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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.