Frequently Asked Questions
Base or Select Coverage

Q:1 **How do I know what type coverage (Base or Select) I have now?**

A:1 If you are not sure what type coverage you currently have, you can call Blue Cross & Blue Shield of Mississippi (BCBSMS) at 800-709-7881, or the Office of Insurance at 601-359-3411 or toll-free 866-586-2781.

Q:2 **How do I know what my premium rate is?**

A:2 Your premium rate will depend on the coverage type you select, whether you are a Legacy or Horizon participant, and whether you elect to have dependents covered under the Plan. Please refer to the current premium rate documents on the KnowYourBenefits website, consult with Human Resources or contact Blue Cross & Blue Shield of Mississippi at 800-709-7881.

Q:3 **How can I decide which coverage type is right for me?**

A:3 You first should review your estimated claims activity for the prior year including all medical and prescription drug claims. If you think you will have similar claims in the current year, include these amounts in your estimate. If you are not sure about the total cost of a 30-day supply of a prescription drug you are currently taking, you can talk to your pharmacist, call CVS Caremark at 888-996-0050, or call the Office of Insurance at 601-359-3411 or toll-free 866-586-2781.

After estimating the types of claims and the total cost of each claim, consider how each coverage type works, including the various deductibles and coinsurance maximums. Also remember that the premium rates differ for Base Coverage and Select Coverage.

Q:4 **How does each type of coverage work?**

A:4 Under Select Coverage, there is a separate deductible (individual and family) for medical expenses and a separate individual deductible for prescription drugs. Once the appropriate medical deductible is met, you will start paying 20 percent of the allowable charge for covered medical services. Regardless of whether or not you have met your medical deductible, you will have to meet the $75 individual prescription drug deductible before you start paying a copayment for a covered drug. Under Select Coverage, there is no prescription drug copayment maximum, so you will continue to pay the copayment for your drug each time you have it filled for the remainder of the year.

Under Base Coverage, you will have to meet the full deductible ($1,800 for individual coverage, $3,000 for family coverage) before any covered medical or prescription drug charges will be paid by the Plan. This means that you will pay the full allowable charge for both medical and prescription drugs until the deductible is met. Once the deductible is met, you will start paying 20 percent of the allowable charge for covered medical services and a copayment for covered drugs. There is a $75 preventive medications individual deductible. Other medications are subject to the calendar year deductible. Once your coinsurance/copayment maximum is met, the Plan will pay 100 percent of the allowable charge for both covered prescription drugs and medical services.

Q:5 **What do I need to do to change coverage types?**

A:5 You need to complete an *Application for Coverage* form during Open Enrollment in October. If you are an active employee, you will need to return the completed form to your Human Resources office. Contact your Human Resources office to find out the deadline for submitting your form.

Q:6 **What do I need to do to keep the coverage type I have now?**

A:6 Nothing – your coverage will remain the same if you do not submit an *Application for Coverage* form to elect to change your coverage type.

Q:7 **What are some of the main differences in Base and Select Coverage?**

A:7 The premium rates differ for Base and Select Coverage. Another difference between Base and Select Coverage is how the deductibles work. Under Base Coverage, all charges (medical and prescription drug) apply to the calendar year deductible. Under Select Coverage, there is a separate deductible for medical charges and a separate deductible for prescription drug charges.

Q:8 **Are the same services covered in Base and Select Coverage?**

A:8 Yes, covered services are the same in both coverage types.

Q:9 **If I choose Base Coverage and have covered dependents but I am the only one in the family that has claims, what is my deductible?**

A:9 The family deductible for Base Coverage is $3,000; therefore, you would have to meet the entire $3,000 deductible.

Q:10 **If my spouse and I are both employees under the Plan, one of us has family coverage and one of us has individual coverage, and we both enroll in Base Coverage, do we share the family deductible?**

A:10 Yes.

Q:11 **Under Base Coverage, what is my in-network deductible and my out-of-network deductible?**

A:11 Under Base Coverage, the Calendar Year Deductible, ($1,800 individual or $3,000 family) applies to both in-network and out-of-network services. Remember that the coinsurance maximum amounts differ between in-network and out-of-network services.

Q:12 **If I have Base Coverage, what is my deductible for prescriptions drugs?**

A:12 There is no separate deductible for prescription drugs in Base Coverage with the exception of a $75 preventive medications deductible for certain drugs. Refer to the Plan Document for additional information. Medical and prescription drug expenses all apply to the calendar year deductible. This means that prescription drug expenses along with medical expenses are included in the deductible ($1,800 individual or $3,000 family). Until you meet your deductible (whether through medical and/or pharmacy claims), the Plan will not provide any prescription drug benefits.

Q:13 Can I change coverage types if I have a Special Enrollment Event during the year?

A:13 Yes, you can change coverage types if you have a Special Enrollment Event during the year; however, any deductible or out-of-pocket credit previously met will not transfer to your new coverage type.

Q:14 Why do I have to pay for a part of my active employee premium under Select Coverage while someone enrolled in Base Coverage does not pay any part of the active employee premium?

A:14 The State is required by law to provide 100 percent of the cost of a "basic level" (currently Base Coverage) of health insurance coverage to active full-time employees.

Q:15 What is a Health Savings Account (HSA) and am I required to have one if I choose Base Coverage?

A:15 A Health Savings Account allows an individual to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. You must be covered by a High Deductible Health Plan (HDHP) to be able to take advantage of HSAs. Just because you choose Base Coverage does not mean you have to have a Health Savings Account.

Q:16 When do I start paying a copayment for prescription drugs under Base Coverage?

A:16 After you meet your calendar year deductible ($1,800 individual or $3,000 family), you will start paying a copayment for covered prescription drugs.

Q:17 When do I start paying a copayment for prescription drugs under Select Coverage?

A:17 Under Select Coverage, you must first pay your $75 individual prescription drug deductible before you start paying a copayment for covered prescription drugs.

Q:18 If my spouse and I are both employees participating in the Plan and neither has dependent coverage, can one of us choose Select Coverage and the other choose Base Coverage?

A:18 Yes.

Q:19 If my spouse and I are both employees participating in the Plan, can one choose family coverage under Base Coverage and the other choose individual coverage under Select Coverage?

A:19 Yes, however, deductibles cannot be shared between Base and Select Coverage.

Q:20 Who can I contact if I have questions on Base and Select Coverage?

A:20 You can email your question to KnowYourBenefits@dfa.ms.gov or call Blue Cross & Blue Shield of Mississippi at 800-709-7881, or the Office of Insurance at 601-359-3411 or toll-free at 866-586-2781.

Mississippi's State and School Employees' Health Insurance Plan

Frequently Asked Questions

Medical Plan

Q. What is included in the AHS State Network?

A. You can receive the maximum benefits available under the Plan if you choose to receive care from providers who participate in the Network. Participating providers include a variety of physicians, hospitals, facilities and medical service providers. For more information on the Plan or to view or download a copy of the Plan Document (PD), go to KnowYourBenefits.dfa.ms.gov and click on the "Publications" tab.

Q. Why should I choose to receive medical care from a Network provider?

A. Participating providers have agreed to accept pre-negotiated fees in exchange for their medical services. For you, this means that you are not responsible for any amounts over the allowable charge for covered services when you receive care from a participating provider.

Q. How do I know if my doctor is participating in the Network?

A. To find a participating provider, go to KnowYourBenefits.dfa.ms.gov and click "Find a Participating Provider." You can also go to https://www.myaccessblue.com/AHSProviderSearchWeb/#/ or contact the Network at (800) 294-6307.

Q. What is an out-of-network review?

A. This is the process of determining if the Plan will allow in-network level benefits for services provided by a non-participating provider. You should contact Kepro at (888) 801-1910 to request an out-of-network review.

Q. If the Plan is not my primary source of health benefit coverage, how does my insurance coverage work?

A. When a participant is covered by another group health plan, there may be some duplication in the coverage. To determine how plans coordinate benefits, one is considered "primary" and the other is considered "secondary." How this is decided is called Coordination of Benefits.

Q. Where can I learn more about Coordination of Benefits?

A. Refer to the Plan Document for additional information on how to determine which of your plan coverage options are considered "primary" or "secondary."

Q. When I reach age 65, will my Plan coverage coordinate with my Medicare coverage?

A. Yes. The Plan will coordinate with Medicare to provide you with health care benefit coverage. Information on coordination with Medicare is included in the PD.

Q. What services require certification?

A. The following services require certification and must be certified as medically necessary by Kepro prior to admission or treatment:

- 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

Kepro must be contacted in advance of any anticipated non-emergency 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 Kepro.

Q. What kind of coverage does the Plan provide for medical care in an emergency situation?

A. Medical emergencies are defined as an unplanned event that may force you to seek prompt medical attention. Emergency care received from a non-participating provider will be paid at the in-network benefit level (for example, deductibles and coinsurance will be the same for visits to a hospital emergency room whether the hospital is in-network or out-of-network). However, the participant is still responsible for amounts charged by the non-participating provider that exceed the allowable charge.

Prescription Drug Program

Q. What is a Preferred Drug List (PDL) or Formulary?

A. A list of preferred brand drugs or formulary is maintained by CVS Caremark, the pharmacy benefit manager (PBM). Drugs are chosen based on their clinical appropriateness and cost effectiveness. CVS Caremark may add drugs to the list at any time. Typically, deletions to the list will only occur on an annual basis. You can access a list of preferred drugs by going to Caremark.com or by contacting CVS Caremark Customer Care at (888) 996-0050.

Q. What is a generic drug?

A. Typically, generic drugs cost less than equivalent brand name drugs. Because the generic drug copayment is less, participants save money when purchasing generic drugs. Participants are encouraged to use generic drugs whenever allowed by their physician. To be covered by the Plan, a generic drug must:

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

Q. What is a "non-preferred drug"?

A. A "non-preferred drug" refers to those drugs that are available at the higher copay.

Q. How can I find out if a drug is preferred?

A. You can access a list of preferred drugs online at Caremark.com or by calling CVS Caremark Customer Care directly at (888) 996-0050.

Q. What mail service will be used for the Plan?

A. As part of the prescription drug program, you can enjoy the convenience of home delivery by using the CVS Caremark Mail Order Pharmacy program. You must register at Caremark.com or contact CVS Caremark Customer Care at (888) 996-0050.

To get started, register at Caremark.com or contact CVS Caremark Customer Care at (888) 996-0050.

Q. What levels of coverage are available to me under the prescription drug program?

A. The following chart outlines prescription drug copayments:

	Retail Pharmacy		**Home Delivery (CVS Caremark)**	
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	$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 name drug and the generic drug, plus the applicable brand copayment amount.

Note: Participants in Base Coverage will be charged the full allowable charge for each 30-day supply until the annual deductible is met.

Filing a Claim

Q. When do I need to file a medical claim?

A. You need to file a claim when you receive care from a non-participating provider. Participating providers have agreed to file your claims for you. Before you can file a claim, you need to receive an itemized bill from your health care provider.

Q. How do I file a medical claim?

A. For care received from a non-participating provider, you first must receive the proper itemized bill from the provider and obtain a claim form from your personnel office or from Blue Cross & Blue Shield of Mississippi (BCBSMS). Be sure to read the instructions on the claim form carefully and complete the entire form to avoid delays in processing. Send your completed form, itemized bills and any other supporting documents, records and receipts to BCBSMS. Keep copies of all documents for your records.

Q. With whom do I file a medical claim?

A. You should mail your completed medical claim forms to:

Blue Cross Blue Shield of Mississippi
3545 Lakeland Drive
Flowood, MS 39232

Q. How do I file a claim when the Plan is not my primary source of medical coverage?

A. File a claim with your "primary" plan and request an Explanation of Benefits (EOB) from that plan. You then file the claim with your "secondary" plan, which in this case is the State and School Employees' Health Plan. When you file with the Plan, be sure to include a copy of your primary plan's EOB with your paperwork.

If Medicare is your primary coverage, you would use this same claims filing process when filing for secondary coverage under the Plan.

Q. How can I get a claim form?

A. For a claim form, contact BCBSMS at (800) 709-7881 or go to the BCBSMS website. You can also get a claim form through your personnel office.

Q. When do I need to file a prescription drug claim?

A. When you use a participating pharmacy, they will file a claim for you. If you use a non-participating pharmacy, you will need to file a completed claim form with CVS Caremark that includes your receipts from the pharmacy. Keep copies of the claim and receipts for your records.

Q. What if I use a pharmacy that is not in the CVS Caremark network?

A. If you choose to use a pharmacy that doesn't participate in the CVS Caremark retail network, you'll be charged the full cost for the medicine and you'll need to send a Claim Reimbursement Form to CVS Caremark. Under your plan, your reimbursement will be based on the cost you would have paid if you used a participating retail pharmacy, minus your applicable deductible and/or co-pay/co-insurance. Be sure to complete the entire claim form, attach the sales receipt showing the price you paid, and send them to CVS Caremark at the address on the form. Members can also submit reimbursement claims online from their Caremark.com account. To download a claim form, go to Caremark.com, login using your login credentials, and follow the link to print a form under the Plan & Benefits tab. Forms are also available by calling CVS Caremark Customer Care at (888) 996-0050.

Q. With whom do I file a prescription drug claim?

A. You should mail your completed prescription drug claim forms to:

CVS Caremark
P.O. Box 94467
Palatine, IL 60094-4467
888-996-0050

Q. Is there a time limit for filing claims?

A. Yes. There is a deadline for filing medical and prescription drug claims. All claims must be filed with BCBSMS or CVS Caremark within 12 months of the day you received services, prescriptions or supplies.

Q. I would like to have a claim reviewed. How do I begin the appeals process?

A. You have 180 days to submit a written request for a review after receiving notice of denial from BCBSMS or CVS Caremark. If you do not request a review within this timeframe, you will lose your right for a review. If you need more detailed information, you should refer to the PD. Here are some tips to help you file a claim.

- Keep all receipts from non-participating pharmacies and physicians.
- File your claim promptly.
- Use the correct form. (Remember, there are separate claim forms for medical and prescription drug benefits.)
- Complete the entire form.
- Make a copy of your completed form to keep for your own records.
- Mail the claim form to the correct address.

Coinsurance, Copayment and Deductibles

Q. What is a deductible?

A. A deductible is the amount that you must pay each year before the Plan will begin to cover your health care expenses.

2021 Select Coverage Medical Deductibles

Select Deductibles	In-Network	Out-of-Network
Calendar Year Deductible	$1,300	$2,300
Family Deductible	$2,600	$4,600

2021 Base Coverage Medical Deductibles

Base Deductibles	In-Network	Out-of-Network
Calendar Year Deductible – Individual Coverage	$1,800	
Calendar Year Deductible – Family Coverage	$3,000	

Q. What is the difference between coinsurance and copayments?

A. Coinsurance is a percentage of the cost you pay for certain medical expenses, like doctors' visits. A copayment is a flat fee you pay for expenses such as prescription drugs.

Q. How can I be sure to get the most out of my benefit dollar?

A. The Plan can provide you with the highest benefit coverage when you receive medical care from a participating provider. Use a participating pharmacy or the CVS Caremark Mail Order Pharmacy for mail order prescriptions, and elect to fill your prescriptions using generic or preferred brand drugs whenever possible.

To get the most out of your benefit dollars, the Plan encourages you to:

- Receive care from participating providers.
- Certify appropriate medical services.
- Choose to fill your prescriptions using generic or preferred brand drugs whenever possible.
- Visit a participating pharmacy to fill your prescriptions or use the CVS Caremark Mail Order Pharmacy program for maintenance medications.
- File your claims promptly.

For questions about medical claims, call **Blue Cross & Blue Shield of Mississippi** (800) 709-7881

To certify a hospital admission or other service, call **Kepro** (888) 801-1910

For questions about prescription drug claims, call **CVS Caremark** (888) 996-0050

To find a participating provider, call **AHS State Network** (800) 294-6307

For general questions about the Plan, call the **Office of Insurance** (866) 586-2781

Know Your Benefits

MISSISSIPPI STATE & SCHOOL EMPLOYEES' LIFE AND HEALTH INSURANCE PLAN

Plan Document Notice

The State and School Employees' Life and Health Insurance Plan Document is available online. You can access this valuable resource by visiting the Plan's website at http://knowyourbenefits.dfa.ms.gov.

A paper copy may be requested by completing the bottom section of this form and returning it to:

Department of Finance and Administration
c / o Office of Insurance
P.O. Box 24208
Jackson, MS 39225-4208

Note: a paper copy is automatically mailed to all state agency human resource offices, schools, universities, colleges and libraries that participate in the Plan.

PLEASE PRINT LEGIBLY.

Name: _____

Address: _____

City, State, ZIP Code: _____

Know Your Benefits

MISSISSIPPI STATE & SCHOOL EMPLOYEES' LIFE AND HEALTH INSURANCE PLAN

Plan Document Notice

The *State and School Employees' Life and Health Insurance Plan Document* contains the benefits and eligibility guidelines of the State and School Employees' Life and Health Insurance Plan. You can find the latest Plan Document on our website, knowyourbenefits.dfa.ms.gov under *Publications*. Also on the site are links to find a participating provider, information on covered wellness and preventive services, and the latest premium rates.

You may request a paper copy of the Plan Document by calling the Department of Finance and Administration, Office of Insurance toll free at (866) 586-2781 or (601) 359-3411, or send an email to KnowYourBenefits@dfa.ms.gov.

- The DFA, Office of Insurance provides day-to-day management of the Plan for the State and School Employees' Health Insurance Management Board.
- Blue Cross & Blue Shield of Mississippi is the Plan's medical claims administrator, and processes health claims and maintains eligibility information.
- ActiveHealth is the Plan's medical management administrator, and provides medical management and pre-certification services.
- CVS Caremark is the Plan's pharmacy benefit manager and is responsible for processing prescription drug claims and managing the Plan's prescription drug mail order program.
- The AHS State Network is a system of physicians, hospitals and other health care providers who have agreed to accept the allowable charges set by the Network and file claims for medical services provided to Plan participants. Participant will receive the maximum benefit by using a "participating" network provider.

For questions about medical claims, call **Blue Cross & Blue Shield of Mississippi** (800) 709-7881	To certify a hospital admission or other service, call **ActiveHealth** (866) 939-4721	For questions about prescription drug claims, call **CVS Caremark** (888) 996-0050	To find a participating provider, call **AHS State Network** (800) 294-6307	For general questions about the Plan, call the **DFA, Office of Insurance** (866) 586-2781

motivating MISSISSIPPI

keys to living healthy

State and School Employees' Health Insurance Plan Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under the State and School Employees' Health Insurance Plan (Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify your employer within 60 days after the qualifying event occurs. This requires you to notify your employer by completing an *Application for Coverage* form. This form can be obtained from your employer or at the Plan's website, http://knowyourbenefits.dfa.ms.gov.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify Blue Cross & Blue Shield of Mississippi in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must make sure that Blue Cross & Blue Shield of Mississippi is provided with a copy of the Social Security Administration's determination letter within 60 days of the

date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to Blue Cross & Blue Shield of Mississippi, 3545 Lakeland Drive, Jackson, MS 39232.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Patient Protection and Affordable Care Act or the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan Contact Information

The Plan Administrator is the State and School Employees Health Insurance Management Board, P. O. Box 24208, Jackson, MS 39225, (601) 359-3411 or (866) 586-2781. COBRA continuation coverage for the Plan is administered by the Claims Administrator, Blue Cross & Blue Shield of Mississippi, 3545 Lakeland Drive, Jackson, MS 39232, (800) 709-7881.

State and School Employees' Health Insurance Plan

NOTICE OF ENROLLMENT RIGHTS

If you have declined health insurance coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you will be eligible to enroll yourself or your dependents in the State and School Employees' Health Insurance Plan (Plan) during an annual open enrollment period. A dependent may be enrolled only if you are enrolling yourself or you are already enrolled in the Plan. Open enrollment periods will be in October of each year for a January 1 coverage effective date.

You may also be eligible to enroll yourself or your dependents if one of the following special events occur:

Special Enrollment Following Loss of Other Coverage - If you declined coverage for yourself or your dependent(s) because you have other health insurance coverage through your spouse's employer, under an individual health insurance policy, or under COBRA or other continuation coverage through a former employer, you will be eligible to enroll if your coverage under that plan is terminated. You must apply for coverage for yourself/your dependent(s) within 60 days of losing other coverage. Loss of coverage must be due to one of the following events:

- You or your dependent becomes ineligible for coverage under another group health plan or health insurance coverage. Loss of coverage due to non-payment of premiums does not qualify for this special enrollment period.
- The employer contribution for the other group health plan was terminated.
- When you declined coverage for yourself and/or your dependent, you or your dependent had COBRA continuation under another group health plan and the COBRA continuation coverage has been exhausted.

Special Enrollment Upon Marriage, Birth, or Adoption of Dependent - If you declined coverage for yourself, you will be eligible to enroll in this Plan if you apply for coverage within 60 days of marriage, birth, adoption, placement in anticipation of adoption, legal guardianship, or a Qualified Medical Child Support Order (Qualifying Events). You must apply for coverage for yourself **and** the newly-acquired dependent within 60 days of the Qualifying Event. You may also apply for coverage for any other eligible dependent at this time.

The *Plan Document* contains more specific details on your enrollment rights.

MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN

Health Insurance Portability and Accountability Act (HIPAA), Notice of Privacy Practices

State and School Employees' Health Insurance Plan

This Health Insurance Portability and Accountability Act, Notice of Privacy Practices (HIPAA) Notice 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, 2021.

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 (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 payment for health services.

The 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 http://KnowYourBenefits.dfa.ms.gov. 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 mailed 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 printed copy of this Notice upon request. Contact information is included at the end of this notice.

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 a doctor, hospital or other health care provider. 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 disease management 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.

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 disease management 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. 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 should be submitted in writing to the Department of Finance and Administration (DFA), 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 DFA, 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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kelly Reid @ (601) 403-1489 OR kareid@prcc.edu

.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Pearl River Community College		4. Employer Identification Number (EIN) 64-6000960
5. Employer address 101 Highway 11 N		6. Employer phone number (601) 403-1000
7. City Poplarville	8. State MS	9. ZIP code 39470
10. Who can we contact about employee health coverage at this job? Kelly Reid		
11. Phone number (if different from above) (601) 403-1489	12. Email address kareid@prcc.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Those who work 20+ hours

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse and / or dependent coverage

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ **$0.00 for the Base Plan**
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? **None at this time**
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)