September 2013

STATE AND SCHOOL EMPLOYEES' Life AND Health PLAN

Know Your Benefits

Good News — No Rate Increase!

The State and School Employees Health Insurance Management Board voted at their August 28, 2013 meeting to not increase the health insurance premium rates for January 1, 2014. The Board is able to keep rates at their current level due in part to successful cost control measures, including substantially reducing administrative expenses. More good news – No change in life insurance premiums either!

You can help minimize future increases by being a smart healthcare consumer. Familiarize yourself with the *Plan Document* to maximize your benefits, use emergency rooms only for emergencies, request generic drugs when available, and participate in wellness activities to stay healthy!

You can find the current health and life insurance rates on the Plan's website at http://knowyourbenefits.dfa.ms.gov.

Summary of Benefits and Coverage and Uniform Glossary

The Patient Protection and Affordable Care Act (PPACA) requires that group health plans provide participants with an easy-to-understand summary of benefits and coverage and a uniform glossary of terms commonly used in health insurance coverage. Coverage examples in the summary illustrate how the Plan covers care for common benefit scenarios.

You can find a summary for both Base and Select Coverage and the Uniform Glossary on the Plan's website at http://knowyourbenefits.dfa.ms.gov. You can also find the glossary on the health care reform website at www.HealthCare.gov and www.dol.gov/ebsa/healthreform. If you do not have access to the internet, you may request a paper copy of these documents by calling the Office of Insurance at 601-359-3411 or toll-free at 866-586-2781.

2014 BENEFIT CHANGES

Prescription Drug Program

In an ongoing effort to help curb the spiraling costs of prescription drugs, the Board voted to encourage the use of generic drugs by keeping the current $12 copayment in place for 2014. Due to the substantial increases over the past few years, a slight increase in brand and specialty drug copayments is necessary. Beginning January 1, 2014, copayments for preferred brand drugs will increase from $40 to $45, while copayments for non-preferred brands and specialty drugs will increase from $65 to $70 for each 30 day supply. Remember, taking generic drugs whenever possible saves you money. The following chart shows the new copayment amounts for prescription drugs:

	Retail Pharmacy (30-day supply)	Mail Order (90-day supply)
Generic Drug	$12	$24
Preferred Brand Drug	$45	$90
Non-Preferred Brand Drug	$70	$140
Specialty Drug	$70	N/A

If you have Select Coverage, your prescription drug deductible will remain at $75. For participants enrolled in Base Coverage, you still must meet the applicable calendar year deductible (medical and/or prescription drug) before receiving prescription drug benefits under the Plan.

Participating Pharmacies to Administer Certain Vaccines Under Wellness Benefits

As a part of the Plan's wellness benefits, coverage for annual vaccines for influenza (flu), pneumonia, and shingles (for those non-Medicare participants over age 60) administered by an immunization-certified pharmacist is provided through the Catamaran Vaccine Program. These vaccines are provided at no cost to you but may require a prescription. Starting in 2014, the following vaccines will be added to the vaccine program: Hepatitis A and B, HPV, Measles, Mumps, Rubella, Varicella, Meningococcal, Polio, Rabies, Rotavirus, Tetanus, Diphtheria, and Acellular Pertussis (whooping cough).

Dietitian Counseling

The Plan currently provides coverage for one dietitian visit per year under wellness/preventive benefits at no cost to the participant. Effective January 1, 2014, regular Plan benefits for an additional three (3) dietitian visits will be covered subject to the calendar year deductible for dietitians participating in the AHS State network. Consulting with a dietitian can provide you with nutritional education that will help produce a wide variety of health benefits, resulting in improved management and outcome of your condition.

Weight Management Enhancement Program

Due to the increased interest in the Plan's Weight Management Enhancement Program, the Board has elected to allow participants with a Body Mass Index of 30 or greater to participate in this program beginning in January. Administered by ActiveHealth, the Plan's medical management vendor, this 12-month program provides participants with a personalized plan to not only lose weight but also reduce health risks. As a key component of the program, individual phone counseling with dieticians, nurses, and fitness experts, will provide the expertise and support to help participants achieve their specific weight goals. This confidential program is available at no cost to qualifying participants. For more information about this program, call ActiveHealth at 866-939-4721.

A1C Test

Diabetes negatively impacts the lives of thousands of Plan participants. If detected early, this costly and debilitating disease can be controlled in many instances. One of the best ways to identify diabetes in its early stages is with the A1C test, which measures a person's average blood sugar level for the past 2-3 months. In an effort to help improve quality of life through early detection, starting in January adult Plan participants will be eligible to receive one (1) A1C test per calendar year at no cost to them under the Plan's wellness/preventive benefits.

Hospital Private Room Copayment

Under current Plan benefits, participants must pay a $20 private room copayment for each day spent in the hospital, in addition to any deductible and coinsurance that applies. Originally put in place to encourage participants to use less expensive semi-private rooms, this requirement no longer applies due to the lack of semi-private rooms in most hospitals. As a result, the $20 per day private room copayment will be eliminated effective January 1, 2014.

Speech Therapy for Delayed Language Development

Starting in 2014, benefits for speech therapy will be expanded to include limited coverage for delayed language development disorder. A lifetime maximum of 15 speech therapy visits for delayed language development disorder will be allowed, subject to the calendar year deductible and the applicable coinsurance.

Emergency Room Copayments

Did you know that nearly 78% of the emergency room visits by Plan participants in 2012 were for non-emergencies or for treatment that could have been provided elsewhere? With an average cost of over $800 per visit, this overutilization of ER services results in unnecessary costs to the Plan and to you. In an effort to encourage participants to consider less expensive alternatives when available, the following changes have been made to the emergency room copayment effective January 1, 2014:

- A $50 copayment will be applied to the first emergency room visit in a calendar year.
- A $200 copayment will be applied for any subsequent emergency room visits during a calendar year.

A simple call can save you money! Not sure if you need to go to the ER? The ActiveHealth Nurse Line is open 24/7, including weekends and holidays. Just call 866-939-4721 if you aren't sure if you need to go to the ER.

PPACA-Required Benefit Changes

In compliance with PPACA, the following benefit changes are effective January 1, 2014:

- The pre-existing condition exclusion period will be eliminated for all participants.
- One-time screening for hepatitis C virus (HCV) infection will be covered for participants at a higher risk for infection and for adults born between 1945 and 1965 at no cost to the participant.
- Benefits will be provided for Vitamin D when purchased by prescription for active employees and their dependents ages 65 and older under the Plan's wellness/preventive benefits.

New Out-of-Pocket Limits for Select Coverage

As required by PPACA, the Plan will implement out-of-pocket limits for Select Coverage. Beginning in January, the individual out-of-pocket limits will be $6,350 for individual coverage and $12,700 for family coverage. Out-of-pocket costs subject to these limits will include: deductibles, coinsurance, and copayments for in-network providers. Examples of costs not subject to the out-of-pocket limits include premiums, non-covered services, expenses in excess of the allowable charge, and cost sharing for out-of-network providers.

2014 Open Enrollment

The Plan's 2014 Open Enrollment period will be from October 1 through October 31, 2013. Active employees, non-Medicare eligible retirees, and COBRA participants may choose either Base or Select Coverage during Open Enrollment with the coverage to be effective January 1, 2014. Please note that Medicare eligible retirees cannot make coverage changes during Open Enrollment. You can find an *Application for Coverage* form on the Plan's website, at your employer's Human Resources office, or by calling Blue Cross & Blue Shield of Mississippi (BCBSMS) at 800-709-7881 to request a form. Refer to the enrollment categories below to see what changes you can make during Open Enrollment.

ACTIVE EMPLOYEES

If you want to change coverage types or add eligible dependents, you will need to return a completed *Application for Coverage* form to your Human Resources office. Contact your Human Resources office to find out the deadline to submit the form. Remember, you must be participating in the Plan in order to cover your dependents.

NON-MEDICARE RETIREES

If you want to change coverage types, you will need to return a completed *Application for Coverage* form to BCBSMS by October 31, 2013. Please note that retirees cannot add dependents during Open Enrollment.

COBRA PARTICIPANTS

If you are a COBRA participant and want to change coverage types or add eligible dependents, you will need to return a completed *Application for Coverage* form to BCBSMS by October 31, 2013.

WELCOME!

Gulfport Memorial Hospital

We are pleased to announce that Gulfport Memorial Hospital joined the AHS State Network as a participating provider effective September 1, 2013. By using a network hospital such as Gulfport, you receive in-network benefits. Visit our website at http://knowyourbenefits.dfa.ms.gov and click on the link to Provider Search to find a list of all network hospitals and providers to be sure you always receive in-network benefits.

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HAVE YOU HAD YOUR Wellness Visit THIS YEAR?

Did you know that you can have your annual wellness visit – at no cost to you?

All you need to do is call your network provider's office now to schedule your wellness visit! To find the list of covered wellness services, visit the Plan's website at http://knowyourbenefits.dfa.ms.gov and click on Wellness/Preventive Coverage. Remember to share a copy of these guidelines with your provider during your wellness visit to be sure you are receiving the services that are covered at 100%.