Mississippi 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. Then Choose the 2021 Plan Document-Revised July 1, 2021.

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 go to https://www.myaccessblue.com/AHSProviderSearchWeb/AHSSearch.do 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

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. Medical Case Management and Utilization Review

Kepro 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 Kepro is notified in advance of certain types of medical services.

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

- 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 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 Kepro.

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

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)?

A. A list of preferred brand drugs is maintained by https://knowyourbenefits.dfa.ms.gov/cvs-caremark-pharmacy-benefits/ the pharmacy benefit manager. Drugs are chosen based on their

clinical appropriateness and cost effectiveness. Prime 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 www.caremark.com or by contacting CVS Caremark 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 possible. 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 https://knowyourbenefits.dfa.ms.gov/cvs-caremark-pharmacy-benefits/ or by calling CVS Caremark directly at 888-996-0050.

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

A. 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 Service at 888-996-006-50.

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

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

A. *Participants in Base Coverage will be charged the full allowable charge for each 30-day supply until the annual deductible is met.*
Prescription medications are subject to the applicable deductible and the following copayments:

	Retail Pharmacy & Specialty		Home Delivery CVS Caremark	
Prescription Drug Type	1-30 Day Supply	31-60 Day Supply	61-90 Day Supply	90 Day Supply or Less
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.

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?

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 claim filing process when filing for secondary coverage under the Plan.

Q. How can I get a claim form?

A. For a claim form, contact Blue Cross & Blue Shield of Mississippi 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. 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 Blue Cross & Blue Shield or Prime 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 Blue Cross & Blue Shield of Mississippi or Prime. 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 Plan Document.

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.

2022 Select Coverage Medical Deductibles

Select Deductibles	In-Network	Out-of-Network
Calendar Year Deductible	$1,300	$3,000
Family Deductible	$3,000	$4,000

2022 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 Service 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 Service for maintenance medications.
- File your claims promptly.

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 (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 (DFA) Office of Insurance toll free at (866) 586-2781 or (601) 359-3411 or by sending 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 (BCBSMS) is the Plan's medical claims administrator. BCBSMS processes health claims and maintains eligibility information.
- Keystone Peer Review Organization, Inc. (Kepro) is the Plan's medical case management administrator. Kepro provides medical case 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 **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 **DFA Office of Insurance** (866) 586-2781