layoff or nonmedical leave, or loss of eligibility (i.e., no longer a full-time employee).

The participant must apply within 31 days from the date he loses coverage as an active employee. Medical evidence of insurability will not be required. The minimum amount of coverage for which a participant may apply to port is $10,000, while the maximum amount of ported coverage is limited to the actual amount of coverage that the employee is losing. A retiring employee may elect to port coverage, or continue group term life coverage as a retiree ($5,000, $10,000, or $20,000), or both, with the total amount of coverage not to exceed the amount of coverage he had as an active employee. A participant age 65 or older is limited to a maximum of 65 percent of the coverage he had as an active employee, with all such ported coverage to terminate at age 70. All premiums for ported coverage are the responsibility of the participant.

Benefits and provisions under the ported policy may not be the same as the group term life insurance. Employees should contact Minnesota Life for full details on the coverage available under portability and to request an application.

Converting to a Whole Life Policy

An employee may convert some or all of his group term life insurance to an individual whole life policy with Minnesota Life if:

- The employee leaves covered employment (including retirement) with the State of Mississippi or is no longer eligible for coverage; or
- The group term policy terminates and the employee has been covered for at least five years.

Application to convert coverage must be made within 31 days of the loss or benefit reduction of group term coverage. Note: Converting to an individual policy does not extend coverage under the life insurance coverage provided by the State.

Benefits and provisions under the converted policy may not be the same as this group term life insurance. Minnesota Life should be contacted for full details on the coverage available under conversion and how to apply for it.

Applying for Benefits – During the Conversion Period

If a person dies during the 31 days when he could have applied to convert or port to an individual policy, a claim may be made under this group term life insurance coverage by the beneficiary for the maximum amount for which an individual policy could have been issued. This right exists regardless of whether application for an individual policy had actually been made. If application for an individual policy had been made, the beneficiary designation on that application will be followed in the event the person dies during the conversion period.

Filing a Claim

Claims should be filed as soon as possible after a loss.

- **Employees:** The employee's Human Resources office is responsible for completing a *Notice of Death* form and submitting it to the Department of Finance and Administration, Office of Insurance. The Office of Insurance will verify coverage and the completeness of the claim and forward the appropriate documents to Minnesota Life for benefit processing.
- **Retirees and/or totally disabled employees**: The beneficiary or other interested party must notify the Office of Insurance of the death. The Office of Insurance will verify coverage, and submit the appropriate documents to Minnesota Life for benefit processing.

Additional information may be requested by the Office of Insurance or Minnesota Life in order to process a claim.

Note: Claims should not be filed directly with Minnesota Life as this will only delay the process. All claims should be filed through the employer's Human Resources office or, if a retiree, directly with the Department of Finance and Administration, Office of Insurance.

Other State-Sponsored (Alternative) Life Insurance Policy

If an employer (school or community college) was approved by the State and School Employees Health Insurance Management Board to insure with a private group term life insurance policy instead of participating in the State and School Employees' Life Insurance Plan, several of the policies and procedures described above will not apply. Although the basic benefit structure and eligibility requirements must be the same as those provided in this coverage, certain enrollment and premium payment procedures will differ for those private policies.

If an employee is covered under an approved alternative State-sponsored policy, please note:

- Life insurance enrollment forms for private policies should be submitted by the Human Resources/payroll office to the private carrier – not to Minnesota Life.
- Participant change notifications should also be forwarded to the private life insurance company.
- Premiums are billed by, and should be remitted to, the private life insurance company, and should not be sent to the Department of Finance and Administration, Office of Insurance or Minnesota Life.
- Claims should be filed directly with the private life insurance company, not with the Office of Insurance or Minnesota Life.

BCBSMS does not maintain any information in its eligibility system regarding private life insurance policy participation. All communication and problem resolution activities relative to a private life insurance policy must be conducted between the employer and/or the employee and the insurance company.

If an employee is retiring from a district that participates in an approved alternative policy, he is eligible to continue coverage under the private policy as a retiree. Similar to this coverage, benefit levels of $5,000, $10,000, or $20,000 can be elected, and **the retiree will be responsible for the entire premium.** Arrangements must be made directly with the insurance company for payment of the premiums.

If the employer decides to drop the private policy, employees will be offered the opportunity to participate in the group term life insurance coverage through Minnesota Life. If an employee was participating in the private policy when it was dropped and chooses coverage with Minnesota Life, he will be considered a "new employee" and will not have to provide evidence of insurability. If an employee was not participating in the private policy when it was dropped and would like to apply for coverage with Minnesota Life, he will be considered a "late enrollee" applicant, subject to the evidence of insurability requirements.

Note: Retirees participating in the private policy are not eligible for coverage in the State Life Insurance Plan under Minnesota Life.

Who to Contact

Minnesota Life should be contacted for questions about the following:

- Beneficiary Designation
- Accidental Death and Dismemberment (AD&D) Benefits
- Policy Conversion
- Portability
- Any other information included in the *Certificate of Coverage* booklet

Note: Minnesota Life does not maintain specific information on insured individuals such as coverage amounts, premium billings, etc. The employee's Human Resources office or BCBSMS should be contacted for specific questions about premiums and coverage amounts (also available on the my*Blue website)*

Please note that to preserve confidentiality, specific coverage information will only be released to the insured individual upon appropriate identity validation. For questions regarding a private group term life insurance policy, the appropriate carrier should be contacted. Neither Minnesota Life nor BCBSMS maintains information on such policies.

Required Federal Notices

Federal law requires health plans to provide the following notices to their participants. The terms included within these notices may or may not apply to a participant's specific situation. For information regarding Plan benefits, please refer to the applicable section of this Plan Document.

Notice of Election of Exemption from Certain Requirements of HIPAA

This notice explains that although the Plan is exempted from certain requirements, the State and School Employees Health Insurance Management Board has elected to generally comply with the intent of these requirements voluntarily.

Notice of Privacy Practices

Health plans must give participants a notice explaining how they may use and share health information and how a participant can exercise his health privacy rights.

Your Prescription Drug Coverage and Medicare

This notice explains that prescription drug coverage is creditable coverage for Medicare eligible employees and their Medicare eligible dependents when the employee retires. If a retired participant decides not to join a Medicare (Part D) prescription drug plan when first eligible, he may pay a late enrollment penalty if he chooses to join later. This notice does not apply to retirees who are currently eligible for Medicare.

Summary of Benefits and Coverage (SBC)

The Affordable Care Act (ACA) requires group health plans to provide a short, plain-language SBC for both Base Coverage and Select Coverage to allow participants to compare the different coverage types. These summaries do not include all benefits and exclusions in the Plan.

Notice of Election of Exemption from Certain Requirements of the Health Insurance Portability and Accountability Act

Name of Plan: State and School Employees' Health Insurance Plan

Plan Sponsor: State and School Employees Health Insurance Management Board
c/o Department of Finance and Administration
P.O. Box 24208
Jackson, MS 39225-4208

Plan Year: January 1, 2024 through December 31, 2024

Notice to Participants:

Federal law imposes upon group health insurance plans the following requirements from which a self-funded nonfederal governmental plan may elect to be exempted in whole or in part:

1. Standards relating to benefits for mothers and newborns;
2. Required coverage for reconstructive surgery following mastectomies.

The State and School Employees Health Insurance Management Board has elected to exempt the State and School Employees' Health Insurance Plan, as a nonfederal governmental plan, from these requirements in their entirety. The Board, however, has elected to generally comply with the intent of these requirements voluntarily. The necessary changes to Plan benefits have been implemented and are included in this *Plan Document*.

Health Insurance Portability and Accountability Act, Notice of Privacy Practices

State and School Employees' Health Insurance Plan

This Health Insurance Portability and Accountability Act of 1996 (HIPAA), Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. This Notice is effective January 1, 2024.

Please review this Notice carefully.

This Notice relates to the State and School Employees' Health Insurance Plan only. This Notice does not apply to other covered programs offered by your employer, such as dental, vision and flexible spending accounts. This Notice does not apply to non-covered programs such as life insurance and workers' compensation.

This Notice describes how the State and School Employees' Health Insurance Plan may use and disclose Protected Health Information (PHI) and also explains your legal rights regarding this information. PHI is individually identifiable information about your past, present, or future health or condition, health care services provided to you, or the payment for health services.

The State and School Employees' Health Insurance Plan (Plan) is required by law to maintain the privacy of your PHI and to provide you with this Notice of the Plan's legal duties and privacy practices. The Plan is required to follow the privacy practices described in this Notice. This Notice is posted on the Plan's website at https://www.dfa.ms.gov/insurance. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time. If a change is made to this Notice, a revised Notice will be provided to those individuals defined as "enrollees" in the *Plan Document*. The revised Notice will be posted on the Plan's website. You have the right to receive a paper copy of this Notice upon request. You may request a paper copy of the Plan's HIPAA Notice of Privacy Practices by calling the Department of Finance and Administration, Office of Insurance at 601-359-3411 or toll-free at 866-586-2781, or by writing to P.O. Box 24208, Jackson, MS 39225-4208.

PERMITTED USES AND DISCLOSURES

The examples of permitted uses and disclosures listed below are not provided as an all-inclusive list of the situations in which PHI may be used and disclosed by the Plan. However, the Plan will only use or disclose your PHI, without your written authorization, in situations falling into one of these categories.

Uses and Disclosures for Purposes of Treatment, Payment or Health Care Operations

The Plan may use and disclose your PHI for the purposes of treatment, payment and health care operations. Examples of the uses and disclosures that the Plan may make under each purpose are listed below.

Treatment: Refers to the provision of health care by medical providers. The Plan generally does not use or disclose your PHI for treatment, but is permitted to do so, if necessary. For example, the Plan may disclose to your treating specialty provider the name of your treating general medical provider so that the specialty provider may have the necessary medical records to evaluate your medical condition.

Payment: Refers to the activities that the Plan undertakes in the payment of claims for covered services received by Plan participants. Examples of uses and disclosures under this section include determination of medical necessity of a treatment or service and what the allowable charge should be; determining if a treatment or service is covered by the Plan; and sharing PHI with insurers in order to settle subrogation claims and to perform coordination of benefits.

Health Care Operations: Refers to the basic functions necessary to operate the Plan. Examples of uses and disclosures under this section include the use of PHI to evaluate the performance of the Plan's vendors; the disclosure of PHI to provide chronic condition coaching programs to participants with specific health conditions; the disclosure of PHI to vendors under contract with the Plan who provide consulting, actuarial, claims review, and legal services to the Plan; the use and disclosure of PHI for general administrative functions such as responding to complaints or appeals; the use and disclosure of PHI for data and information management; and the use and disclosure of PHI for general data analysis used for planning, managing and evaluation purposes. The Plan may use PHI for underwriting purposes, but it will not use or disclose PHI that is genetic information for such purposes.

Disclosures to the Plan's Business Associates

The Plan may disclose your PHI to its business associates as part of contracted agreements to perform services for the Plan, provided that the business associate agrees to protect the information.

Disclosure for Health Related Products and Services

The Plan or its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, the Plan's utilization management vendor may contact you regarding a chronic condition coaching program.

Disclosures to Other Covered Entities

The Plan may disclose your PHI to other covered entities or business associates of those covered entities for the purposes of treatment, payment and certain health care operations. For example, the Plan may disclose PHI to another health plan in order to perform coordination of benefits.

Other Uses and Disclosures Allowed Without Authorization

The Plan may use and disclose PHI, without your authorization, in the following ways;

- To you, as the covered individual;
- To a personal representative designated by you to receive PHI or a personal representative designated by law, such as the guardian ad litem for a minor or a person with power of attorney for health care;
- To the Secretary of Health and Human Services (HHS) or a duly designated employee of HHS as part of an investigation to determine the Plan's compliance with HIPAA;
- In response to a court order, subpoena, discovery request, or other lawful judicial or administrative proceeding or process;
- As required for federal, state and local law enforcement purposes;
- As required to comply with workers' compensation or other similar programs established by law;
- To a health oversight agency for activities authorized by law such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee benefit programs, other governmental regulatory programs, and civil rights laws;
- As required to address certain matters of public interest as required or permitted by law. Examples include threats to the public health or national security matters; and
- To the State and School Employees Health Insurance Management Board, the Plan Sponsor, provided the appropriate language is included in the *Plan Document*, to carry out the payment and health care operations functions discussed above.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will only be made upon receiving your written authorization. For example, most uses and disclosure of psychotherapy notes require written authorization. In addition, the Plan will not use or disclose PHI for marketing purposes or sale without your written authorization. If you have provided an authorization to the Plan, you may revoke your authorization at any time by providing written notice to the Plan. The Plan will honor a request to revoke as of the day it is received and to the extent that the Plan has not already used or disclosed your PHI.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

The federal privacy regulations give you the right to make certain requests regarding your PHI.

Right to be Notified of a Breach

You have the right to be notified in the event that we (or a business associate) discover a breach of unsecured protected health information.

Right to Request Restrictions

You have the right to request that the Plan restrict its uses and disclosures of PHI in relation to treatment, payment and health care operations. Any such request must be made in writing and must state the specific restriction requested and to whom that restriction would apply. The Plan is not required to agree to a restriction that you request.

Right to Request Confidential Communications

You have the right to request that communications involving your PHI be provided to you at a certain location or in a certain way. Any such request must be made in writing. The Plan will accommodate any reasonable request if the normal method of communication would place you in danger and that danger is stated in your request.

Right to Access Your Protected Health Information

You have the right to inspect and copy your PHI maintained in a "designated record set" by the Plan. The designated record set consists of records used in making payment, claims adjudication, medical management and other operations. The Plan may ask that such requests be made in writing and may charge reasonable fees for producing and mailing the copies. The Plan may deny such requests in certain cases.

Right to Request Amendment

You have the right to request that your PHI created by the Plan and maintained in a designated record set be amended. Any such request must be made in writing and must include the reason for the request. If the Plan denies your request for amendment, you may file a written statement of disagreement. The Plan has the right to issue a rebuttal to your statement, in which case, a copy will be provided to you.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any. This accounting does not include disclosures for payment or health care operations or certain other purposes, or disclosures to you or with your permission. Any such request must be made in writing and must include a time period, not to exceed six years. The Plan is only required to provide an accounting of disclosures made on or after

April 14, 2003. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee.

All requests listed above should be submitted in writing to the Department of Finance and Administration, Office of Insurance.

COMPLAINTS

You have the right to file a complaint if you think your privacy rights have been violated. You may file a complaint with the Plan by writing to the Department of Finance and Administration, Office of Insurance, Attention: Privacy Officer at the address listed in this Notice. You may also file a complaint by writing to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

PRIVACY CONTACT

If you have any questions regarding this Notice, please contact:

Department of Finance and Administration, Office of Insurance
P.O. Box 24208
Jackson, MS 39225-4208
Phone 601-359-3411
Toll-free 866-586-2781

Prescription Drug Coverage and Medicare

Important Notice from the Mississippi State and School Employees' Health Insurance Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Mississippi State and School Employees' Health Insurance Plan (Plan) and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. If you are both eligible for Medicare and you are covered by the Plan other than as a retiree, a surviving spouse, or a dependent of a retiree or a surviving spouse, the State and School Employees Health Insurance Management Board has determined that the prescription drug coverage offered by the Plan is, on average expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your coverage under the Plan, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan. You should also know that if you drop or lose your coverage with the Plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage.
Contact Blue Cross & Blue Shield of Mississippi, Customer Service at 800-709-7881.

NOTE: You may receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the Plan changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage.
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans, go to www.medicare.gov.

Call your State Health Insurance Assistance Program (see your copy of the Medicare & You Handbook for their telephone number) for personalized help.

Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.
For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 800-772-1213 (TTY 800-325-0778).

Name of Entity/Sender:	Department of Finance and Administration, Office of Insurance
Contact - Position/Office:	Blue Cross & Blue Shield of Mississippi 3545 Lakeland Drive, Jackson, MS 39232 Phone Number: 800-709-7881

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 https://www.dfa.ms.gov/insurance or call 1-800-709-7881. 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 also view the Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network and Out-of-network: $1,800/individual; $3,200/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is 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. Preventive prescription drugs: $75/individual. 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?	Network providers: $6,500/individual; $13,000/family. Out-of-network providers: no out-of-pocket limit.	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?	Premiums, balance-billing, charges this health care plan doesn't cover and penalties for failure to obtain prior approval.	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. Go here for a list of network providers or call 1-800-294-6307.	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 and Other Important Information
		Network Provider (You will pay the least)	Out-of-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 Specialist visit	20% coinsurance	40% coinsurance	Telehealth provider visit: $10 Copayment (Subject to deductible)
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work). Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition, or information about prescription drug coverage. Additional information is available at www.caremark.com	Preferred Generic drugs	Retail: $12 copay Mail order: $24 copay	You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay.	$75 individual preventive prescription drug deductible (for certain preventive medications) if the Base Coverage deductible has not been met. Mail Order (2X Copay) quantity 60-90 day supply. No charge for FDA-approved generic contraceptives or brand name contraceptives if a generic is medically inappropriate or unavailable. If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the brand copayment. Certain prescriptions require prior approval.
	Non-Preferred Generic drugs	Retail: $30 copay Mail order: $60 copay		
	Preferred brand drugs	Retail: $45 copay Mail order: $90 copay		
	Non-preferred brand drugs	Retail: $100 copay Mail order: $200 copay		
	Specialty drugs	Retail: $100 copay	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Provider/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance.	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance.	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room) Provider/surgeon fees	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Certification required.
	Habilitation services	20% coinsurance	40% coinsurance	Maintenance or exercise therapy is excluded.
	Skilled nursing care	20% coinsurance	40% coinsurance	Certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	Hospice services	20% coinsurance	40% coinsurance	Certification Required. Benefits available for up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in network.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in network.
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in network.

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 • Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease) • Dental care (Adult)	• Dental care (Children) • Hearing aids • Infertility treatment • Routine eye care (Adult)	• Routine eye care (Children) • Routine foot care • Weight loss programs (except as required by ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (prior approval required) • Chiropractic services (limited to 30 visits/individual/year)	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing (prior approval required)

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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 https://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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, call the claims administrator at 1-800-709-7881. Additionally, a consumer assistance program can help you file your appeal. Contact Health Help Mississippi at 1-877-314-3843 or healthhelpms@mhap.org.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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

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 prenatal care and a hospital delivery)

The **plan's** overall deductible	$1,800
Specialist coinsurance	20%
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$4,000

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

The **plan's** overall deductible	$1,800
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care provider office visits (*including chronic condition education)*
Diagnostic test *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$144
Coinsurance	$1091.20
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$3,035.20

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

The **plan's** overall deductible	$1,800
Specialist coinsurance	20%
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$50
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,860

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 https://www.dfa.ms.gov/insurance or call 1-800-709-7881. 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 also view the Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,800/individual; $3,600/family. Out-of-network: $2,300/individual; $4,600/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care and primary care network provider office visits 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. Prescription drugs: $75/individual. 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?	Network providers: $6,500/individual; $13,000/family. Out-of-network providers: no out-of-pocket limit.	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?	Premiums, balance-billing, charges this health care plan doesn't cover and penalties for failure to obtain prior approval.	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. Go here for a list of network providers or call 1-800-294-6307.	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 and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-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	$25 copay/visit. Deductible does not apply.	40% coinsurance	Telehealth provider visit: $10 copayment
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work) Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition, or information about prescription drug coverage. Additional information is available at www.caremark.com	Preferred Generic drugs Non-Preferred Generic drugs	Retail: $12 copay Mail order: $24 copay Retail: $30 copay Mail order: $60 copay	You pay 100% then request reimbursement of the in-network amount, less the applicable deductible or copay.	$75 individual prescription drug deductible Mail Order (2X copay) Quantity: 60-90-day supply. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate or unavailable). If you choose a brand drug for which a generic version is available, you will pay the difference in cost between the brand drug and generic drug plus the brand copayment. Certain prescriptions require prior approval
	Preferred brand drugs	Retail: $45 copay Mail order: $90 copay		
	Non-preferred brand drugs	Retail: $100 copay Mail order: $200 copay		
	Specialty drugs	Retail: $100 copay	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Provider/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance	$50 copay/1st visit; $200 copay/each additional visit plus 20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room) Provider/surgeon fees	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	Prior approval required to avoid penalty. Penalty for no prior approval: $500. Penalty for prior approval less than five days before admission (or more than 48 hours after emergency admission): $250.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Preventive services are subject to frequency limitations. Prenatal/postnatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Delivery expenses are not covered for dependent children. Delivery expenses are covered at no charge for employees and covered spouses who complete the Maternity Management Program.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Certification required.
	Habilitation services	20% coinsurance	40% coinsurance	Maintenance or exercise therapy is excluded.
	Skilled nursing care	20% coinsurance	40% coinsurance	Certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Coverage is limited to allowable charge for basic equipment. Prior approval recommended.
	Hospice services	20% coinsurance	40% coinsurance	Certification Required. Benefits available for up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered.	Not covered.	You must pay 100% of this service, even in-network.
	Children's dental checkup	Not covered.	Not covered.	You must pay 100% of this service, even in-network.

Excluded Services and 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 • Cosmetic surgery (except after mastectomy or due to defect from traumatic injury or disease) • Dental care (Adult)	• Dental care (Children) • Hearing aids • Infertility treatment • Routine eye care (Adult)	• Routine eye care (Children) • Routine foot care • Weight loss programs (except as required by ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (prior approval required) • Chiropractic services (limited to 30 visits/individual/year)	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing (prior approval required)

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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 (Medical and Rx)	$1,800
Copayments	$0
Coinsurance	$2,180
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,980

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

The **plan's** overall deductible	$1,800
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Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care provider office visits (*including chronic condition education)*
Diagnostic test *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles (Medical and Rx)	$75
Copayments	$194
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$469

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

The **plan's** overall deductible	$1,800
Specialist coinsurance	20%
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	$1,800
Copayments	$50
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,040