The State Employees' Health Insurance Plan

State of Alabama

Effective January 1, 2014

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

INTRODUCTION

This summary of health care benefits of the State Employees' Health Insurance Plan (SEHIP) is designed to help you understand your coverage. This booklet replaces any previously issued information. All terms, conditions and limitations are not covered here. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the State Employees' Insurance Board (SEIB) and Blue Cross Blue Shield of Alabama (BCBS) or other third party administrators that the SEIB may contract with that it deems is necessary to carry out its statutory obligations. Copies of all contracts are kept on file at the SEIB office and are available for review.

The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the SEHIP and reserves the right to change the terms and conditions and/or end the SEHIP at any time and for any reason.

The following provisions of this booklet contain a summary in English of your rights and benefits under the SEHIP. If you have questions about your benefits, please contact Customer Service at 1-877-255-7250. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favorEste folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-877-255-7250. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

STATE EMPLOYEES' INSURANCE BOARD
201 South Union Street, Suite 200
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: 334.263.8341
Toll Free: 1.866.836.9737
Website: www.alseib.org

SUMMARY OF BENEFITS

This table is a summary of benefits and is subject to all other terms and conditions of the Plan.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. To see if your provider is a PPO member, call 1-800-810-BLUE (2583) or access the Blue Cross website at www.bcbs.com/healthtravel/finder.html.

Please be aware that not all providers participating in the BlueCard PPO Program will be recognized by Blue Cross as approved providers for the type of service being furnished as explained more fully in "Benefit Conditions".

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance, subject to a $200 per admission deductible if precertification obtained within 72 hours. If precertification received late, covered at 100% of the allowance, subject to a $600 per admission deductible. $25 co-pay per day for days 2-5.	Covered at 80% of the allowance, subject to a $200 per admission deductible if precertification obtained within 72 hours. If precertification received late, covered at 80% of the allowance, subject to a $600 per admission deductible.
Preadmission Certification	All hospital admissions, including emergency admissions, require preadmission certification within 72 hours, except maternity. For preadmission certification, call 1-800-551-2294. If preadmission certification is not obtained, no benefits are available.	
OUTPATIENT HOSPITAL BENEFITS		
Surgery	Covered at 100% of the allowance subject to a $150 facility co-pay. Certain outpatient surgeries require precertification, call 1-800-551-2294.	Covered at 80% of the allowance subject to the calendar year deductible. Certain outpatient surgeries require precertification, call 1-800-551-2294.
Medical Emergency	Covered at 100% of the allowance subject to a $150 facility co-pay for true medical emergencies.	Covered at 100% of the allowance subject to a $150 facility co-pay for true medical emergencies.
Accidental Injury	Covered at 100% of the allowance with no deductible or co-pay required within 72 hours of the accident. Thereafter, covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 100% of the allowance with no deductible or co-pay within 72 hours of the accident. Thereafter, covered at 80% of the allowance, subject to the calendar year deductible.
Urgent Care Facility	Covered at 100% of the allowance subject to a $50 co-pay.	Covered at 80% of the allowance subject to the calendar year deductible.
Diagnostic X-rays and Tests	Covered at 100% of the allowance subject to a $75 facility co-pay (one co-pay per test; limited to 2 copays per date of service.) for each of the following: Angiography/arteriography, cardiac cath/ arteriography, colonoscopy, UGI endoscopy, CAT Scan, MRI, MUGA-Gated Cardia Scan, ERCP, PET/PECT and Thallium Scan.	Covered at 80% of the allowance subject to the calendar year deductible.
Diagnostic Lab and Pathology	Covered at 100% of the allowance subject to a $7.50 co-pay per test.	Covered at 80% of the allowance subject to the calendar year deductible.
Note: In Alabama, inpatient and outpatient benefits for non-member hospitals are available only in cases of accidental injury and covered as an out-of-network hospital.		
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Physician Office Visits, Office Surgery and Outpatient Consultations	Covered at 100% of the allowance subject to a $35 office visit co-pay.	Covered at 80% of the allowance subject to the calendar year deductible.
Nurse Practitioner / Nurse Midwives, Physician Assistant Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance subject to a $20 office visit co-pay.	Covered at 80% of the allowance subject to the calendar year deductible.
Emergency Room Physician Fees	Covered at 100% of the allowance subject to the applicable office visit co-pay.	Covered at 100% of the allowance subject to the applicable office visit co-pay.
Out of Office Surgery and Anesthesia	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.
Inpatient Visits	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Maternity	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.
Diagnostic X-rays and Tests	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.
Lab and Pathology Exams	Covered at 100% of the allowance subject to a $7.50 co-pay per test.	Covered at 80% of the allowance subject to the calendar year deductible.
ROUTINE PREVENTIVE CARE		
Routine Immunizations and Preventive Services	Covered at 100% of the allowance with no deductible or copay. See **www.bcbsal.com/preventiveservices** for a listing of the specific immunizations and preventive services.	Covered at 80% of the allowance subject to the calendar year deductible. See **www.bcbsal.com/preventiveservices** for a listing of the specific immunizations and preventive services.
Additional Routine Preventive Services	Covered at 100% of the allowance with no deductible or copay. In addition to the standard, the following will apply: • Urinalysis (once by age 5, then once between ages 12-17) • CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) • Glucose testing (once every calendar year age 18 and over) • Cholesterol testing (once every calendar year age 18 and over) • TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)	Covered at 80% of the allowance subject to the calendar year deductible. In addition to the standard, the following will apply: • Urinalysis (once by age 5, then once between ages 12-17) • CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) • Glucose testing (once every calendar year age 18 and over) • Cholesterol testing (once every calendar year age 18 and over) • TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)
MENTAL HEALTH SERVICES		
Inpatient Facility Services	Covered at 80% of the participating allowance with no deductible.	Covered at 80% of the allowance subject to a $100 per admission deductible.
Inpatient Provider Services	Covered at 80% of the allowance with no deductible or co-pay.	Covered at 80% of the allowance subject to the calendar year deductible.
Outpatient Provider Services	Covered at 80% of the allowance with no deductible; limited to 20 visits per person each calendar year.	Covered at 80% of the allowance subject to the calendar year deductible; limited to 20 visits per person each calendar year.
SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance with no deductible or co-pay.	Covered at 80% of the allowance subject to a $100 per admission deductible
Inpatient Physician Services	Covered at 80% of the allowance with no deductible or co-pay.	Covered at 80% of the allowance subject to the calendar year deductible.
Outpatient Physician Services	Covered at 80% of the allowance; limited to 20 visits per person each calendar year.	Covered at 80% of the allowance subject to the calendar year deductible, limited to 20 visits per person each calendar year.
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar Year Deductible	$300 per person each calendar year; maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$6,250 individual annual out-of-pocket maximum; $12,500 aggregate family maximum. **In-Network Services:** Deductibles, copays and coinsurance apply to the out-of-pocket maximum, including prescription drugs (excludes Medicare Blue Rx plan). **Out-of-Network Services:** Do not apply to the out-of-pocket maximum.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MAJOR MEDICAL SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th visit. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.	**Non-Participating:** Covered at 80% of the allowance subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 18th visit. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.
Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. *Preauthorization* is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	
Allergy Testing and Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Participating Home Health Services	Covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency; Precertification is required; call 1-800-551-2294. **Note:** No coverage for services rendered by a non-participating Home Health agency.	
Diabetic Education	Covered at 100% of the allowance with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1-800-551-2294.	
PRESCRIPTION DRUGS – ACTIVE AND NON-MEDICARE MEMBERS		
Prescription Drugs	**Participating Pharmacy:** Prescription drugs will be covered at 100%, subject to the following co-pays: ● Tier 1 - $10 co-pay per prescription ● Tier 2 - 20% of the cost of the prescription with a minimum co-pay of $25 and a maximum co-pay of $40 per prescription ● Tier 3 - 20% of the cost of the prescription with a minimum co-pay of $55 and a maximum co-pay of $105 per prescription; **limited to 30-day supply.**	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a participating pharmacy where your drug card was not used.
PRESCRIPTION DRUGS – MEDICARE MEMBERS – BLUERX		
Tier 1 Drugs	**Preferred/Extended Supply Pharmacy:** • $10 co-pay for 30-day supply • $10 co-pay for 60-day supply • $10 co-pay for 90-day supply **Non-Preferred Pharmacy:** • $10 co-pay for 30-day supply • $10 co-pay for 60-day supply • $15 co-pay for 90-day supply	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a participating pharmacy where your drug card was not used.
Tier 2 Drugs	**Preferred/Extended Supply Pharmacy:** • $30 co-pay for 30-day supply • $30 co-pay for 60-day supply • $30 co-pay for 90-day supply **Non-Preferred Pharmacy:** • $30 co-pay for 30-day supply • $30 co-pay for 60-day supply • $55 co-pay for 90-day supply	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a participating pharmacy where your drug card was not used.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS – MEDICARE MEMBERS – BLUERX (continued)		
Tier 3 & 4 Drugs	**Preferred/Extended Supply Pharmacy:** • $60 co-pay for 30-day supply • $60 co-pay for 60-day supply • $60 co-pay for 90-day supply **Non-Preferred Pharmacy:** • $60 co-pay for 30-day supply • $60 co-pay for 60-day supply • $115 co-pay for 90-day supply	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a participating pharmacy where your drug card was not used.
Zostavax, Flu & Pneumonia vaccines $0 co-pay when administered at a BlueRx Pharmacy. If administered at MD office or non-BlueRx Pharmacy, covered under Medicare Part B.		
SEIB DISCOUNTED VISION CARE PROGRAM (Note: This is an SEIB administered benefit. No claims are to be filed with Blue Cross and Blue Shield of Alabama.)		
Routine Eye Exam	Examinations are limited to one per year subject to a $40 member payment when a participating provider is used. Please see benefit booklet for additional program provisions. SEIB's vision network is on our website at www.alseib.org	Not covered

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Chapter 1
OVERVIEW OF THE PLAN

Purpose of the Plan
The SEHIP is intended to help you and your covered dependents pay for the costs of medical care. The SEHIP does not pay for all of your medical care. For example, you may be required to pay deductibles, copayments, and coinsurance.

Using *my*BlueCross to Get More Information over the Internet
Blue Cross Blue Shield of Alabama (BCBS) is the Claims Administrator for the SEHIP. BCBS's home page on the Internet is www.bcbsal.com. If you go there, you will see a section of BCBS's home page called ***my*BlueCross**. Registering for ***my*BlueCross** is easy and secure. Once you have registered, you will have access to information and forms that will help you take maximum advantage of your benefits under the SEHIP.

Definitions
Near the end of this booklet you will find a section called "Definitions," which identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with these definitions so that you will understand your benefits.

Receipt of Medical Care
Even if the SEHIP does not cover benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Beginning of Coverage
The section of this booklet called Eligibility and Enrollment will tell you what is required for you to be covered under the SEHIP and when your coverage begins.

Limitations and Exclusions
In order to maintain the cost of the SEHIP at an overall level that is reasonable to all plan members, the SEHIP contains a number of provisions that limit benefits. There are also exclusions that you need to pay particular attention to as well. These provisions are found through the remainder of this booklet. You need to be aware of these limits and exclusions in order to take maximum advantage of the SEHIP.

Medical Necessity and Precertification
The SEHIP will only pay for care that is medically necessary and not investigational, as determined by BCBS. BCBS developed medical necessity standards to aid BCBS when BCBS makes medical necessity determinations. BCBS publishes these standards on the Internet at www.bcbsal.com/providers/policies. The definition of medical necessity is found in the Definitions section of this booklet.

In some cases, the SEHIP requires that you or your treating provider precertify the medical necessity of your care. The provisions later in this booklet will tell you when precertification is required. Look on the back of your ID card for the phone number that you or your provider should call. In some cases, BCBS's contracts with providers require the provider to initiate the precertification process for you. Your provider should tell you when these requirements apply. You are responsible for making sure that your provider initiates and complies with any precertification requirements under the SEHIP. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the SEHIP.

Precertification also does not mean that we have been paid all monies necessary for our administration of the SEHIP to be in force on the date that services or supplies are rendered.

In-Network Benefits

One way in which the SEHIP tries to manage healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of in-network provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. As one example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the SEHIP. Additionally, out-of-network providers have not contracted with BCBS or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the SEHIP.

In-network providers are hospitals, physicians, pharmacies, and other healthcare providers or suppliers that contract with BCBS or any Blue Cross and/or Blue Shield plans (directly or indirectly through, for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced price. Examples of in-network providers include PMD, Preferred Care, and BlueCard PPO. To locate in-network providers in Alabama, go to www.bcbsal.com.

- First, click “Find a Doctor.”
- Second, select a healthcare provider type: doctor, hospital, pharmacy, other healthcare provider, or other facility or supplier.
- Third, enter a search location by using the zip code for the area you would like to search, or by selecting a state.

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder website at http://provider.bcbs.com. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross plan where services are rendered. The local Blue Cross plan will then forward the claims to BCBS for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the SEHIP or is not covered under the contract between the provider and the local Blue Cross plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the SEHIP.

Relationship between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association

BCBS is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits BCBS to use the Blue Cross and Blue Shield service marks in the state of

Alabama. BCBS is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than BCBS and the State Employees' Insurance Board will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of BCBS not created under the original agreement.

Claims and Appeals

When you receive services from an in-network provider, your provider will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with BCBS for reimbursement under the terms of the SEHIP. If BCBS denies a claim in whole or in part, you may file an appeal with BCBS. BCBS will give you a full and fair review. Thereafter, you may have the right to an independent external review. The provisions of the plan dealing with claims or appeals are found further on in this booklet.

Termination of Coverage

The section below called Eligibility and Enrollment tells you when coverage will terminate under the SEHIP. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the SEHIP or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your SEHIP coverage terminates. COBRA coverage is explained in detail later in this booklet.

Chapter 2
ELIGIBILITY AND ENROLLMENT

Visit our web page at www.alseib.org to download forms.

Eligible Employees

The term "employee" includes only:

1. Full-time State employees and employees of County Health Departments, who are paid by the State Comptroller, the State Department of Mental Health, Historic Blakeley, Ft. Payne Improvement Authority, Historic Ironworks Commission, Bear Creek Development Authority, International Motor Sports Hall of Fame, Space and Rocket Center, the Sports Hall of Fame, the State Docks, St. Stephens Historical Commission, USS ALABAMA Battleship Commission, Red Mountain Greenway Commission and County Soil & Water Conservation Districts are to be eligible for coverage under this plan.

2. Part-time employees working at least ten hours per week are eligible if they agree to have the required premium paid through payroll deduction.

3. Members of the Legislature and the Lieutenant Governor are eligible during their term of office (excluding optional and supplemental plans).

Exclusion: You are not eligible for coverage if the SEIB determines that you are classified as an employee employed on a seasonal, temporary, intermittent, emergency or contract basis.

Eligible Dependent

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes divorced or common-law spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter,
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you),
   c. your stepchild,
   d. your grandchild, niece, or nephew for whom the court has granted custody to you or your spouse.
3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent on you for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or

2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

In the event of the death of an active employee, who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payment to the SEIB. The SEIB must be notified within 90 days of the death.

Exclusion: You may not cover your wife, husband, or other dependents if they are independently covered as a State employee.

PCET's with ALDOT may remain dependents if their employment is part of their educational training.

Changes in Dependent Eligibility

It is the responsibility of the subscriber to notify the SEIB immediately when the eligibility of a covered dependent changes. If it is determined that an act (such as adding a ineligible person to coverage) or omission (such as failing to remove a person no longer eligible from coverage) of the subscriber results in or contributes to the payment of claims by the SEHIP for persons ineligible for coverage, the subscriber will be personally responsible for all such overpayments and shall be subject to disciplinary action including termination of coverage. (Note: an ex-spouse is ineligible for coverage and cannot be maintained as a dependent under your family coverage regardless of a judgment or divorce decree requiring you to provide health care for your ex-spouse. However, an ex-spouse may be eligible for COBRA continuation coverage.)

Qualified Medical Child Support Orders

If the SEIB receives an order from a court or administrative agency directing the SEHIP to cover a child, the SEIB will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The SEIB has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting your SEIB.

The SEHIP will cover an employee's child if required to do so by a QMCSO. If the SEIB determines that an order is a QMCSO, the child will be enrolled for coverage effective as of a date specified by the SEIB, but not earlier than the later of the following:

- If the SEIB receives a copy of the order within 30 days of the date on which it was entered, coverage will begin as of the date on which the order was entered.
- If the SEIB receives a copy of the order later than 30 days after the date on which it was entered, coverage will begin as of the date on which the SEIB received the order. The SEIB will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the SEIB

may increase the employee's payroll deductions. During the period the child is covered under the SEHIP as a result of a QMCSO, all SEHIP provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the QMCSO is in effect the SEHIP will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. The SEIB will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the SEHIP. The SEIB will also send claims reports directly to the child's custodial parent or legal guardian.

Enrollment & Commencement

Employees and dependents can enroll and coverage commences as stated below.

Employee

New employees who do not decline coverage will be enrolled as of the effective date of employment, subject to SEIB Rules and Procedures. An SEIB enrollment form (IB2) must be completed by the employee and his/her employer and submitted to the SEIB.

Part-time employees may elect coverage to be effective on their date of employment, subject to appropriate premium payment, or on the first day of the month following first payroll deduction.

Dependents

When adding dependents to family coverage, you must submit appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) to the SEIB. NOTE: To avoid enrollment deadlines you should submit enrollment forms to the SEIB even if you do not have all of the appropriate documentation at the time of enrollment.

New employees may elect to have dependent coverage begin on the date of their employment or no later than the first day of the second month following their hire date, subject to appropriate premium payments.

You may enroll dependents, subject to appropriate premium payments, within 60 days of acquiring a new dependent and the effective date of coverage will be the date of marriage, birth or adoption.

Payroll deduction for insurance is taken from the last paycheck of the month. A **direct payment** for dependent coverage premium must be submitted with the enrollment form for any coverage period before payroll deduction. The deduction from your payroll check or the deposit by the SEIB of your direct payment does not constitute acceptance of coverage.

Open Enrollment

Open enrollment is November 1 through November 30 for an effective date of coverage of January 1 and is available for:

- employees who have declined coverage and now wish to enroll in the SEHIP,
- employees who wish to change plans,
- part-time employees who wish to begin coverage,
- employees who wish to add family coverage or add a dependent to existing family coverage.

Special Enrollment

Alabama law allows active full-time employees to decline coverage in the SEHIP. The Health Insurance Portability and Accountability Act of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for employees and eligible dependents if:

1. the employee declined to enroll in the SEHIP because of other employer group coverage and submitted a completed "Declination of Coverage"; and

2. the employee gains a new dependent through marriage, birth or adoption; or
3. the employee or dependent loses the other employer group coverage because:
   a. COBRA coverage (if elected) is exhausted, or
   b. loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
   c. employer stopped contribution to coverage; and,
4. the employee requests enrollment in the SEHIP in writing no later than 30 days after the loss of other coverage.

A request for Special Enrollment must include:
1. a letter requesting special enrollment submitted to the SEIB within 30 days of the qualifying event, along with a completed enrollment form or status change form if only adding dependents.
2. thereafter, the following documentation must be submitted within 60 days of the qualifying event:
   a. proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers, etc.) or
   b. proof of coverage loss listing the reason and the date of the coverage loss for all individuals affected (e.g. employment termination on company letterhead),

Enrollment in the SEHIP for Subscribers of the Supplemental Coverage Plan

Eligible employees who enroll in the State Employees' Supplemental Coverage Plan may reenroll in the SEHIP at any time during the year. Coverage will be effective no later than the first day of the following month upon approval by the SEIB.

Active Employees Over 65

Active employees and their dependents over age 65 are covered under the same conditions as any employee under age 65. The SEHIP is primary for services covered by Medicare.

Re-Employed State Retiree

To comply with the Medicare, Medicaid and the SCHIP Expansion Act, the SEIB has to verify that it is the primary payer for all employees covered by the SEHIP, including re-employed Medicare retirees. This applies to all re-employed State retirees with a FICA deduction.

All re-employed State retirees must submit a Re-employed State Retiree Health Insurance Form to the SEIB. If the employee and/or dependent are Medicare eligible, SEHIP will be the primary payer and premiums will be adjusted.

You must notify the SEIB when your employment ends so that the SEIB can change the coverage back to Medicare when applicable.

Survivor Enrollment

In the event of the death of an employee covered under the SEHIP who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payments to the SEIB. Pursuant to Act 2012-498, the spouse and dependents of an employee covered under the SEHIP who is killed in the line of duty or who dies as a result of injuries received in the line of duty may continue coverage under the SEHIP with the cost of continued coverage to be paid by the State Treasury. (Coverage shall cease upon remarriage or upon the attainment of an alternate health insurance provider.) SEIB must be notified within 90 days of the date of death.

Notice

Notice of any enrollment changes is the responsibility of the employee (for example, status changes or address changes). Please visit our web page at www.alseib.org to download applicable forms.

Status Changes

A status change form must be completed for an addition or deletion of dependent coverage. The Status Change Form must be submitted directly to the SEIB by mail or by visiting our website at www.alseib.org.

Address Changes

All correspondence and notices required under the provisions of the SEHIP or state or federal law will be delivered to the address provided by you in our records. It is your responsibility to ensure that your address of record is accurate. To change an address, a written request may be submitted to the SEIB office at PO Box 304900, Montgomery, Alabama 36130-4900 or by visiting our web page at www.alseib.org.

Employee Name Changes

Name changes are processed electronically once they are changed on payroll with your agency.

Chapter 3
PREMIUMS

As the Plan Administrator for SEHIP, the SEIB is responsible for establishing the monthly premiums for the various rate classes. These rate classes are defined as follows:

- active employee, single
- active employee, family
- non-Medicare retiree, single
- non-Medicare retiree, family
- Medicare retiree, single
- Medicare retiree, dependent
- non-Medicare retiree with Medicare dependent
- Medicare retiree with non-Medicare dependent(s).

The premiums for these rate classes change from year to year. Contact the SEIB or your insurance clerk to determine what the applicable premium is for each rate class.

New employees will have 60 days from their date of hire to apply for the non-tobacco user premium discount. When a spouse is added, the 60-day period will also apply.

Non-Tobacco User Premium Discount

If you (and your spouse if covered as a dependent under SEHIP) have not used tobacco products in the last twelve months, you may be eligible for a premium discount. In order to obtain the discount you must submit a completed non-tobacco user premium discount application to the SEIB. You may also qualify for the discount if you submit acceptable documentation to the SEIB each year verifying that you (and your spouse if covered as a dependent under SEHIP):

- have completed an SEIB approved tobacco usage cessation program; or
- cannot stop using tobacco products as advised by your physician because it is unreasonably difficult due to a medical condition.

New employees will have 60 days from date of hire to apply for the non-tobacco user discount. When a spouse is added, the 60-day period will also apply.

Contact the SEIB or your insurance clerk about how to apply for the discount.

Wellness Premium Discount

Eligibility - All active employees covered under the State Employees' Health Insurance Plan (Group 13000) are eligible for a wellness premium discount. The wellness qualifying period is October 1, 2013 through October 31, 2014, for a January 1, 2015 effective date. Every active employee must be screened either through the SEIB's worksite wellness screening program, a county health department, a participating pharmacist, or by a healthcare provider (through the submission of a Provider Screening Form).

Effective for the 2015 plan year, covered spouses of active employees, non-Medicare retirees and non-Medicare covered spouses of retirees are eligible for a wellness premium discount. In order to receive the wellness discount in 2015 and thereafter, every covered spouse of an active employee, non-Medicare retiree and non-Medicare covered spouse of a retiree must be screened either through the SEIB's worksite wellness screening program, a county health department, a participating pharmacist, or by a healthcare provider (through the submission of a Provider Screening Form). The qualifying period is October 1, 2013 thru October 31, 2014 for a January 1, 2015 effective date.

Risk Factors - Risk factors are blood pressure, total cholesterol, glucose, and body mass index. You are considered to be "at risk" if your:

1. Blood pressure systolic reading is 160 or higher, or your diastolic reading is 100 or above;
2. Cholesterol reading is equal to or above 250;
3. Glucose reading is equal to or above 200;
4. Body mass index is equal to or above 40.

Screening Referral - Participants screened at the worksite, county health department, or pharmacies that are discovered to have one or more of these risk factors may be eligible for an office visit copay waiver referral. The office visit copay waiver is only for members covered under Group 13000 and only waives the office visit copay. You are responsible for all other applicable copays, such as lab test copays. **This copay waiver is not applicable at an emergency room or urgent care center.**

Managing Your Screening Results - You can earn the wellness premium discount within the wellness plan year in the following ways:

1. Submission of health screening results through a SEIB wellness program indicating that you *are not* at risk for one or more of the above health risk indicators;
2. Submission of a *completed and signed* office referral form indicating that you have been counseled by a healthcare provider for your identified risk(s) indicators;
3. Submission of participation in a YMCA, Gold's Gym, Curves or other SEIB approved program(s). You must provide documentation of your participation;
4. Provide valid proof that you are self-managing and have *made improvement* in your identified risk(s). You must provide documentation of your improvement; or
5. Submission of a completed Provider Screening Form.

Exceptions - An eligible individual may also receive the wellness premium discount if it is deemed that the eligible individual cannot participate in the wellness program due to pregnancy, disability or other infirmity as documented by the eligible individual's physician.

The effective date of the wellness premium discount depends on when the screening results and/or other required documentation are submitted to the SEIB. However, in order for the wellness premium discount to be effective on January 1 (provided that the criteria listed above are met), you must meet the criteria no later than October 31 of the preceding year. New employees will have 60 days from date of hire to apply for the wellness premium discount. Covered spouses of active employees, non-Medicare retirees and non-Medicare covered spouses of retirees will have 60 days from their effective date to apply for the wellness premium discount.

For More Information: Call 1.866.838.3059 or visit www.alseib.org.

Federal Poverty Level Discount

If your combined family income is less than or equal to 300% of the Federal Poverty Level as defined by the federal law, you may be eligible for a percentage discount off the approved premium. In order for employees and retirees enrolled in the SEHIP to qualify for the discount, acceptable proof of total family income must be submitted to the SEIB.

Family income will be determined based upon current income in conjunction with the prior year's federal and state income tax returns. As a condition of participating in the Federal Poverty Level Discount Program, applicants must authorize the Alabama Department of Revenue (or the appropriate agency of the applicant's state of residence) to release to the SEIB all of the applicant's tax related information in their records for the current and prior tax year.

The premium discount will be applied as follows:

Greater than 300% of the FPL – employee pays 100% of the employee contribution
Equal to or less than 300% of the FPL – employee contribution reduced 10%
Equal to or less than 250% of the FPL – employee contribution reduced 20%
Equal to or less than 200% of the FPL – employee contribution reduced 30%
Equal to or less than 150% of the FPL – employee contribution reduced 40%
Equal to or less than 100% of the FPL – employee contribution reduced 50%

Certification of income level will be effective for twelve months. Thereafter, re-certification will be made annually on the employee's or retiree's birthday.

Employees Retired after September 30, 2005, but Before January 1, 2012 - Premium Based on Years of Service

If you retired after September 30, 2005, but before January 1, 2012, you will be subject to a sliding scale premium structure based on your years of State service. The premium for retiree coverage is broken down into the "employer contribution" and the "employee contribution." The dollar amount of these contributions is subject to change each year.

Under the sliding scale, the retiree will still be responsible for the "employee contribution" of the premium, however, the amount the State will pay toward the "employer contribution" of the premium will increase or decrease based upon a retiree's years of State service. For those employees retiring with 25 years of State service, the State would pay 100% of the "employer contribution" of the premium. Each year less than 25, the amount the State will pay toward the "employer contribution" would be reduced by 2% and the "employee contribution" will be increased accordingly. Each year over 25, the amount the State pays toward the "employer contribution" would be increased by 2% and the employee contribution reduced accordingly.

NOTE: The retiree sliding scale is not applicable to the non-tobacco user premium discount.

Years of creditable service are determined by the Retirement Systems of Alabama. Effective for all employees retiring after July 31, 2008, Act 2008-280 authorizes the SEIB to exclude from RSA's years of creditable service calculation any service not related to service as a State employee (as defined in Section 36-29-1 Code of Alabama 1974) except for creditable service related to the following:

- service in the United States armed forces;
- service as an employee as defined in Sections 16-25A-1 and 16-25A-11 Code of Alabama 1974;
- service as an employee of a postsecondary institution eligible for PEEHIP coverage as a retiree.

Employees Retired on or after January 1, 2012 - Premium Based on Years of Creditable Coverage in the SEHIP

If you retired on or after January 1, 2012, you will be subject to a sliding scale premium structure based on your years of creditable coverage in the SEHIP. The premium for retiree coverage is broken down into the "employer contribution" and the "employee contribution." The dollar amount of these shares is subject to change each year.

Under the sliding scale, the retiree will still be responsible for the "employee contribution" of the premium, however, the amount the State will pay toward the "employer contribution" of the premium will increase or decrease based upon a retiree's years of creditable coverage in the SEHIP. For those employees retiring with 25 years of creditable coverage in the SEHIP, the State would pay 100% of the "employer contribution" of the premium. Each year less than 25, the amount the State will pay toward the "employer contribution" would be reduced by 4% and the "employee contribution" will be increased accordingly. Each year over 25, the amount the State pays toward the "employer contribution" would be increased by 2% and the employee contribution reduced accordingly. NOTE: The retiree sliding scale is not applicable to the non-tobacco user premium discount.

Years of creditable coverage in the SEHIP are determined by the SEIB. Creditable coverage may be allowed for the following service time:

- service in the United States armed forces, or
- service as an employee as defined in Sections 16-25A-1 and 16-25A-11 Code of Alabama 1974, or
- service as an employee of a postsecondary institution eligible for PEEHIP coverage as a retiree, provided the postsecondary institution contributes an amount equal to the amount appropriated by the state to fund benefits for such retired employees.

Employees Retired on or after January 1, 2012, Without Medicare - Premium Based on Years of Creditable Coverage in the SEHIP and Age at Retirement

In addition to the changes in the retiree sliding scale, employees retired on or after January 1, 2012, without Medicare will also be subject to an additional premium based on age at retirement. The employer contribution of the retiree sliding scale premium will be reduced by 1% for every year of age of employee at
retirement less than the Medicare entitlement age. This percentage will remain the same each year until entitlement to Medicare. Upon Medicare entitlement, the percentage deduction of the state contribution will be removed. (Most people are entitled to Medicare at age 65 or earlier if disabled.)

Deferred Retirement Option Plan (DROP)

The new sliding scale premium effective for employees retired on or after January 1, 2012, will not apply to employees who have elected to participate in the Deferred Retirement Option Plan (DROP) if the DROP participant:

1. does not voluntarily terminate participation in the DROP within the first three years and
2. withdraws from service at the end of the DROP participation period.

This will exempt employees who entered the DROP from being subject to the new sliding scale premium if they do not voluntarily exit the DROP within the first three years and withdraw from service at the end of the DROP participation period.

Disability Retirement on or after January 1, 2012 – Exemption

Employees who retire on disability on or after January 1, 2012 are exempt from the retiree sliding scale premium calculation for a period of two years, provided the retiree applies for Social Security disability. To obtain the two-year exemption, the retiree must submit documentation from the Social Security Administration acknowledging the retiree's application for disability benefits.

To maintain the exemption after two years the retiree must be approved for Social Security disability. If the retiree fails to obtain Social Security disability within two years from retirement the retiree permanently loses the eligibility for this exemption.

Employees who retire on disability on or after January 1, 2012 are not exempt from the retiree sliding scale premium calculation based on age.

Chapter 4
TERMINATION OF COVERAGE

When Coverage Terminates

Coverage under the SEHIP will terminate:

1. On the last day of the month in which your employment terminates. The SEIB may continue your coverage if you are absent from work because of injury or sickness, or if you are absent from work due to leave of absence or temporary layoff, but only for a limited period. Premiums may be required from the employee by direct pay. For details, contact the SEIB.
2. On the last day of the month in which you decline coverage or opt out of the SEHIP.
3. When the SEHIP is discontinued.

Coverage under the SEHIP will also terminate for a dependent:

1. On the first day of the following month in which such person ceased to be an eligible dependent.
2. If the dependent becomes covered as an employee.
3. When premium payments cease for coverage of a deceased active or deceased retired employee.
4. When dependent premium payments cease.

When dependent coverage is terminated, it is your responsibility to notify the SEIB to discontinue payroll deductions. If deductions are still being made from your paycheck after the month of termination, this does not mean that your dependents have coverage. It is your responsibility to request a refund from SEIB.

In many cases you will have the option to choose continuation of group benefits as provided by the Public Health Service Act. (See COBRA Section.)

Family & Medical Leave Act

The SEIB will follow the provisions of the Family and Medical Leave Act as approved by the appropriate authority.

Employees on Leave without Pay (LWOP)

State health insurance coverage for employees on official leave without pay may be continued for a maximum of 12 months provided the employee elects to make the premium payment required for coverage directly to the SEIB. Official leave without pay is established when an employee has received approval of the Personnel Department (for classified employees) or appointing authority, where applicable, to be taken off the payroll for an extended period.

Chapter 5
CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

Introduction

The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that the SEIB offer covered employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the SEHIP would otherwise end. COBRA coverage can be particularly important because it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it.

This chapter is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of this law. ***You and your spouse should take the time to read this carefully.***

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the SEHIP when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed under the section entitled "Qualified Beneficiaries" below. 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 SEHIP is lost because of a qualifying event. Under the SEHIP, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Qualified Beneficiaries

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under the SEHIP on the day before the event that caused a loss of coverage, such as termination of employment, or a divorce from, or death of, the covered employee. In addition, a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the SEHIP because either one of the following qualifying events happens:

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

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform the SEIB that you do not intend to return to work, whichever occurs first.

COBRA Rights for a Covered Spouse and Dependent Children

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the SEHIP because either one of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than 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 SEHIP because any of the following qualifying events happens:

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

Coverage Available

If you choose continuation coverage, the SEIB is required to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the SEHIP to similarly situated employees or family members.

When Your Agency Should Notify the SEIB

COBRA continuation coverage will be offered to qualified beneficiaries only after the SEIB has been notified that a qualifying event has occurred. Your agency is responsible for notifying the SEIB of the following qualifying events:

- End of employment,
- Reduction of hours of employment or
- Death of an employee.

When You Should Notify the SEIB

The employee or a family member has the responsibility to inform the SEIB of the following qualifying events:

- Divorce,
- Legal separation, or
- A child losing dependent status.

Written notice must be given to the SEIB within 60 days of the date of the event or the date, in which coverage would end under the SEHIP because of the event, whichever is later. All notices should be sent to the address listed under "SEIB Contact Information" at the end of this section.

Election Period

When the SEIB is notified that a qualifying event has happened, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. In addition, a Covered employee may elect COBRA continuation coverage on behalf of his or her spouse and either covered parent may elect COBRA continuation coverage on behalf of their children. If you do not choose continuation coverage, your group health insurance will end.

After the SEIB receives timely notice that a qualifying event has occurred, the SEIB will (1) notify you that you have the option to buy COBRA, and (2), send you a COBRA election notice.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the SEHIP, or (2), the date on which the SEIB notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an

independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date the election notice is sent back to the SEIB.

Once the SEIB has been notified of your qualifying event, your coverage under the SEHIP will be retroactively terminated and payment of all claims incurred after the date coverage ceased will be rescinded. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, the SEIB will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that the SEHIP may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the SEHIP. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage will last for up to a total of 36 months when one of the following qualifying events occurs:

- Death of the employee,
- Divorce or legal separation, or
- Dependent child loses eligibility as a "dependent child" under SEHIP.

COBRA continuation coverage will last for up to a total of 18 months when one of the following qualifying events occurs:

- End of employment or
- Reduction in the hours of employment.

There are only two ways to extend the 18-month COBRA continuation coverage period:

- **Disability** – If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the SEIB, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

  The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

  For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under "Extensions of COBRA for Second Qualifying Events" for more information about this.

  For this disability extension of COBRA coverage to apply, you must give the SEIB timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the SEIB within 30 days of any revocation of Social Security disability benefits.

- **Extensions of COBRA for Second Qualifying Events** – For a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the SEIB timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

  This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, or gets divorced, or if the child stops being eligible under the plan as a dependent child, *but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.* For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

  For this 18-month extension to apply, you must give the SEIB timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

Adding New Dependents to COBRA

You may add new dependents to your COBRA coverage under the circumstances permitted under the SEHIP. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the SEIB of Social Security's disability determination as explained above.

Family and Medical Leave Act

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage. The period of your COBRA continuation coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

Premium Payment

If you qualify for continuation coverage, you will be required to pay the group's premium plus 2% administrative fee, directly to the SEIB. Members who are disabled under Title II or Title XVI of the Social Security Act when a qualifying event occurs, will be required to pay 150% of the group's premium for the 19th through the 29th month of coverage or the month that begins more than 30 days after the date is determined that you are no longer disabled under Title II or Title XVI of the Social Security Act, whichever comes first. (If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.) Your coverage will be canceled if you fail to pay the entire amount in a timely manner.

Your initial premium payment must be received by the SEIB within 45 days from your date of election. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

Termination of Continuation Coverage

The law provides that your COBRA continuation coverage may be terminated for any of the following reasons:

1. SEIB no longer provides group health coverage.
2. The premium for your continuation coverage is not paid on time.
3. You become covered by another group plan.
4. You become entitled to Medicare.
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the SEHIP. For example, if you submit fraudulent claims, your coverage will terminate.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your COBRA continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

Note: If you are entitled to Medicare before you become a qualified beneficiary, you may elect COBRA continuation coverage; however, your Medicare coverage will be primary and your COBRA continuation coverage will be secondary. You must have Medicare Parts A and B in order to have full coverage.

Keep the SEIB Informed of Address Changes

In order to protect your family's rights, you must keep the SEIB informed of any changes in the address of family members. You should also keep a copy for your records of any notices you send to the SEIB.

If You Have Any Questions

Questions concerning your COBRA continuation coverage rights may be addressed by calling the SEIB at 1.866.836.9737 or by mail at the contact listed below. For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1.866.444.3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

SEIB Contact Information

All notices and requests for information should be sent to the following address:

State Employees' Insurance Board
COBRA Section
Post Office Box 304900
Montgomery, AL 36130-4900

Chapter 6
RETIREE ELIGIBILITY AND ENROLLMENT

Eligible Retired State Employee
A retired employee of the State of Alabama who has at least 10 years of creditable coverage in the SEHIP and receives a monthly benefit from the Employees' Retirement System or Teachers' Retirement System of Alabama or Judicial Retirement System.

Eligible Dependent - (see page 6)

Enrollment/Continuation
A retiring employee may elect coverage under the SEHIP by agreeing to have the monthly premium amount (if applicable) deducted from his retirement check.

If coverage is declined at the date of retirement, SEIB will provide the retiree with a Declination of Coverage Form that must be completed and returned to the SEIB in order to be eligible for Special Enrollment.

Open Enrollment
Retired employees who do not elect to continue their coverage under the SEHIP may do so during the annual open enrollment held each November for coverage to be effective January 1. Retirees may elect to add family coverage. Contact the SEIB for details.

Special Enrollment Period
The Health Insurance Portability and Accountability Act of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for retired employees and eligible dependents if:

1. the retired employee declined to enroll in the SEHIP because of other coverage and submitted a completed "Declination of Coverage;" and
2. the retiree gains a new dependent through marriage, birth or adoption; or
3. the retiree or dependent loses the other employer group coverage because:
   a. COBRA coverage (if elected) is exhausted, or
   b. loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
   c. employer stopped contribution to coverage; and,
4. the retiree requests enrollment in the SEHIP in writing no later than 30 days after the loss of other coverage.

A request for Special Enrollment must include:

1. a letter requesting special enrollment submitted to the SEIB within 30 days of the qualifying event, along with a completed enrollment form or status change form if only adding dependents.
2. thereafter, the following documentation must be submitted within 60 days of the qualifying event:
   a. proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers, etc.)
   b. proof of coverage loss listing the reason and the date of the coverage loss for all individuals affected (e.g. employment termination on company letterhead).

Enrollment in the SEHIP for Subscribers of the Supplemental Coverage Plan
Eligible Non-Medicare retirees who enroll in the State Employees' Supplemental Coverage Plan may reenroll in the SEHIP at any time during the year.

Survivor Enrollment

In the event of the death of a retired employee, who carried family coverage, the eligible dependents may continue coverage by making appropriate premium payments to the SEIB. The SEIB should be notified within 90 days of the date of death.

Re-Employed State Retiree

To comply with the Medicare, Medicaid and SCHIP Expansion Act, SEIB has to verify that it is the primary payer for all employees covered by the SEHIP, including re-employed Medicare retirees. This applies to all re-employed State retirees with a FICA deduction.

All re-employed State retirees must submit a Re-employed State Retiree Health Insurance Form to the SEIB. If the employee and/or dependent are Medicare eligible, SEHIP will be the primary payer and premiums will be adjusted.

You must notify the SEIB when your employment ends so that the SEIB can change the coverage back to Medicare when applicable.

Provisions for Medicare

The SEHIP remains primary for members until the member is entitled to Medicare. Health benefits will be modified when you or your dependent becomes entitled to Medicare. Upon entitlement to Medicare, SEHIP will be your secondary coverage and Medicare will be your primary coverage (unless otherwise provided under the Medicare secondary payer regulations).

A Medicare retiree and/or Medicare dependent should have both Medicare Parts A and B to have adequate coverage with the State of Alabama.

If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, he/she must notify the SEIB.

Retirees who start receiving retirement benefits because they reach age 60 may enroll for health insurance.

NOTE: The SEHIP is not a supplement to Medicare.

Medicare Part B

Effective October 1, 2006, retirees who are eligible for Medicare primary coverage but do not have Medicare Part B will:

- Not receive State primary coverage for services that would have been covered by Medicare Part B if they are enrolled as a Medicare retiree. State primary coverage for these services will be "carved out" and the Medicare retiree will be responsible for the payment of these claims.

- Pay the SEHIP an amount equal to the Medicare Part B premium in addition to the regular non-Medicare premium if they are enrolled as a non-Medicare retiree. These retirees have until the next available Medicare enrollment period to enroll in Medicare Part B. As of the effective date, the retiree will be changed to Medicare primary for Medicare Part B services and the State coverage will become secondary.

Retiree dependents that do not have Medicare Part B will be treated similarly. If the additional premium equal to the Medicare Part B premium is not paid to the SEHIP, State primary coverage will be "carved out" for all benefits Medicare Part B would have paid and the retiree and his/her Medicare dependent will be responsible for the payment of these claims.

Medicare Part D Prescription Drug Coverage

Effective January 1, 2013, the State Employees' Health Insurance Plan's (SEHIP) prescription drug benefit for Medicare retirees will change to the SEHIP Employer Group Waiver Plan (EGWP). The SEHIP

EGWP is a Medicare Prescription Drug (Part D) plan that is in addition to your coverage under Medicare Part A or Part B. Plan documents, as well as an EGWP Blue Rx card, will be mailed to you shortly after SEIB receives a copy of your Medicare card and verifies that Medicare is your primary insurance plan.

It is your responsibility to inform SEHIP of any prescription drug coverage that you have or may get in the future. You can only be enrolled in one Medicare prescription drug plan at a time. You are not required to be enrolled in the SEHIP EGWP but if you want to opt out, you must complete an EGWP Opt-Out Form and return it to the SEIB. Opt-out forms are available on SEIB's website at www.alseib.org or by calling SEIB toll free at 1.866.836.9737.

If you opt out of this plan, **you will have no prescription drug coverage from the SEHIP**. You will, however, still have the SEHIP secondary Medicare Part A and B coverage if you opt-out of the SEHIP EGWP. You can also decide to join a different Medicare Part D prescription drug plan. You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for help in learning how to enroll in another Medicare Part D prescription drug plan. (TTY users should call 1-877-486-2048.)

Keep in mind that if you leave the SEHIP plan and do not have or do not enroll in another prescription drug plan, you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

Medicare limits when you can make changes to your coverage. You may leave this plan only at certain times of the year or under certain special circumstances. Generally, there is an open enrollment period at the end of each year when you can change Medicare Part D prescription drug plans for coverage that will be effective January 1 of the following year. To request to leave the SEHIP EGWP, please submit the EGWP Opt-Out Form to:

State Employees' Insurance Board
PO Box 304900,
Montgomery, AL 36130-4900.

Once you are a member of the SEHIP EGWP, you have the right to appeal plan decisions about payment of services if you disagree. Read EGWP plan documents to know the rules you must follow to receive coverage with this Medicare prescription drug plan.

Certain Retirees Required to Enroll in Other Employer Health Insurance Coverage if:

1. you retired after September 30, 2005, and
2. you become employed by another employer and are eligible for your other employer's group health insurance coverage, and
3. your other employer provides at least 50 percent of the cost of single health insurance coverage.

If you meet these three criteria you will be required to use your other employer's health benefit plan for your primary coverage.

If you don't meet the above requirements and fail to enroll in your other employer's group health plan, the SEIB will:

- terminate your coverage in the SEHIP and
- recall all claims back to the date you were eligible for your other employer's group health plan.

Retiree Premiums - See Chapter 3.

Chapter 7
BENEFIT CONDITIONS

To qualify as plan benefits, medical services and supplies must meet the following:

- They must be furnished after your coverage becomes effective;
- BCBS must determine before, during, or after services and supplies are furnished that they are medically necessary. All inpatient hospital stays and some outpatient procedures must be reviewed for medical necessity.
- PPO benefits must be furnished while you are covered by the SEHIP and the provider must be a PPO provider when the services are furnished to you;
- Separate and apart from the requirement in the previous paragraph, services and supplies must be furnished by a provider (whether Preferred Provider or not) who is recognized by Blue Cross as an approved provider for the type of service or supply being furnished. For example, Blue Cross reserves the right not to pay for some or all services or supplies furnished by certain persons who are not Medical Doctors (MD's), even if the services or supplies are within the scope of the provider's license. Call Blue Cross Customer Services if you have any question whether your provider is recognized by Blue Cross as an approved provider for the services or supplies you plan on receiving.
- Services and supplies must be furnished when the SEHIP and your coverage are both in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition that began before the SEHIP or your coverage ends.

Chapter 8
COST SHARING

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Out-of-Pocket Maximum	$6,250 per individual, $12,500 per family Certain benefits pay at 100% of the allowed amount thereafter.	out-of-network services do not apply to the out-of-pocket

Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is specified in the table above. All cost-sharing amounts (calendar year deductible, copayment and coinsurance) for in-network covered services that you or your family are required to pay under the SEHIP apply to the calendar year out-of-pocket maximum. Once the maximum has been reached, covered expenses of the type that count towards the maximum will be paid at 100% of the allowed amount for the remainder of the calendar year.

There may be many expenses you are required to pay under the SEHIP that **do not** count towards the calendar year out-of-pocket maximum, and that you must continue to pay even after you have met the calendar year out-of-pocket maximum. The following are some examples:

- Out-of-network cost-sharing amounts (deductibles, copayments, coinsurance);
- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges);
- Amounts paid for services or supplies in excess of any plan limits (for example, a limit on the number of covered visits for a particular type of provider); and,
- Amounts paid as a penalty (for example, failure to pre-certify).

The calendar year out-of-pocket maximum applies on a per person per calendar year basis, subject to the family maximum.

The calendar year family out-of-pocket maximum is an aggregate dollar amount. This means that all amounts that count towards the individual calendar year out-of-pocket maximum will count towards the family aggregate amount. Once the family calendar year out-of-pocket maximum is met, affected benefits for all covered family members will pay at 100% of the allowed amount for the remainder of the calendar year.

Example: If one member in the family reaches the maximum of $6,250, that one member’s covered benefits would be covered at 100%. Out of pocket expenses for all other family members will continue to count toward the family maximum of $12,500.

Other Cost Sharing Provisions

The SEHIP may impose other types of cost sharing requirements such as the following:

- **Per admission deductibles:** These apply upon admission to a hospital. Only one per admission deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- **Copayments:** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor's office.

- **Coinsurance:** Coinsurance is the amount that you must pay as a percent of the allowed amount. A common example is the percentage of the allowed amount that you must pay when you receive services covered under major medical.
- **Amounts in excess of the allowed amount:** As a general rule, and as explained in more detail in Definitions, the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with BCBS or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount. For example: Out-of-network provider claims may include expensive ancillary charges (billed by the facility or a physician) such as implantable devices for which no extra reimbursement is available as these charges are not separately considered under the SEHIP. This means you will be responsible for these charges if you use an out-of-network provider.

Out-of-Area Services

BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of BCBS's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program and may include negotiated National Account arrangements available between BCBS and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the BCBS service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. BCBS in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBS will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside the BCBS service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to BCBS.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBS uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBS would then calculate your liability for any covered healthcare services according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the negotiated price [lower of either billed covered charges or negotiated price] (Refer to the description of negotiated price under Section A., BlueCard Program) made available to BCBS by the Host Blue.

C. Non-Participating Healthcare Providers Outside the Blue Cross and Blue Shield of Alabama Service Area

1. Member Liability Calculation
   When covered healthcare services are provided outside of BCBS service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

2. Exceptions
   In some exception cases, BCBS may pay such claims based on the payment BCBS would make if we were paying a non-participating provider inside of the BCBS service area, as described elsewhere in this benefit booklet, where the Host Blue's corresponding payment would be more than the BCBS in-service area non-participating provider payment, or in BCBS's sole and absolute discretion, BCBS may negotiate a payment with such a provider on an exception basis. In other exception cases, BCBS may use other payment bases, such as billed covered charges, to determine the amount BCBS will pay for services rendered by non-participating healthcare providers.

   In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment BCBS will make for the covered services as set forth in this paragraph.

Chapter 9
INPATIENT HOSPITAL BENEFITS

Pre-admission Certification and Post-admission Review

BCBS provides all health management for SEIB members and covered dependents. To be eligible for inpatient hospital benefits, all inpatient hospital admissions and stays (except medical emergencies that must have Post-admission Review) must be reviewed, approved, and certified by BCBS as medically necessary before you are admitted to the hospital.

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

To obtain pre-admission certification:

- You or your provider must telephone BCBS before the proposed elective admission at 1.800.551.2294. **It is your responsibility to make sure this is done. Failure to comply may result in reduced benefits.**
- BCBS will determine whether the proposed inpatient hospital admission and stay are medically necessary.

To obtain post-admission review:

- You, your provider or a person acting for you must telephone BCBS at 1.800.551.2294 with details of an elective admission prior to the admission. Admissions due to emergency diagnosis should be reported to BCBS no later than 72 hours after the admission. It is your responsibility to make sure this is done. After your admission, you or your physician may be asked to supply written information regarding your condition and treatment plan. Failure to comply may result in reduced benefits.
- Your provider and the hospital must provide BCBS with all medical records about your admission upon request.
- BCBS will determine whether the inpatient hospital admission and stay were medically necessary and whether the admission was for a medical emergency.

Subject to your rights of appeal, if you do not obtain pre-admission certification or post-admission approval of an inpatient hospital admission and stay, BCBS will pay no benefits for your hospital stay or for any related charges. If you obtain admission certification, but not within the specified time limits, you will be responsible for a $600 deductible for the admission instead of the normal $200. <u>It is your responsibility to make sure all procedures are correctly followed.</u>

Inpatient Hospital Benefits for Maternity

The SEIB may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the SEHIP or insurance issuer for prescribing a length of stay not in excess of the above periods. However, if the inpatient hospital stay is greater than 48 hours for vaginal delivery and 96 hours for Caesarean Section, post admission review must be obtained from BCBS.

NOTE: Newborns who remain hospitalized after the mother is discharged will require certification of medical necessity from BCBS.

Deductible

For each certified hospital admission, the deductible for inpatient hospital benefits is $200 (with a $25 per day copay for the second through the fifth day). You are responsible for payment of the deductible and copayment to the hospital. There is a separate deductible for each admission or readmission of each member to a hospital except when:

- there is more than one admission to treat the same pregnancy,
- two or more family members with family coverage are admitted for accidental injuries received in the same accident, or
- you are transferred directly from one hospital to another.

Inpatient Hospital Benefits in a Non-Participating Hospital in Alabama

If you receive inpatient hospital services in a non-participating hospital in the Alabama service area, no benefits are payable under the plan unless the services are to treat an accidental injury.

Women's Health and Cancer Rights Act

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema.

The attending physician and patient make treatment decisions. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Organ and Tissue Transplant Benefits

Inpatient and/or outpatient benefits are available for eligible transplantation services and expenses for the following organs and tissues:

- heart
- lungs
- liver
- cornea
- pancreas
- small bowel
- skin
- kidney
- bone marrow*
- heart-valve

* As used for the SEHIP, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

Benefits shall be payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in a hospital or facility with which BCBS has a written contract. (You may call Customer Service for the name of the facility nearest you.) The approval of a hospital or facility for transplantation services is limited to the specific types of organs and tissues stated in the approval.

For transplantation services to be considered eligible for coverage, prior benefit determination from BCBS shall be required in advance of the procedure. BCBS shall obtain the necessary medical information and make a determination as to whether the services are in accordance with generally accepted professional medical standards and not 'investigational.' (See "Definitions.")

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. The initial transplantation evaluation at the transplant facility does not require a prior benefit determination.

If the member is the recipient of a human organ or tissue transplant previously stated, donor organ procurement costs are covered, limited to search, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other medically necessary procurement costs.

Organ and Tissue Transplant Benefits are excluded:

- for services or expenses for replacements of natural organs with artificial or mechanical devices, in all hospitals and facilities for all organs without exception;
- when donor benefits are available through other group coverage;
- when government funding of any kind is provided;
- when the recipient is not covered under the SEHIP;
- for recipient or donor lodging, food or transportation costs;
- for donor and procurement services and costs incurred outside the United States.

Chapter 10
OUTPATIENT FACILITY BENEFITS

The benefits below are available for charges by a facility for the types of services and supplies listed (except bed, board, and nursing care) when ordered by a provider and provided as outpatient services:

- Charges to treat an accidental injury within 72 hours after the injury.
- Charges for outpatient surgery **after you pay a $150 copayment.**
- Charges for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention) **after a $150 copayment.** Claims with emergency room charges that do not meet medical emergency guidelines will be considered under Major Medical.
- Charges for medical services provided in a participating urgent care center **after a $50 copayment.**
- Charges for sleep disorder services rendered in an approved sleep disorder facility.
- Hospital charges for hemodialysis in its outpatient department **after you pay a $25 copayment**. Services received in a free-standing dialysis center are only covered under Major Medical.
- Bariatric Surgical Procedures are limited to one per lifetime, subject to prior authorization by BCBS. Benefits for these services are provided only when a PPO provider performs the services. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.
- Chemotherapy and radiation therapy services in the treatment of malignant disease **after a $25 copayment per visit.**
- Hemodialysis services **after a $25 copayment per visit.**
- IV therapy **after a $25 copayment per visit.**
- Laboratory and pathology services **after a $7.50 copayment per test.**
- X-ray services covered in full (except the procedures listed in the section entitled "Outpatient Diagnostic Procedures" that have a $75 copay).

Certain outpatient surgical procedures require prior authorization. Contact BCBS at 1.800.551.2294 before receiving the following services:

- Blepharoplasty
- Uvula procedure
- Reduction Mammoplasty
- Bariatric Surgery
- Septo/Rhinoplasty

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit.

Outpatient Hospital Benefits in a Non-Participating Hospital in Alabama

If you receive outpatient hospital services in non-participating hospital in the Alabama service area, no benefits are payable under the plan unless the services are to treat an accidental injury.

Chapter 11
OUTPATIENT DIAGNOSTIC PROCEDURES

It is your responsibility to make sure that your provider obtains prior authorization from CareCore National, BCBS's radiology review organization, for certain outpatient diagnostic procedures. Failure to comply may result in reduced benefits. If you do not obtain prior authorization of an outpatient diagnostic procedure listed below, BCBS will pay no benefits for your outpatient procedure or for any related charges. If you obtain prior authorization, but not within the specified time limits, you will be responsible for a **$25** penalty for the outpatient procedure. You are also responsible for being aware of the limitations of your benefits. The following outpatient diagnostic procedures are subject to a **$75** copay per test, limited to two co-payments per date of service, and require prior authorization:

- CAT Scan
- MRI
- PET Scan
- MUGA-gated Cardiac Scan
- Angiography/ Arteriography
- Cardiac Cath/Arteriography

The following outpatient diagnostic procedures are subject to a $75 copay per test, limited to two co-payments per date of service, and *do not* require prior authorization:

- Colonoscopy
- ERCP
- UGI endoscopy
- Thallium Scan

Chapter 12
UTILIZATION MANAGEMENT

Inpatient Hospitalization
It is your responsibility to notify BCBS about all admissions. Failure to notify BCBS may result in a **$600 deductible** on the hospital admission. NOTE: BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

Continued Stay Review
If your hospital stay must be extended beyond the days initially authorized, BCBS will contact your provider 24 hours before your scheduled discharge to obtain clinical data and process a request for extension-of-stay authorization. At the completion of the review, BCBS will confirm discharge or authorize additional days for your stay.

Determinations by BCBS to Limit or Reduce Previously Approved Care
If BCBS has previously approved a course of treatment to be provided over a period of time or number of treatments, and later decides to limit or reduce the previously approved course of treatment, BCBS will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules established for filing of your appeal, such as time limits within which the appeal must be filed.

Retrospective Review
If you fail to notify BCBS about a hospitalization you may request a Retrospective Review for medical necessity. Requests for retrospective review must be submitted to BCBS either in writing or by telephone. All information required to process the retrospective review must be submitted to Blue Cross within two years from the date the claims report is issued by BCBS.

In order to expedite the retrospective review process you may mail a copy of your medical records to BCBS. The records can be obtained from the hospital or treating provider. You will be responsible for any and all charges associated with retrieval and copying of medical records for medical review. Upon determination of medical necessity the claim will be processed according to the plan benefits and will include any applicable penalty for failure to pre-certify.

Maternity Management
"Baby Yourself", SEIB's Maternity Management Program offers a mechanism for identifying high-risk pregnancies and managing them to prevent complications at the time of delivery. As soon as a pregnancy is confirmed, the patient or the doctor should call BCBS at 1.800.551.2294. **By participating in "Baby Yourself" and notifying** BCBS **before the end of the second trimester, your inpatient deductible and applicable daily copay(s) will be waived.** After asking some questions regarding the pregnancy and medical history, BCBS's nurse contacts the doctor to obtain additional clinical information.

Following BCBS's evaluation, the expectant mother and the provider are sent information further explaining the program. Additionally, the expectant mother is sent a special Baby Yourself kit that includes educational materials related to pregnancy and childcare.

Case Management
You may be eligible to receive certain alternative benefits through individual case management when your condition is catastrophic or requires long term care. The program is administered by BCBS. To contact them call 1.800.551.2294.

If BCBS determines that you are a suitable candidate for individual case management, they will notify you. The letter will tell you that you are eligible to receive Alternative Benefits if you, your provider and BCBS can agree to an Alternative Benefit plan. Except for exceptions stated in your Alternative Benefits plan, all terms and conditions of the contract apply to you while you receive Alternative Benefits.

Alternative Benefits are available to you only when they replace services, care, treatment or supplies covered by another section of this contract. For example, alternative benefits may not be made available as an alternative to any benefit excluded (such as radial keratotomy).

Because individual case management is designed to provide the most appropriate benefits for each individual case, the Alternative Benefits plan for any member may differ from another member's plan even if they have the same medical condition. Providing Alternative Benefits to you or any other member is not to be construed as a waiver of the right to administer and enforce the contract exactly as it is written.

If you believe that you should receive Alternative Benefits, you may write BCBS explaining the reasons for your belief. If BCBS determines that you are a candidate for individual case management, they will contact you and begin the process. If BCBS determines that your medical condition does not make you a suitable candidate for Alternative Benefits or it is determined that you are not eligible for Alternative Benefits, they will write you of that decision. After receiving the decision you may write for reconsideration stating all the reasons why you believe that you are still entitled to Alternative Benefits. You may also submit any additional written information that you think is related to your request for reconsideration. If you fail to submit a request for reconsideration within sixty days of the decision you waive any right to challenge that decision later.

You must follow the procedures in this section before you can bring legal action against BCBS for Alternative Benefits. This does not change your right to have individual claims reviewed under the section titled "Filing a Claim, Reviewing Claim Decision and Appeal of Benefit Denial."

BCBS will terminate your Alternative Benefits when any of the following happens:

- The time limit (if any) of the written Alternative Benefits plan expires.
- BCBS determines that the Alternative Benefits being provided to you are no longer Medically Necessary or are no longer cost effective.
- You receive care, treatment, services, or supplies that are not set forth in the Alternative Benefits plan. This does not apply if care, treatment, services or supplies were for a separate medical condition.
- Your coverage ends.
- You tell BCBS, in writing, that you wish to stop Alternative Benefits. This will terminate your Alternative Benefits no more than five days after receipt of your notice by BCBS.

Disease Management

Disease Management is a program for members diagnosed with Diabetes, Coronary Artery Disease, or Chronic Obstructive Pulmonary Disease (COPD). This program is available to eligible members at no cost as a part of your benefits.

Blue Cross translates your doctor's treatment plan into daily actions to improve your health. They educate you in the disease process in hopes of avoiding relapses that can lead to hospital and emergency room visits.

First, Blue Cross identifies members who would benefit from the program by analyzing medical and pharmaceutical claims. Once identified, an invitation and welcome kit is mailed.

Working with you and your doctor, a health care professional specializing in your condition develops your personal health goals such as losing weight or lowering your blood pressure or blood sugar. You get support to help you reach your goals.

Everything about the program is confidential. Only you, your doctor and Blue Cross know you are in the program. Call Blue Cross at 1.800.551.2294

Appeal of Utilization Management Decision

BCBS provides a three-step appeals process that either the patient or the attending provider can initiate. All information required to process the appeal must be submitted to BCBS within one year from the date the claims report is issued by Blue Cross Blue Shield.

"Peer to Peer" Review

The attending provider can initiate **a peer to peer review** by contacting BCBS at 1.800.551.2294 **or 1.866.578.7395** to discuss any case for which requested services were reduced or non-authorized. Based on the telephone discussion, the BCBS physician will determine whether the original decision was appropriate or should be amended. Proper documentation is provided to the patient and the attending provider after the review.

Appeal

When a disagreement between the attending provider and a BCBS physician is not resolved by **a peer to peer review**, review of the case can be initiated by the attending provider and/or patient via a telephonic or written request to:

Blue Cross Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298
1.800.551.2294

Medical records are obtained and reviewed once a written release has been received from the patient. If the Committee finds additional medical information to justify the authorization, the services are certified. If not, the non-authorization is upheld. If an original adverse decision is reversed by the Committee, the attending provider, patient and claims office are notified in writing.

Independent Review

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with BCBS for an independent, external review of the decision. You must request this external review within 4 months of the date of your receipt of adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 10744
Birmingham, AL 35202-0744

If you request an external review, an independent organization will review BCBS's decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will provide BCBS with copies of this additional information to give allow BCBS an opportunity to reconsider the denial. Both will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding, subject to arbitration.

Chapter 13
ROUTINE PREVENTIVE CARE

Routine immunizations and preventive care services when provided by an in-network PPO provider are covered at 100% of the BCBS allowable rate with no deductible or copayment.

Visit www.bcbsal.com/preventiveservices for a listing of specific immunizations and preventive care service. Please note that this list is subject to change. In addition to the services listed on the website, the following preventive services are also provided at 100% of the allowable rate with no deductible or copayment;

- Urinalysis (once by age 5, then once between ages 12-17)
- CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and older)
- Glucose testing (once every calendar year age 18 and older)
- Cholesterol testing (once every calendar year age 18 and older)
- TB skin testing (once before age 1, once between ages 14-18)

Routine immunizations and preventive care services when provided by an out-of-network or non-PPO provider are covered at 80% of the allowable rate, subject to the calendar year deductible.

Chapter 14
PREFERRED PROVIDER ORGANIZATION (PPO)

When you use a PPO Provider for services or treatment other than routine preventive services, you will receive enhanced benefits. When you DO NOT use a PPO Provider for services covered under the PPO program, covered services are paid at 80% of the PPO fee schedule under Major Medical subject to the deductible.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. Please call 1.800.810.BLUE (2583) or access the Blue Cross website at www.bcbs.com/healthtravel/finder.html to find out if your provider is a PPO member.

Preferred Provider (PPO) Benefits for Physicians, Nurse Practitioners, and Physicians Assistants

To take advantage of PPO benefits, simply choose a PPO Provider from the BlueCard PPO directory. Your provider will file all claims for PPO benefits. When your PPO provider requests the services of another provider for you, that provider must also be a PPO Provider in order for you to receive PPO benefits for his or her services, i.e., an anesthesiologist when surgery is performed or an independent laboratory or radiologist for diagnostic services.

- **Office Care Services** - the examination, diagnosis, and treatment for an illness or injury in a PPO Provider's office. The term treatment is inclusive of in-office minor surgery. **You must pay a $35 Physician copay or a $20 Nurse Practitioner or Physician Assistant copay for each visit.**
- **Surgical Care Services -** services for operations and cutting procedures and the usual care before and after operations, for reducing fractures and dislocations, for the endoscopic procedures recognized and accepted by Blue Cross, and of an assisting provider who assists in performance of surgical procedures when medically necessary. Surgeries performed in the office are subject to a **$35 copay**.
- **Inpatient Medical Care Services -** visits by a PPO Provider for your care or treatment while you are an inpatient and entitled to inpatient hospital benefits under this contract. However, you will not receive benefits for inpatient medical care services if you receive benefits for surgical care, obstetrical care, or radiation therapy services during the same hospital stay because medical care services are included in the surgical, obstetrical or radiation therapy fee. However, if Blue Cross decides inpatient medical care was medically necessary and unrelated to the condition for which you were hospitalized you will receive medical care services benefits.

  You will not be responsible for non-covered medical services when you use a PPO Provider, except when there is a signed agreement on file in the PPO Provider's office, taking patient responsibility for non-covered services. In which case, you will be responsible for the total charges for the non-covered medical services.
- **Consultation Services** - limited to one consultation each for medicine, surgery, and maternity by a PPO Provider while an inpatient during each period of continual hospitalization. The consultation must be for an illness or injury requiring the special skill or knowledge of the PPO Provider.
- **Diagnostic X-ray -** services are covered in full.
- **Outpatient Diagnostic Lab and Pathology -** coverage is provided for outpatient diagnostic lab and pathology services when performed by a PPO Provider. **The member pays $7.50 copay per test**.
- **Emergency Room Physician Services** - care and treatment by a PPO Provider in hospital emergency rooms in an emergency other than for surgery or childbirth. **You must pay a $35 Physician copay or a $20 Nurse Practitioner or Physician Assistant copay for each visit.**

Chapter 15
MENTAL HEALTH & SUBSTANCE ABUSE PREFERRED PROVIDER ORGANIZATIONS

The SEHIP is designed to provide the following mental health and substance abuse benefits:

- Outpatient Care
  - —- Individual Therapy/Counseling
  - —- Family Therapy/Counseling
- Emergency Services
- Inpatient and Outpatient Services in a SEIB Approved Facility
- Alcohol and Drug Abuse Counseling

Your benefit coverage will vary depending on whether you choose an approved or non-approved provider. Your coverage with an approved provider is as follows:

Approved Outpatient Providers - When you visit a Certified Regional Mental Health Center or other approved provider outpatient treatment for mental and nervous disorders will be covered up to a maximum of 20 visits each calendar year at $14 copay per visit. (Other copayments may apply based on the services received.) Mental illness day hospitalization, intensive day treatment and supportive day treatment are covered up to a maximum of 60 days each calendar year at 80% of fee schedule with no deductible. You can receive up to 40 outpatient substance abuse sessions covered at 100% of fee schedule with no deductible at an approved day/evening or weekend treatment program.

Approved Inpatient Providers - Inpatient psychiatric care and substance abuse treatment received at an approved SEIB Facility will be covered at 80% of fee schedule with no deductible. You are responsible for the 20% copayment.

To be eligible for inpatient facility benefits, all inpatient admissions and stays must be reviewed, approved, and certified by BCBS as medically necessary. The SEIB contracts with BCBS for Utilization Management. BCBS can be reached at 1.800.551.2294.

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

To take advantage of benefits provided by the approved providers under the SEIB's Preferred Provider Organization (PPO), contact SEIB, BCBS Customer Service, or visit www.bcbsal.org. When you make an appointment identify yourself as having the SEIB's Mental Health and Substance Abuse PPO.

Non-approved Outpatient Providers - When you use a non-approved mental health provider for outpatient mental and nervous and-or substance abuse, services will be covered up to a maximum of 20 visits per calendar year at 80% of fee schedule after a $300 deductible. You will be responsible for 20% of fee schedule, **plus** any difference between the fee schedule amount and the amount the provider charges. There is no coverage for services provided by a non-approved facility that is solely classified as a **substance abuse outpatient or residential facility.**

Non-approved Inpatient Providers - Inpatient psychiatric care and substance abuse treatment received at a non-approved hospital will be covered at 80% of fee schedule after a $100 deductible per admission. You are responsible for 20% of fee schedule, plus any difference between the fee schedule amount and the amount that the Facility charges. This amount can be substantial, as much as 40% of your bill, and is not eligible for coverage under any other part of your contract. Admission Precertification is the same as in an Approved Facility.

Note: The term "fee schedule" refers to the SEIB's negotiated fee that the approved facilities and providers have agreed to accept for providing psychiatric or substance abuse services. The fee schedule applied to non-approved facilities is consistent with the fee paid to the approved facilities.

A comprehensive listing of all approved mental health providers is available on the Blue Cross Blue Shield website at www.bcbsal.org

Chapter 16
PARTICIPATING CHIROPRACTOR BENEFITS

The Participating Chiropractor Program offers members several advantages when they visit a Participating Chiropractor. Services are covered at 80% of the Chiropractic Fee Schedule with no deductible. Participating Chiropractors have agreed to file all claims and accept Blue Cross' payment (along with the 20% coinsurance due from the patient) as payment in full; the patient will not be balance-billed for any "over-range" charges. All benefit payments will go to the Participating Chiropractor.

Precertification is required after the 18th visit. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.

If precertification is denied, you will have the right to appeal the denial.

Chapter 17
PRESCRIPTION DRUG BENEFITS

To take advantage of the program, you should choose a Participating Pharmacy and show your ID card to the pharmacist. The Participating Pharmacist will file all claims for you. There are no benefits available for prescriptions that are purchased at a non-participating pharmacy. There are no benefits available if you fail to show your ID card to the pharmacist.

A Participating Pharmacy is any pharmacy that has contracted with BCBS for the furnishing of prescription drugs. Eligible prescriptions are legend drugs prescribed by a provider. A legend drug is a medical substance whose label is required by the Federal Food, Drug and Cosmetic Act to bear the legend "Caution: Federal Law prohibits dispensing without a prescription."

In 2002, the Alabama Legislature enacted a law that requires a pharmacist to dispense a generic equivalent medication to fill a prescription for a member covered by SEHIP when one is available unless the physician indicates in longhand writing on the prescription “Medically Necessary” or “Dispense as Written” or “Do Not Substitute.” The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent and contain the same active ingredient, or ingredients, and shall be of the same dosage, form and strength.

BCBS reserves the right to place limits on or require prior approval on certain medications.

Generics First

When you get a prescription for a Brand name drug that has a Tier 1 generic equivalent, you must first try the generic equivalent drug in order for your prescription to be covered by your prescription drug program. The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent and contain the same active ingredient, or ingredients, and shall be of the same dosage, form and strength as the Brand name drug. If you choose to get the Brand name drug without trying the generic equivalent first there will be no coverage for the Brand name drug.

If you have a failed trail of the generic equivalent drug, your health care provider can request a plan exception documenting the medical necessity for the Brand drug. If the request is approved, the physician must indicate in longhand writing on the prescription “Medically Necessary” or “Dispense as Written” or “Do Not Substitute.”

Generics costing more than $50 for a 30-day supply will be considered as a Tier 2 drug.

To search for your prescription drug coverage, visit **www.bcbsal.com** and login to *my*BlueCross. Select “Find Drugs/Pricing/Mail Order” located under *Manage My Prescriptions*. This online tool can also help you research therapeutic alternatives. There may be more than one drug available to treat your health condition. These drugs are known as therapeutic alternatives and may help save you money.

Eligible prescription drugs dispensed by a Participating Pharmacy will be covered as follows:

Active employees and Non-Medicare retirees

Tier 1 – low cost generics

- **$10 copay for 30-day Supply**
- **$10 copay for 60-day Maintenance Drug Supply**
- **$15 copay for 90-day Maintenance Drug Supply**

Tier 2 – high cost generics and preferred brand drugs

- **30-day Supply -** 20% of the cost of the prescription with a minimum copay of $25 and a maximum copay of $40 per prescription
- **60-day Maintenance Drug Supply -** 20% of the cost of the prescription with a minimum copay of $25 and a maximum copay of $40 per prescription

Tier 3 – non-preferred brand drugs

- **30-day Supply -** 20% of the cost of the prescription with a minimum copay of $55 and a maximum copay of $105 per prescription

Tier 4 – specialty drugs

- **30-day Supply -** 20% of the cost of the prescription with a minimum copay of $55 and a maximum copay of $105 per prescription

(Tiers 3 & 4 prescriptions are only allowed in a 30 day supply even if they are classified as maintenance drugs.)

In order for a drug to be considered a Maintenance Drug, the drug must meet the all following Maintenance Drug Criteria:

1. The drug has low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic response over a course of prolonged therapy.
2. The drug's most common use is to treat a chronic disease state.
3. The drug is administered continuously rather than intermittently.
4. Excluded are dosage forms that are not practical for large dispensing quantities (such as liquids) and drugs known for life-threatening toxicity when taken as an intentional overdose.
5. The drug is an SEIB Tier 1 or Tier 2 drug.

The drug lists are also available on BCBS's website at www.bcbsal.org. **Please note that the drug list and/or formulary are subject to change without notice.** BCBS reserves the right to place limits on or require prior approval on certain medications.

Medicare Retirees Enrolled in SEHIP EGWP

To take advantage of the SEHIP EGWP, you have to use a participating pharmacy in the Blue Rx network. The participating pharmacy will file the claims for you. **There are no SEHIP EGWP benefits available for prescriptions that are purchased at a non-participating pharmacy.**

SEHIP EGWP copayments are:

Preferred/Extended Supply Network Pharmacy: Tier 1 Drugs

- **$10 copay for 30-day supply**
- **$10 copay for 60-day supply**
- **$10 copay for 90-day supply**

Non-Preferred Pharmacy: Tier 1 Drugs

- **$10 copay for 30-day supply**
- **$10 copay for 60-day supply**
- **$15 copay for 90-day supply**

Preferred/Extended Supply Network Pharmacy: Tier 2 Drugs

- **$30 copay for 30-day supply**
- **$30 copay for 60-day supply**
- **$30 copay for 90-day supply**

Non-Preferred Pharmacy: Tier 2 Drugs

- **$30 copay for 30-day supply**
- **$30 copay for 60-day supply**
- **$55 copay for 90 day supply**

Preferred/Extended Supply Network Pharmacy: Tier 3 and 4 Drugs

- **$60 copay for 30-day supply**
- **$60 copay for 60-day supply**
- **$60 copay for 90-day supply**

Non-Preferred Pharmacy: Tier 3 and 4 Drugs

- **$60 copay for 30-day supply**
- **$60 copay for 60-day supply**
- **$115 copay for 90-day supply**

$0 copay for Zostavax (shingles), Flu and Pneumonia Vaccines when administered at a Blue Rx pharmacy. If administered at physician's office or non-Blue Rx pharmacy, vaccines was covered under Medicare Part B.

NOTE: All Medicare Part B-eligible prescription drugs, to include Flu, Pneumonia and Hepatitis Vaccines and all diabetic supplies are excluded from EGWP coverage since they are covered by Part B.

Drugs **purchased at an out-of-network pharmacy** may be covered under certain circumstances, such as for an illness while traveling outside the plan's service area where a network pharmacy is unavailable. Drugs purchased at an out-of-network pharmacy may require higher cost-sharing. Additionally, you may have to pay the full charge for the drug and submit documentation to receive reimbursement.

If you are not enrolled in EGWP, you have no prescription drug coverage through the State Employees' Health Insurance Plan. Please see the EGWP plan documents to know the rules you must follow to receive coverage with this Medicare prescription drug plan.

Coverage for Fertility Drugs

The copay for oral and injectable fertility drugs will be 50% of the allowable charge.

Chapter 18
TOBACCO CESSATION PROGRAM

Tobacco Cessation Program

A Tobacco Cessation Program is now provided by the SEIB for its covered members. Program literature can be obtained through our Wellness Program and on our website. For more information about available programs, call ***Alabama's Tobacco Quitline at 1.800.QUIT.NOW (1.800.784.8669)***.

American Cancer Society	*www.cancer.org* *www.everydaychoices.org*
Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov
National Cancer Institute	www.cancer.gov
American Lung Association	www.lung.org
Mayo Clinic	www.mayoclinic.org

The SEIB will reimburse each member 80% of the cost of the program, with no deductible. There is a lifetime maximum benefit of $150. Tobacco cessation seminars and all forms of nicotine replacement are covered services. Forward your name, address, contract number and a copy of tobacco cessation program receipts to:

State Employees' Insurance Board
Wellness Division
PO Box 304900
Montgomery, Al. 36130-4900

Prescription medications for tobacco cessation are covered through the Prescription Drug Program and are not subject to the $150 lifetime maximum benefit.

All claims must be filed with the SEIB, not BCBS.

Chapter 19
PHYSICIAN SUPERVISED WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING PROGRAMS

The SEIB will cover approved physician supervised weight management and nutritional counseling programs. The SEIB will reimburse up to 80% of the cost of a physician supervised weight management program and/or nutritional counseling, with no deductible, not to exceed $150 per calendar year. You can apply for reimbursement by forwarding your name, address, contract number, daytime phone number, copy of the program receipt(s), and program contact information to:

State Employees' Insurance Board
Wellness Division
PO Box 304900
Montgomery, AL 36130-4900
866.838.3059

Medications, either by prescription or over the counter, are excluded from the program. Food and Dietary Supplements, except for those distributed by the Physician Supervised Weight Management Plan, are excluded from the program.

You must file your claims for this benefit with the SEIB, not BCBS.

Chapter 20
DISCOUNTED VISION CARE PROGRAM

The SEIB has contracted independently with eye care providers across the state to form the Routine Vision Care Network. **This is not a Blue Cross provider network**. Check with your provider or visit our web page at www.alseib.org prior to receiving services to determine whether the provider is a participating provider.

Under the Routine Vision Care Network, participating providers will offer the following discounted services:

Routine vision examination (one per year)…….……..…. $40 Member payment
Routine vision examination-with dilation (one per year)……..……$45 Member payment
Initial contact lens fitting…….…… $25 Member payment*
Follow-up contact lens visit…….……..……$25 Member payment

* Initial contact lens fitting fee of $25 is in addition to the routine vision examination fee.

Routine vision care examinations, initial contact lens fitting and follow-up contact lens visits are subject to the member payments stated above and will be accepted by the participating provider as full and complete. Be sure you identify yourself as a state employee before receiving services.

Laser vision corrective surgery is available at a discounted rate through Participating Vision Care Providers. You may obtain a list of Participating Providers at the SEIB at www.alseib.org or contact the SEIB at 1.866.836.9737.

Chapter 21
MAJOR MEDICAL BENEFITS

Services not covered under the BlueCard PPO program are paid at 80% of the allowed amount as Major Medical benefits after a $300 calendar year deductible, maximum of 3 deductibles per family. Major Medical deductibles and coinsurance apply to annual out-of-pocket maximums of $6,250 for individuals and $12,500 aggregate for families.

Only one deductible is applicable to covered Major Medical expenses incurred for treatment of accidental injuries received in the same accident by two or more family members with family coverage.

You are responsible for payment of your covered Major Medical expenses to which the deductible applies.

Covered Major Medical Expenses

Some of the most frequently utilized major medical services are listed below. Contact BCBS Customer Service at 1.800.824.0435 for specific coverage questions prior to services being provided.

- Semi-private room and board, general nursing care and all normal and necessary hospital services and supplies when hospital benefits have expired, subject to the requirements and limitations of preadmission certification and post admission review.

- Allergy testing and treatment. This coverage is offered only under the Major Medical benefit regardless of whether a PPO provider is used.

- Diabetic education is covered at 100% of the allowance, with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1.800.551.2294.

- Prosthetic devices such as an artificial arm and orthopedic devices such as a leg brace.

- Medical supplies such as oxygen, crutches, splints, casts, trusses and braces, catheters, colostomy bags and supplies and surgical dressings.

- Professional ambulance service approved by BCBS to the closest hospital that could furnish the treatment needed for your condition.

- Rental of durable medical equipment prescribed by a provider for therapeutic use in a member's home, limited to the amount of its allowed purchase price. If you can buy it for less than you can rent it, or if it is not available for rent, BCBS will pay its reasonable and customary purchase price. Some examples of durable medical equipment are wheelchairs and hospital beds.

- Hemodialysis services provided by a Participating Renal Dialysis Facility.

- Private duty nursing services of a licensed registered nurse (RN) or a licensed practical nurse (L.P.N.) if: the services actually require the professional skills of an RN or L.P.N.; are provided outside a hospital or other facility; and are provided by a person not related to you by blood or marriage or a member of your household. No benefits are provided for custodial care. In order to be covered, private duty nursing services **must** be certified through case management prior to services being provided; call 1.800.551.2294.

- Home health care is covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency. It is your responsibility to make sure that precertification has been obtained. Call 1.800.551.2294.

- Physical therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that precertification has been obtained. Please call 1.800.551.2294.

- Speech therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that preauthorization has been obtained. Please call 1.800.551.2294.

- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that precertification has been obtained. Please call 1.800.551.2294.

Chapter 22
SUPPLEMENTAL ACCIDENT BENEFITS

Supplemental Accident Benefits are provided when a member suffers accidental bodily injury. Treatment, care and services for the injury must be provided within 90 days of the date of the accident, must be medically necessary, and must be rendered, ordered or prescribed by the member's physician. (The injury must occur after the effective date of this benefit.)

Benefits are provided up to a MAXIMUM OF $500 for care because of a single accident. These benefits pay ***after Major Medical*** benefits are paid. The Major Medical coinsurance and deductible (or any portion remaining) that you pay will be paid as a part of the $500 maximum. (However, this will not reduce your Major Medical deductible amount for future Major Medical covered medical expenses.)

Covered services under this Supplemental Accident rider include:

- $35 PPO provider or $20 Nurse Practitioner or Physician Assistant office visit copay.
- Services of a provider for medical care and treatment and for surgical operations and procedures.
- Outpatient services provided by a hospital.
- X-ray and laboratory examinations and diagnostic tests.
- Professional ambulance service to the nearest hospital able to provide necessary care, when certified as necessary by a physician.
- Pre-certified private duty nursing services of a licensed professional nurse or licensed practical nurse that is neither related to the member by blood or marriage nor regularly resides in the member's home (if such nursing care is medically necessary).
- Anesthetics, including supplies and use of equipment, and the administration of anesthetic drugs and agents.
- Oxygen and use of equipment for its administration.
- Treatment by a provider of injuries to natural teeth, including replacement of the injured teeth.
- Purchase or rental of durable medical equipment.

The following services **are not** covered under the Supplement Accident rider:

- PPO Services (except $35 PPO Physician or $20 Nurse Practitioner **or** Physician Assistant office visit copay)
- Eye refractions;
- Fitting or furnishing of eyeglasses;
- Inpatient expenses from a hospital (i.e., hospital deductible, copays, private room difference, non-covered services);
- Services or expenses from a Doctor of Chiropractic (DC);
- Prescription drugs and medicines
- Charges incurred for accidental injury to natural teeth caused by a force inside the body or the oral cavity (mouth) including but not limited to biting, chewing, clenching and grinding.
- Orthodontics

Chapter 23
MEDICAL EXCLUSIONS

In addition to other exclusions set forth in this handbook, the SEHIP will not provide benefits for the following, whether or not a Provider performs or prescribes them:

A

- Services or expenses for elective **abortions**.
- Services or expenses for **acupuncture**, biofeedback, and other forms of self-care or self-help training.
- **Anesthesia** services or supplies or both by local infiltration.
- Services, care, treatment, or supplies furnished by a provider that is not recognized by BCBS as an **approved provider** for the type of service or supply being furnished. For example, the SEHIP reserves the right not to pay for some or all services or supplies furnished by certain persons who are not medical doctors (M.D.s), even if the services or supplies are within the scope of the provider's license. Call BCBS Customer Service if you have any question as to whether your provider is recognized as an approved provider for the services or supplies that you intend to receive.
- Services or expenses for or related to **Assisted Reproductive Technology (ART)**. ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

C

- Services or expenses of a hospital stay, except one for an emergency, unless BCBS has approved and pre-**certified** it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 72 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.
- Services or expenses for which a **claim** is not properly submitted to Blue Cross.
- Services or expenses for a **claim we have not received within 12 months** after services were rendered or expenses incurred.
- Services or expenses for personal hygiene, **comfort or convenience** items such as: air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.
- Services or expenses for sanitarium care, **convalescent care**, or rest care, including care in a nursing home.
- Services or expenses for **cosmetic surgery**. Cosmetic surgery is any surgery done primarily to improve or change the way one appears. “Reconstructive surgery” is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. (See “Women’s Health and Cancer Rights Act” for exceptions.) Complications or later surgery related in any way to

- cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.
    - You may contact BCBS prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.
    - Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.
- Services or expenses for treatment of injury sustained in the commission of a **crime** (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.
- Services or expenses for **custodial care**. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

D

- **Dental** implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.
- Services for or related to a **dependent pregnancy**, including the six-week period after delivery. A dependent pregnancy means the pregnancy of any dependent other than the contract holder's wife.

E

- Services, care, or treatment you receive after the **ending date of your coverage.** This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.
- Prescription drugs for **erectile dysfunction**.
- **Eyeglasses** or contact lenses or related examinations or fittings.
- Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.

F

- Services or expenses in any **federal hospital or facility** except as required by federal law.

- Services or expenses for routine **foot care** such as removal of corns or calluses or the trimming of nails (except mycotic nails).

G

- Unless otherwise required by applicable law, services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other **governmental** agency that provides or pays for care, through insurance or any other means.

H

- **Hearing aids** or examinations or fittings for them.

I

- **Investigational** treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including investigational services that are part of a clinical trial. Under federal law, the plan cannot deny a member participation in an approved clinical trial, is prohibited from dropping coverage because member chooses to participate in an approved clinical trial, and from denying coverage for routine care that the plan would otherwise provide just because a member is enrolled in an approved clinical trial. This applies to all approved clinical trials that treat cancer or other life-threatening diseases.

L

- Services or expenses that you are not **legally obligated to pay**, or for which no charge would be made if you had no health coverage.

- Services or expenses for treatment which does not require a **licensed provider**, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency, or duration.

M

- Services or expenses we determine are not **medically necessary**.

- Services or supplies to the extent that a member is, or would be, entitled to reimbursement under **Medicare**, regardless of whether the member properly and timely applied for, or submitted claims to Medicare, except as otherwise required by federal law.

- Care and treatment for **mental health** disorders or disease (including substance abuse).

N

- Services or expenses of any kind for **nicotine addiction** such as smoking cessation treatment. The only exception to this exclusion is expenses for nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist from an in-network pharmacy.

- Services or expenses of any kind provided by a **Non-Participating Hospital** located in Alabama for Major Medical benefits or any other benefits under this contract except inpatient and outpatient hospital benefits in case of accidental injury.

- Services, care or treatment you receive during any period of time with respect to which payment for your coverage has not been made and that **nonpayment** results in termination of coverage.

O

- Services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, that is based upon weight reduction or dietary control. This exclusion does not apply to Bariatric Surgical procedures if medically necessary and in compliance with BCBS's guidelines. Bariatric Surgical procedures are limited to one per lifetime, subject to prior authorization. Benefits are those services are provided only when the services are performed by a PPO Provider. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.
- Services or expenses provided by an **out-of-network provider** for any benefits under this plan, unless otherwise specifically stated in the plan.

P

- **Physical, Speech, and/or Occupational therapy** for the 16th and subsequent visits that were not preauthorized.
- **Private duty nursing**.

R

- Services or expenses for **recreational** or educational therapy.
- Hospital admissions in whole or in part when the patient primarily receives services to **rehabilitate** such as physical therapy, speech therapy, or occupational therapy.
- Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical therapist.
- **Room and board** for hospital admissions in whole or in part when the patient primarily receives services that could have been provided on an outpatient basis based upon the patient's condition and the services provided.
- **Routine well child care** and routine immunizations except for the services described in "Routine Preventive Benefits."
- **Routine physical examinations** except for the services described in "Routine Preventive Benefits."

S

- Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition) or which are related to surgical sex transformations.
- **Sleep studies** performed outside of a healthcare facility, such as home sleep studies, whether or not supervised or attended.
- Services or expenses of any kind for or related to reverse **sterilizations**.
- Services or supplies for substance abuse including any service furnished by a **substance abuse residential facility**.

T

- Services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which

contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. For example, braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw or because of injury of natural teeth. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under major medical.

- Services provided through **teleconsultation**.

- Dental treatment for or related to **temporomandibular joint (TMJ) disorders**. This includes Phase II according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.

- Services, supplies, implantable devices, equipment and accessories billed by any out-of-network **third party vendor** that are used in surgery or any operative setting. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.

- Services or expenses for or related to organ, tissue or cell **transplants** except specifically as allowed by this plan.

- **Travel**, even if prescribed by your physician (not including ambulance services otherwise covered under the plan).

W

- Services or expenses for an accident or illness resulting from active participation in **war**, or any act of war, declared or undeclared, or from active participation in riot or civil commotion.

- Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation is available in whole or in part under the provisions of any **workers' compensation** or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the group. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your group has insurance coverage for benefits under the law.

Chapter 24
RESPECTING YOUR PRIVACY

Privacy of Your Protected Health Information

The confidentiality of your personal health information is important to the SEIB. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the SEHIP's notice of privacy practices. You may request a copy of this notice by contacting the SEIB.

Disclosures of Protected Health Information to the Plan Sponsor:

In order for your benefits to be properly administered, the SEHIP needs to share your protected health information with the plan sponsor (the State of Alabama). Following are circumstances under which the SEHIP may disclose your protected health information to the plan sponsor:

- The SEHIP may inform the plan sponsor whether you are enrolled in the SEHIP.
- The SEHIP may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The SEHIP may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the SEHIP.

Following are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the SEHIP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you or the SEHIP to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the SEHIP must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the SEHIP to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.

- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the SEHIP and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the SEHIP or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- Benefits Administration and Operations
- Legal
- Finance

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions – which may include termination of employment. If the plan sponsor becomes aware of any such violation, the plan sponsor will promptly report the violation to the SEIB and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

Security of Your Personal Health Information:

Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.

- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

The plan sponsor will report to the SEIB any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information:

As a business associate of the SEIB, BCBS has an agreement with the SEIB that allows BCBS to use your personal health information for treatment, payment, healthcare operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the SEHIP, you agree that BCBS may obtain, use and release all records about you and your minor dependents that BCBS needs to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to BCBS about you and your minor dependents that BCBS needs in order to administer the plan.

HIPAA Exemption: As a non-federal governmental health plan, the State of Alabama can elect to exempt the SEHIP from certain provisions of HIPAA. The State of Alabama has elected to exempt the SEHIP from the following HIPAA requirement:

Parity in the application of certain limits to mental health benefits: Group health plans that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The privacy provisions of the Health Insurance Portability and Accountability Act require that you be notified at least once every three years about the availability of the SEIB's privacy practices [45 CFR 164.520(c)(1)(ii)]. Accordingly, you may obtain a copy for our privacy practices by going to our website at www.alseib.org or you can request a copy by writing to us at:

State Employees' Insurance Board
Attn: Privacy Officer
P. O. Box 304900
Montgomery, AL 36130-4900.

Chapter 25
GENERAL PROVISIONS

Delegation of Discretionary Authority to Blue Cross

The SEIB has delegated to BCBS the discretionary responsibility and authority to determine claims under the SEHIP, to construe, interpret, and administer claims, and to perform every other act necessary or appropriate in connection with claims administration services under the SEHIP.

Whenever BCBS makes reasonable determinations that are neither arbitrary nor capricious in the administration of claims of the SEHIP, those determinations will be final and binding on you, subject only to your right of review under the SEHIP.

Incorrect Benefit Payments

Every effort is made to process claims promptly and correctly. If payments are made to you or to a provider who furnished services or supplies to you, and BCBS finds at a later date that the payments were correct,
you or the provider will be required to repay any overpayment or BCBS may deduct the amount of the overpayment from any future payment to you or the provider. If BCBS does this, they will notify you.

Responsibility for Actions of Providers of Services

BCBS and the SEIB will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. BCBS and SEIB will not be responsible if any provider of service fails or refuses to admit you to a facility, or treat you, or provide services to you. BCBS and SEIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

Any misrepresentation by you in application for or in connection with coverage under the contract will make your coverage invalid as of your effective date, and in that case BCBS and SEIB will not be obligated to return any portion of any fees paid by or for you. Any misrepresentation by SEIB in application for or in connection with the contract will make the entire contract invalid as of the contract effective date, and in that case BCBS will not be obligated to return any fees paid by the group for you or any other member.

Any employee or retiree knowingly and willfully submitting materially false information to the SEIB or engaging in fraudulent activity that causes financial harm to the SEHIP, may be required, upon a determination by the SEIB, (1) to repay all claims and other expenses, including interest, incurred by the plan related to the intentional submission of false or misleading information or fraudulent activity and (2) be subject to disqualification from coverage under the SEHIP.

Obtaining, Use and Release of Information

By submitting your application for coverage or any claims for benefits you authorize BCBS to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records which in its judgment are necessary or desirable for processing your claim, performing our contractual duties or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to BCBS any such records or information it requests. Further you authorize BCBS to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither BCBS or any provider or other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

Responsibility of Members and Providers to Furnish Information

By submitting an application for coverage or a claim for benefits you agree that in order to be eligible for benefits:

A claim for the benefits must be properly submitted to and received by BCBS.

A provider, hospital, or other provider that has furnished or prescribed any services or supplies to a member must provide the records, information, and evidence BCBS requests in connection with benefits claimed or paid for the services or supplies.

A member who receives services or supplies for which benefits are claimed must provide the records, information and evidence BCBS requests.

Refusal by any member or provider of services to provide BCBS records, information, or evidence reasonably requested will be grounds for denial of any further payments of benefits to or for this member or provider.

Providers of Services Subject to Contract Provisions

Any hospital, provider, or other provider of services or supplies for which benefits are claimed or paid will be considered, through acceptance of the benefits or payment, to be bound by this contract's provisions.

Benefit Decisions

By submitting a claim for benefits you agree that any determination BCBS makes in deciding claims or administering the contract that is reasonable and not arbitrary or capricious will be final.

Charges for More than the Allowed Amount

When benefits for provider services are based on the allowed amount, the amounts of benefit payments are determined and made by BCBS upon consideration of the factors described in the definition of the Allowed Amount (see Definitions). If a provider charges you more than the amount of the allowed amount paid by BCBS as benefits, you are responsible for the charges in excess of the allowed amount.

Applicable State Law

This contract is issued and delivered in the State of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

Plan Changes

The SEIB may amend any or all of the provisions of the SEHIP at any time by an instrument in writing.

No representative or employee of BCBS is authorized to amend or vary the terms and conditions of the SEHIP, make any agreement or promise, not specifically contained in the SEHIP, or waive any provision of the SEHIP.

Rescission

Under the Patient Protection and Affordable Care Act (the ACA), the SEIB cannot rescind your coverage once you are covered under the SEHIP unless you perform an act, practice, or omission that constitutes fraud, or unless you make an intentional misrepresentation of material fact as prohibited by the terms of the SEHIP. The SEIB must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded.

A rescission is a retroactive cancellation or discontinuance of coverage. A cancellation of coverage is not a rescission if (a) the cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively due to a failure to timely pay required premiums or contributions towards the cost of coverage.

No Assignment

The SEHIP will not honor an assignment of your claim to anyone. Some of the contracts BCBS has with providers of services, such as hospitals, require BCBS to pay benefits directly to the providers. With other claims BCBS may choose whether to pay you or the provider. If you or the provider owes the SEHIP money BCBS may deduct the amount owed from the benefit paid. When BCBS pays or deducts the amount owed from you or the provider, this completes our obligation to you under the SEHIP. Upon your death or incompetence, or if you are a minor, the SEHIP may pay your estate, your guardian or any relative the SEHIP believes is due to be paid. This, too, completes SEHIP's plan obligation to you.

Chapter 26
COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a provision designed to help manage the cost of health care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary.

A primary plan is one whose benefits for a person's health care coverage must be determined first without taking the existence of any other plan into consideration.

A secondary plan is one that takes into consideration the benefits of the primary plan before determining benefits available under its plan.

Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies:

Noncompliant Plan: If the other plan is a noncompliant plan, then the other plan shall be primary and this plan shall be secondary unless the COB terms of both plans provide that this plan is primary.

Employee/Dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

Dependent Child – Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

Dependent Child – Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
    a. first, the plan of the custodial parent;
    b. second, the plan covering the custodial parent's spouse;
    c. third, the plan covering the non-custodial parent; and,
    d. last, the plan covering the non-custodial parent's spouse.
2. If a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

    If the court-ordered parent has no healthcare coverage for the dependent child, benefits will be determined in the following order:

    a. first, the plan of the spouse of the court-ordered parent;
    b. second, the plan of the non-court-ordered parent; and,

c. third, the plan of the spouse of the non-court-ordered parent.

If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of "Dependent Child – Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.

3. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the "birthday rule" as if those individuals were parents of the child.

Active Employee or Retired or Laid-Off Employee:

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

COBRA or State Continuation Coverage:

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the "COBRA plan") and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the "COBRA plan") and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

Longer/Shorter Length of Coverage: If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

Equal Division: If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Determination of Amount of Payment

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is required to make a secondary payment according to the above rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term "allowable expense" means any healthcare expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term "allowable expense" does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for mental health disorders and substance abuse, dental services and supplies, vision care, prescriptions drugs, or hearing aids, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term "allowable expense" does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

Birthday: The term "birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial Parent: The term "custodial parent" means:

- A parent awarded custody of a child by a court decree; or,
- In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contract: The term "group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. The term does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Hospital Indemnity Benefits: The term "hospital indemnity benefits" means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Noncompliant Plan: The term "noncompliant plan" means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are "excess" or "always secondary."

Plan: The term "plan" includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care;

medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term “plan” does not include non-group or individual health or medical reimbursement insurance contracts. The term “plan” also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term “primary plan” means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or,
- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan: The term “secondary plan” means a plan that is not a primary plan.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. BCBS may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. BCBS is not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give BCBS any facts it needs to apply these COB rules and to determine benefits payable as a result of these rules.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, BCBS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. BCBS will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by BCBS is more than BCBS should have paid under this COB provision, BCBS may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Special Rules for Coordination with Medicare

Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.

Chapter 27
SUBROGATION

Right of Subrogation

If BCBS pays or provides any benefits for you under the SEHIP, the SEHIP is **subrogated** to all rights of recovery that you have in contract, tort, or otherwise against any person or organization for the amount of benefits the SEHIP has paid or provided. The SEHIP may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, the SEHIP has a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which the SEHIP has paid plan benefits. This means that you promise to repay the SEHIP from any money you recover the amount the SEHIP has paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay the SEHIP. And, if you are paid by any person or company besides the SEHIP, including the person who injured you, that person's insurer, or your own insurer, you must repay the SEHIP. In these and all other cases, you must repay the SEHIP.

The SEHIP has the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay the SEHIP first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay the SEHIP first even if another person or company has paid for part of your loss. And it means that you promise to repay the SEHIP first even if the person who recovers the money is a minor. In these and all other cases, the SEHIP still has the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to promptly furnish BCBS all information that you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with BCBS in protecting and obtaining the SEHIP's reimbursement and subrogation rights in accordance with this Section. **You may receive questionnaires requesting more information. Any member who has not responded within 30 days of receiving three questionnaires will have their claims suspended until they have complied with the questionnaire.**

You or your attorney will notify BCBS before filing any suit or settling any claim so as to enable the SEHIP to participate in the suit or settlement to protect and enforce the SEHIP's rights under this section. If you do notify BCBS so that the SEHIP is able to and does recover the amount of SEHIP benefit payments for you, the SEHIP will share proportionately with you in any attorney's fees charged you by your attorney for obtaining the recovery. If you do not give BCBS such notice, the SEHIP's reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow the reimbursement and subrogation rights of the SEHIP under this section to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, the SEIB may suspend or terminate payment or provision of any further benefits for you under the SEHIP.

Chapter 28

FILING A CLAIM, CLAIM DECISIONS & APPEAL OF BENEFIT DENIAL

The following explains the rules under SEHIP for filing claims and appeals with Blue Cross and for filing voluntary appeals with the SEIB. The procedures relating to BCBS's pre-certification, pre-approval or review of certain benefits, including inpatient hospital benefits, private duty nursing, and certain surgical/diagnostic procedures, case management and certain predeterminations are explained in other sections of this booklet.

Filing of Claims Required

A claim prepared and submitted to Blue Cross must be received by Blue Cross before it can consider any claim for payment of benefits for services or supplies. In addition, there are certain services (such as Preadmission Certification and pre-certification of nursing services) that must be approved by BCBS in advance before they will be recognized as benefits. No communications with Blue Cross by you, your provider, or anyone else about the existence or extent of coverage can be relied on by you or your provider or will be binding in any way on Blue Cross when the communications are made before the services or supplies are provided and a claim for them is submitted and received.

Who Files Claims

Providers of services who have agreements with Blue Cross generally prepare and submit claims directly to BCBS. Claims for services or supplies furnished to you by providers without agreements with BCBS must be prepared and submitted by either you or the provider. For services requiring preadmission or precertification requests and approvals, the responsibility and manner for submitting requests are mentioned previously.

Who Receives Payment

Blue Cross' agreements with some providers require it to pay benefits directly to them. On all other claims it may choose to pay either you or the provider. If you or the provider owes BCBS any sums, it may deduct from its benefit payment the amount that it is owed. Its payment to you or the provider (or deduction from payments to either) of amounts owed will be considered to satisfy its obligation to you. Blue Cross does not have to honor any assignment of your claim to anyone, including a provider.

Nothing in the contract gives a provider the right to sue for recovery from BCBS for benefits payable under the contract.

If you die or become incompetent or are a minor, Blue Cross pays your estate, your guardian or any relative that, in its judgment, is entitled to the payment. Payment of benefits to one of these people will satisfy its obligation to you.

How to File Claims

When you use your benefits, a claim must be filed before payment can be made. The SEHIP will pay for covered services you receive after the effective date of your coverage.

Hospital Benefits

In most cases, presenting your identification card is all you will need to establish credit for you and your dependents for admission to any hospital in Alabama and across the nation. Benefit payments are normally made to the hospital. If care is received in a hospital outside of Alabama, reimbursement will be made through the Blue Cross Blue Card program. If a hospital outside of Alabama does not file claims with BCBS, you should file the claim directly to: BCBS of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.

Note: Preadmission Certification and Post Admission Review is required for all hospital admissions and for many outpatient diagnostic tests and surgeries. Ask your provider to contact BCBS at 1.800.551.2294.

Provider Services and Other Covered Expenses

To file a claim for provider services and other covered Major Medical expenses, present your identification card to the provider of service. Benefit payments are normally made directly to the provider.

However, if the provider does not file for benefits, claims should be filed directly by you. When it is necessary for you to file claims, complete a Medical Expense Claim form (CL-438) and obtain itemized bills from the provider to attach. It is to your advantage to file your claims as they are incurred or at least every three months.

The itemized bills must contain:

Patient's full name	Type of service	Contract number
Charge for each service	Name and address of provider	Diagnosis
Date of service	Date of accident (if applicable)	

Send the claim to: BCBS of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298. You should always make copies for your personal records before filing. For your convenience, Medical Expense Claim forms (CL-438) are available from any BCBS office.

Blue Cross Preferred Care Benefits

One of the greatest advantages of visiting a PPO Provider or PPO Facility is that you are relieved of any claim filing. PPO Providers agree to handle all claim filing procedures for you. All Participating Pharmacies will also file your claims for you.

When Claims Must Be Submitted

All claims for benefits must be submitted properly by you or your provider of services within 365 days of the date you receive the services or supplies. Claims not submitted and received by BCBS within this 365-day period will not be considered for payment of benefits.

Receipt and Processing Claims

Claims for medical benefits under the SEHIP can be post-service, pre-service, or concurrent. Claims for dental benefits are always post-service. The following explains how BCBS processes these different types of claims and how you can appeal a partial or complete denial by BCBS of a claim.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. BCBS has developed a form that you must use if you wish to designate an authorized representative. You can also go to the BCBS Internet web site at www.bcbsal.com and ask BCBS to mail you a copy of the form. If a person is not properly designated as your authorized representative, BCBS will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, your provider is deemed to be your authorized representative unless you advise BCBS otherwise in writing.

Post-Service Claims

What Constitutes a Post-Service Claim? For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), BCBS must receive a properly completed and filed claim from you or your provider.

In order for BCBS to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS's claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the BCBS customer service department and ask for a claim form. Tell BCBS the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and BCBS will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by BCBS within 24 months after the service takes place to be eligible for benefits.

If BCBS receives a submission that does not qualify as a claim, it will notify you or your provider of the additional information needed. Once BCBS receives that information, it will process the submission as a claim.

Processing of Claims: Even if BCBS has received all of the information needed to treat a submission as a claim, from time to time it might need additional information in order to determine whether the claim is payable. The most common example of this is medical records needed to determine whether services or supplies were medically necessary. If additional information is needed, BCBS will ask you to furnish it, and will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. BCBS will send you a copy of its request. However, you will remain responsible for seeing that BCBS gets the information on time.

Ordinarily, BCBS will notify you of the decision within 30 days of the date on which your claim is filed. If it is necessary to ask you for additional information, BCBS will notify you of its decision within 15 days after it receives the requested information. If BCBS does not receive the information, your claim will be considered denied at the expiration of the 90-day period BCBS gave you for furnishing the information.

In some cases, BCBS may ask for additional time to process your claim. If you do not wish to give BCBS additional time, it will go ahead and process your claim based on the information it has. This may result in a denial of your claim.

Pre-Service Claims

What is a Pre-Service Claim? A pre-service claim is one in which you or your provider are required to obtain approval before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If BCBS grants a pre-service claim, BCBS is not telling you that the service or supply is, or will be, covered; BCBS is only telling you that the service or supply meets BCBS's medical necessity guidelines.

In order to file a pre-service claim with BCBS, you or your provider must call the Blue Cross Health Management Department at 205.988.2245 (in Birmingham) or 1.800.248.2342 (toll free). You must give your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person BCBS can call back, and a phone number to reach that person. You may also, if you wish, submit
pre-service claims in writing. Written pre-service claims should be sent to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to BCBS during its regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to BCBS within 48 hours of the admission and BCBS certifies the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD Physician). If your plan provides chiropractic, physical therapy, or

occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you.

If you attempt to file a pre-service claim but fail to follow BCBS's procedures for doing so, BCBS will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). BCBS's notification may be oral, unless you ask for it in writing. BCBS will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of BCBS that is customarily responsible for handling benefit matters, and (2), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent Pre-Service Claims: BCBS will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician indicates that your claim is urgent, BCBS will treat it as such.

If your claim is urgent, BCBS will notify you of the decision within 72 hours. If more information is needed, BCBS will let you know within 24 hours of your claim. BCBS will tell you what further information is needed. You will then have 48 hours to provide this information to BCBS. You will receive notice of the decision within 48 hours after BCBS receives the requested information. BCBS's response may be oral; if it is, BCBS will follow it up in writing. If the requested information is not received, your claim will be considered denied at the expiration of the 48-hour period you were given for furnishing the information.

Non-Urgent Pre-Service Claims: If your claim is not urgent, you will receive a decision within 15 days. If more information is needed, BCBS will let you know before the 15-day period expires.

You will then have 90 days to provide needed information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. However, you will remain responsible for seeing that the information is provided on time. You will be notified of the decision within 15 days after BCBS receives the requested information. If the requested information is not received, your claim will be considered denied at the expiration of the 90-day period you were given for furnishing the information.

Courtesy Pre-Determinations: For some procedures BCBS encourages, but do not require, you to contact BCBS before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask BCBS to determine beforehand whether the procedure is cosmetic or reconstructive. BCBS calls this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, BCBS will do its best to provide you with a timely response. If BCBS decides that it cannot provide you with a courtesy pre-determination (for example, BCBS cannot get the information it needs to make an informed decision), BCBS will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When BCBS processes requests for courtesy pre-determinations, BCBS is not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call the BCBS customer service department.

Concurrent Care Determinations

Determinations by BCBS to Limit or Reduce Previously Approved Care: If BCBS has previously approved a course of treatment to be provided over a period of time or number of treatments, and later decides to limit or reduce the previously approved course of treatment, BCBS will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules established for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by You to Extend Previously Approved Care: If a previously approved course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in

writing or orally either directly to BCBS or through your treating physician. The phone numbers to call in order to request an extension of care are:

- For inpatient hospital care, call 205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network physical therapy or occupational therapy, call 205-220-7202.
- For care from an in-network chiropractor, call 205-220-7202.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, BCBS will give you the decision within 24 hours of when your request is submitted. If your request is not made before this 24 hour time frame, and your request is urgent, BCBS will give you its determination within 72 hours. If your request is not urgent, BCBS will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

Your Right To Information: You have the right, upon request, to receive copies of any documents that BCBS relied on in reaching its decision and any documents that were submitted, considered, or generated by BCBS in the course of reaching a decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that BCBS may have relied upon in reaching the decision. If the decision was based on a medical or scientific determination (such as medical necessity), you may also request that BCBS provide you with a statement explaining its application of those medical and scientific principles to you. If BCBS obtained advice from a health care professional (regardless of whether it relied on that advice), you may request that BCBS give you the name of that person. Any request that you make for information under this paragraph must be in writing. BCBS will not charge you for any information that you request under this paragraph.

Member Satisfaction

If you are dissatisfied with the adverse benefit determination of a claim, you may file an appeal with BCBS. You cannot file a claim for benefits under the plan in federal or state court unless you exhaust these administrative remedies.

Customer Service

If you have questions about your coverage, or need additional information about how to file claims, you should contact BCBS. BCBS Customer Service (located in Birmingham) is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is:

1.800.824.0435

When you call about a claim, be sure to have the following information available:

- Your contract number
- Name of your employer
- Date of service
- Name of provider.

BCBS also has a special 24 hour-a-day, 7 days a week, Customer Service request line, called Rapid Response, for you to use when you need claim forms and other printed materials relevant to your benefits. Rapid Response is quick and easy to use, so we encourage you to use it when you need materials such as:

- Claim forms
- Replacement ID cards
- Brochures
- Benefit Booklets

A voice activated system will ask for your name, complete mailing address, daytime phone number, what materials you are requesting, how many you need, and the contract number from your ID card. If you know the BCBS form number, you can request the item by that number.

The numbers for Rapid Response are:

205.988.5401 in Birmingham or 1.800.248.5123 toll free.

Your request is recorded and will be mailed to you the next working day if you answer all the questions completely. Allowing mailing time, you should receive your requested materials within 3-5 days (excluding weekends and holidays).

Blue Cross Blue Shield Appeals

In General: The rules in this section of the summary allow you or your authorized representative to appeal any adverse benefit determination by BCBS. An adverse benefit determination includes any one or more of the following:

- any determination by BCBS with respect to a post-service claim that results in your owing any money to your provider other than co-payments you make, or are required to make, when you see your provider;
- the denial by BCBS of a pre-service claim; or,
- an adverse concurrent care determination (for example, BCBS denies your request to extend previously approved services).

In all cases other than determinations by BCBS to limit or reduce previously approved care, you have 180 days following an adverse benefit determination by BCBS within which to submit an appeal.

How to Appeal Post-Service Adverse Benefit Determinations

If you wish to file an appeal of an adverse benefit determination relating to a post-service claim, BCBS recommends that you use a form that is developed for this purpose. The form will help you provide BCBS with the information that it needs to consider your appeal. To get the form, you should call the BCBS Customer Service Department. You may also go to the Internet web site at www.bcbsal.org. Once there, you may ask BCBS to send you a copy of the form.

If you choose not to use the BCBS appeal form, you may send BCBS a letter. Your letter must contain at least the following information:

- the patient's name;
- the patient's contract number;
- sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
- a statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write Blue Cross without following the rules just described for filing an appeal, Blue Cross will not treat your inquiry as an appeal. Blue Cross will, of course, use best efforts to resolve your questions or concerns.

How to Appeal Pre-Service Adverse Benefit Determinations

- You may appeal an adverse benefit determination by BCBS relating to a pre-service claim in writing or over the phone. If over the phone, you should call the appropriate phone number listed below:
- For inpatient hospital care and admissions, call 205.988.2245 (in Birmingham) or 1.800.248.2342
- For Preferred Physical Therapy or Occupational Therapy call 205.220.7202.
- For care from a Participating Chiropractor call 205.220.6128.

If in writing, you should send your letter to the appropriate address listed below:

For inpatient hospital care and admissions:

Blue Cross and Blue Shield of Alabama
Attention: Health Management – Appeals
P.O. Box 2504
Birmingham, Alabama 35201-2504

or

For in-network physical therapy, occupational therapy, or care from an in-network chiropractor:

Blue Cross Blue Shield of Alabama
Attention: Health Management – Appeals
PO Box 362025
Birmingham, Alabama 35236

Your written appeal should provide BCBS with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write BCBS without following the rules just described for filing an appeal, BCBS will not treat your inquiry as an appeal. BCBS will, of course, use best efforts to resolve your questions or concerns.

Conduct of the Appeal

Blue Cross will assign your appeal to one or more persons within the organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires BCBS to make a medical judgment (such as whether services or supplies are medically necessary), BCBS will consult a health care professional who has appropriate expertise. If BCBS consulted a health care professional during its initial decision, it will not consult that same person or a subordinate of that person during our consideration of your appeal.

If BCBS needs more information, BCBS will ask you to provide it to them. In some cases BCBS may ask your provider to furnish that information directly to them. If so, BCBS will send you a copy of its request.

However, you will remain responsible for seeing that BCBS gets the information. If BCBS does not get the information, it may be necessary for BCBS to deny your appeal.

BCBS will consider your appeal fully and fairly.

Time Limits for Consideration of Your Appeal: If your appeal arises from the denial of a post-service claim, BCBS will notify you of its decision within 60 days of the date on which you filed your appeal.

If your appeal arises from the denial of a pre-service claim, and if your claim is urgent, BCBS will consider your appeal and notify you of its decision within one business day or, if during a long weekend, within 72 hours. If your pre-service claim is not urgent, BCBS will give you a response within 30 days.

If your appeal arises out of a determination by BCBS to limit or reduce a course of treatment that was previously approved for a period of time or number of treatments, (see Concurrent Care Determinations this section), BCBS will make a decision on your appeal as soon as possible, but in any event before it imposes the limit or reduction.

If your appeal relates to a decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations this section), BCBS will make a decision on your appeal within one business day or 72 hours if over a long weekend (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, BCBS may ask for additional time to process your appeal. If you do not wish to give BCBS additional time, they will go ahead and decide your appeal based on the information they have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan - Administrative Remedies

If you have filed an appeal and are dissatisfied with the response, you may do one or more of the following:

- You may ask the BCBS Customer Service Department for further help;
- You may file a voluntary appeal (discussed below);
- You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below); or

Voluntary Appeals: If BCBS has given you its appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal. Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), BCBS will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. BCBS will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, BCBS will not impose any fees or costs on you as part of your voluntary appeal. You may ask BCBS to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

External Reviews

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with BCBS for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 10744
Birmingham, AL 35202-0744.

If you request an external review, an independent organization will review our decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give BCBS copies of this additional information to give BCBS an opportunity to reconsider its denial. Both you and BCBS will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both you and BCBS.

Expedited External Reviews for Urgent Pre-Service Claims

If your pre-service claim meets the definition of urgent under law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling BCBS at 1-800-248-2342 (toll-free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll-free).

Chapter 29
SEIB APPEALS PROCESS

General Information
Members of the SEHIP have a right to question the decisions of the SEIB. However, all issues regarding benefit determinations should be addressed through the BCBS appeal process (see Chapter 28). Issues involving eligibility and enrollment must be addressed directly with the SEIB.

Informal Review
If you feel that an enrollment or eligibility ruling was not in conformity with the rules and procedures of the SEHIP you may then contact the SEIB for an Informal Review. In many cases, the problem can be handled over the phone through the Informal Review process without the need for a formal review or appeal.

Administrative Review
If you are unsatisfied with the informal review decision, you may then request an administrative review. All requests for administrative review must be submitted to the SEIB legal department. If it is determined by the SEIB that an administrative review is merited, you will be sent a form IB5 to complete and return to the SEIB.

Receipt of your Administrative Review will be acknowledged by returning a copy of the received form to you. Oral arguments will not be considered in an Administrative Review process unless approved by the SEIB.

An Administrative Review request must be received in the SEIB office within 60 days following receipt of the final notice of a partial or total denial of your claim from BCBS or within 60 days of the receipt of any determination of the SEIB. A copy of the decision of the claims administrator, the utilization review administrator of the SEIB ruling must be attached to the Administrative Review form IB5. The Administrative Review Committee will review the grievance usually within sixty (60) days. The Administrative Review Committee shall issue a decision in writing to all parties involved in the grievance.

Note: Medical decisions will not be questioned.

Formal Appeal
If you do not agree with the response to your Administrative Review, you may file a request for a Formal Appeal before the Board of Directors. Requests for a Formal Appeal must be received in the SEIB office within 60 days following the date of the Administrative Review decision.

The subject of a Formal Appeal shall be limited to exclusions or exceptions to coverage based on extenuating or extraordinary circumstances, or policy issues not recently addressed or previously contemplated by the Board.

If your request for a formal appeal is granted, generally, a decision will be issued within ninety (90) days following approval of the Request for Formal Appeal. The number of days may be extended by notice from the SEIB. The decision by the Board is the final step in the administrative proceedings and will exhaust all administrative remedies.

Items That Will Not Be Reviewed Under the Administrative Review or Formal Appeal Process:

- Medical Necessity
- Cosmetic Surgery
- Investigational Related Services
- Custodial Care
- Allowed Amounts

If you have not received a decision or notice of extension of the Administrative Review or Formal Appeal within 90 days, you may consider your request denied.

Chapter 30
DEFINITIONS

Accidental Injury: A traumatic injury to you caused solely by an accident that occurs while you are covered by the contract.

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.

Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that BCBS recognizes for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by BCBS to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

In-Network Providers: Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered care. The negotiated price applies only to services that are covered under the plan and also covered under the contract that has been signed with the in-network provider.

Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2) which subset of those providers will be considered BlueCard PPO providers, and (3) the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.

See Out-of-Area Services, earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Alabama.

Out-of-Network Providers: The allowed amount for care rendered by out-of-network providers is often determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to in-network providers or may be based on the average charge for the care in the area. In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;
- Pricing data from the local Blue Cross and/or Blue Shield plan where services are rendered;
- The relative complexity of the service;
- The in-network allowance in Alabama for the same or a similar service;
- Applicable state healthcare factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

For services provided by an out-of-network provider, the provider may bill the member for charges in excess of the allowed amount. The allowed amount will not exceed the amount of the provider's charge.

For emergency services for medical emergencies provided within the emergency room department of an out-of-network hospital, the allowed amount will be determined in accordance with the requirements of the Patient Protection and Affordable Care Act.

Alternative Benefits: A benefit program that gives you and your family an alternative to lengthy hospitalizations. It is designed to provide the patient with the best environment for recovery and in the most cost effective long-term arrangement. This program is also known as "Comprehensive Managed Care" and "Individual Case Management," and is administered by BCBS.

Ambulatory Surgical Center: A facility that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed. In order to be considered an ambulatory surgical facility under the plan, the facility must meet the conditions for participation in Medicare.

Assisted Reproductive Technology (ART): Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intra fallopian transfer, zygote intra-fallopian transfer, pro-nuclear stage tubal transfer, artificial insemination and/or intrauterine insemination.

Baby Yourself: A maternity management program administered by BCBS that offers a mechanism for identifying high-risk pregnancies and completely managing them to prevent complications at the time of delivery.

BCBS: Blue Cross Blue Shield of Alabama.

Blue Card Program: An arrangement among Blue Cross Plans whereby a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur.

Blue Cross Blue Shield of Alabama: Company chosen by the SEIB, through competitive bid, to process benefit claims filed by members (also referred to as BCBS).

Certification of Medical Necessity: The written results of BCBS's review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours of the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not consider whether your admission is excluded by the SEHIP.

Chiropractic Fee Schedule: The schedule of Chiropractic procedures and fee amounts for those procedures under the Participating Chiropractic benefits that is on file at the Claims Administrator's office.

Claims Administrator: The Company chosen by the SEIB, through competitive bid, to process benefit claims filed by members. The Claims Administrator is BCBS.

COBRA: See the explanation in the "Termination of Coverage" section of this booklet.

Concurrent Utilization Review Program (CURP): A program implemented by BCBS and in-network hospitals in the Alabama service area to simplify the administration of preadmission certifications and concurrent utilization reviews.

Cosmetic Surgery: Any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, trauma or congenital anomalies. For further information on "Cosmetic Surgery", see the "Exclusions" section.

Custodial Care: Care primarily for the purpose of providing 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 person who is mentally or physically disabled. Custodial care does not include specific medical, surgical or psychiatric treatment that would reduce a member's disability to the extent necessary to enable him to live outside an institution providing medical care.

Dependent: See explanation in the "Eligibility and Enrollment" section.

Diagnostic: Services performed in response to signs or symptoms of illness, condition, or disease or in some cases where there is family history of illness, condition, or disease.

Durable Medical Equipment: Equipment approved by BCBS as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be (a) made to withstand repeated use, (b) mainly for a medical purpose rather than for comfort or
convenience, (c) useful only if you are sick or injured, (d) related to your condition and prescribed by your physician for your use in your home, and (e) determined by BCBS to be medically necessary to diagnose or treat your illness or injury, help a malformed part of your body work better, or keep your condition from becoming worse.

Effective Date: The date on which the coverage of each individual member begins as listed in the SEIB records.

Elective Abortion: An abortion performed for reasons other than the compromised physical health of the mother, severe chromosomal or fetal deformity, or conception due to incest or rape.

Emergency Treatment: Treatment rendered in a hospital, clinic or doctor's office for an injury or illness that requires immediate care or treatment, and must be performed within 48 hours after the injury is sustained or the illness first becomes manifest. A condition that requires immediate care or treatment means only a permanent health-threatening condition. The condition must be one for which failure to receive care or treatment could result in deterioration to the point where the patient's permanent health would be in jeopardy, bodily functions would be significantly impaired, or serious dysfunction would occur in any organ or other part of the patient's body. Emergency treatment includes ambulance service to the facility where treatment is received.

Employee: See the "Eligibility and Enrollment" section.

Employee Contribution: The employee contribution is one of the components of the premium calculation used to determine the premium for each premium class. The employee contribution is the amount the SEIB establishes for employees and retirees to contribute to the cost of their coverage.

Employer Contribution: The employer contribution is one of the components of the premium calculation established by the SEIB to determine the premium for each premium class. The premium for each class is a function of the cost of coverage and can be stated simply as employer contribution + employee contribution = premium. The employer contribution for each premium class is the amount the state pays toward the cost of coverage for a particular premium class.

Family Coverage: Coverage for an employee and one or more dependents.

Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

Home Health Coverage: Skilled nursing visits ordered by a physician, rendered in a patient's home by a Registered Nurse or Licensed Practical Nurse and billed by a home health agency. Any pre-certification requirements and/or any specified benefit maximums are applicable to the skilled nursing visits only. Other services included are home infusion therapy and medications administered by a home health agency. Services such as speech therapy, occupational therapy and physical therapy may be billed by a home health agency; however, they are considered under the major medical portion of the contract and not considered under home health coverage.

Home Plan: The Blue Cross Plan providers or subscribers send claims to when the subscriber receives medical care in a different Plan's geographic area. A group's Home Plan is the Plan that has control of the group.

Hospice Coverage: Hospice service includes supplies or drugs included in the daily fee for hospice care rendered by a hospice provider to a terminally ill member when a physician certifies the member's life expectancy to be less than six months.

Hospital: A Participating or Non-Participating hospital as defined in this section.

Host Plan: The Blue Cross Plan associated with the provider that furnishes services to a subscriber from a different Plan. It is a Plan that helps the Home Plan service the group.

Implantables: An implantable device is a biocompatible mechanical device, biomedical material, or therapeutic agent that is implanted in whole or in part and serves to support or replace a biological structure, support and/or enhance the command and control of a biological process, or provide a therapeutic effect. Examples include, but are not limited to, cochlear implants, neurostimulators, indwelling orthopedic devices, cultured tissues, tissue markers, radioactive seeds, and infusion pumps.

In-Network Provider: A provider is considered to be an in-network provider if, and only to the extent that, the provider is furnishing a service or supply that is specified as an in-network benefit under the terms of the contract between the provider and the Blue Cross and/or Blue Shield plan (or its affiliates). Examples include BlueCard PPO providers, Preferred Medical Doctors (PMD physicians), and Participating Pharmacies. A provider will be considered an in-network provider only if the local Blue Cross and/or Blue Shield plan designates the provider as a BlueCard PPO provider for the service or supply being furnished. This means that if you receive a service or supply from a provider that has a contractual relationship with a Blue Cross and/or Blue Shield plan but is not designated by the local Blue Cross and/or Blue Shield plan as a BlueCard PPO provider, we will pay at the out-of-network level of benefits.

Inpatient: A registered bed patient in a hospital; provided that we reserve the right in appropriate cases to reclassify inpatient stays as outpatient services, as explained above in Inpatient Hospital Benefits and Outpatient Hospital Benefits.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either BCBS has not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, BCBS will develop written criteria (called medical criteria) concerning services or supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and our members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is considered investigational according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If the investigational nature of a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when BCBS makes determinations about the investigational nature of a service or supply BCBS is making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Medical Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Medically Necessary or Medical Necessity: BCBS uses these terms to help determine whether a particular service or supply will be covered. When possible, BCBS will develop written criteria (called medical criteria) that BCBS will use to determine medical necessity. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS make available to the medical community and our members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is not medically necessary according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be medically necessary only if BCBS determines that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not "investigational"; and,
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when BCBS makes medical necessity determinations, BCBS is making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Medicare: The Health Insurance for the Aged Program under Title XVIII of the Social Security Act (P.L. 89-97) as amended.

Member: An active/retired State Employee or eligible dependent who has coverage under the SEHIP and whose application for coverage under the contract is made and accepted by the SEIB. A member also is a former dependent and/or employee eligible for and covered under COBRA.

Mental Health Preferred Provider Organization: Those providers who are contracted with BCBS's Blue Choice Network and Certified Community Mental Health Centers (CMHC) to provide certain mental health and substance abuse services.

Mental Health Disorders and Substance Abuse: These are mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. These disorders, illnesses, and conditions are considered mental health disorders and substance abuse whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders and substance

abuse regardless of how they are caused, based, or brought on. Mental health disorders and substance abuse include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders,

personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are generally intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Non-Participating Chiropractor: A Doctor of Chiropractic (DC) who is not a Participating Chiropractor.

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those classified or classifiable under standards of the American Hospital Association as "special" hospitals, such as those classified as for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease, or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

Non-Participating Pharmacy: Any pharmacy that is not a BCBS Participating Pharmacy.

Non-PPO Provider: Any provider that is not a PPO Provider with any Blue Cross and/or Blue Shield Plan.

Non-Preferred Home Health Care Agency: Any home health care agency that is not a Preferred Home Health Care Agency.

Non-Preferred Hospice: Any hospice that is not a Preferred Hospice.

Out-of-Area Mental Health Benefits: Benefits for mental health services, including services for chemical dependency, if the subscriber lives permanently outside of Alabama and the subscriber or his dependents or both receive treatment outside Alabama.

Open Enrollment: The annual open enrollment period is held each November for a January 1 effective date. During this time you may choose between the insurance carriers available and/or change from single to family coverage. If you make a change during the open enrollment period, waiting periods for preexisting conditions will not be waived.

Out-of-Network Provider: A provider who is not an in-network provider.

Participating Ambulatory Surgical Facility: Any facility with which BCBS has a contract for furnishing health care services.

Participating Chiropractor: A Doctor of Chiropractic who has a contract with the Claims Administrator for the furnishing of chiropractic services.

Participating Hospital: Any hospital with which the Claims Administrator (BCBS) has a contract for furnishing health care services.

Participating Pharmacy: Any pharmacy with which BCBS has a contract for providing pharmacy services.

Participating Renal Dialysis Facility: Any free-standing hemodialysis facility with which BCBS has a contract for furnishing health care services.

Physician: Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

Plan Administrator: The State Employees' Insurance Board.

Plan Sponsor: The State of Alabama.

PPO: Preferred Provider Organization.

PPO Allowance: The amount that any Blue Cross and/or Blue Shield Plan has agreed to pay its PPO Provider for plan benefits.

Preadmission Certification and Post admission Review: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or by the next business day after the admission in the case of emergency admissions, based upon medically recognized criteria. The program is administered by BCBS.

Preferred Care: A program whereby providers have agreements with BCBS to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical, surgical and dental procedures, such services and supplies to members entitled to benefits under the Preferred Care program.

PPO Fee Schedule: Schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

Preferred Provider: Any provider of health care services or supplies when licensed and acting within the scope of that license at the time and place you are treated and receive services (such as a Preferred Physician, Preferred Medical Laboratory, Preferred Outpatient Facility, or Preferred Nurse Practitioner or Physician Assistant Provider) who has an agreement with BCBS to furnish services or supplies to members entitled to benefits under the Preferred Care program.

Pregnancy: Condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body - usually, but not always - in the uterus, lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Prescription Drug Tiers: Tier 1: SEIB low cost generic drugs; Tier 2: SEIB high cost generics and preferred brand drugs; Tier 3: SEIB non-preferred brand drugs; Tier 4: Specialty drugs

Preventive or Routine: Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

Private Duty Nursing: A session of four or more hours during which continuous skilled nursing care is furnished to you alone.

Psychiatric Specialty Hospital: An institution that is classified as a psychiatric specialty facility by such relevant credentialing organizations as BCBS or any Blue Cross and/or Blue Shield plan (or its affiliates) determines. A psychiatric specialty hospital does not include a substance abuse facility.

Skilled Nursing Facility: Any Medicare participating skilled nursing facility which provides non-acute care for patients needing skilled nursing services 24 hours a day. This facility must be staffed and equipped to perform skilled nursing care and other related health services. A skilled nursing facility does not provide custodial or part-time care.

Substance Abuse: The uncontrollable or excessive abuse of addictive substances, such as (but not limited to) alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use.

Substance Abuse Facility: Any institution that is classified as a substance abuse facility by such relevant credentialing organizations as BCBS or any Blue Cross and/or Blue Shield plan (or its affiliates) determine and that solely provides residential and/or outpatient substance abuse rehabilitation services.

Retired Employee: Former employee who receives a monthly benefit check from the State of Alabama.

Semi-Private Room Accommodations: A hospital room containing 2, 3 or 4 beds.

Special Care Unit: A specially equipped unit, set aside as a distinct patient care area, staffed and equipped to treat seriously ill patients requiring extraordinary care on a concentrated and continuous basis. Some examples are intensive care, coronary care, or burn care units.

State Employees' Health Insurance Plan (SEHIP): A self-insured health benefit plan administered by the State Employees' Insurance Board.

State Employees' Insurance Board (SEIB): The State agency charged with the administration of a health benefit plan for state employees and their dependents. This agency is also referred to as SEIB.

Subscriber: The individual whose application for coverage is made and accepted.

Tele-consultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider. Teleconsultations include consultations by e-mail or other electronic means.

Total Disability: Complete inability of an active employee to perform any and every duty pertaining to his occupation or employment, or the complete inability of a retired employee or a dependent to perform the normal activities of a person of like age and sex.

Urgent-Care Center: A primary care provider that provides professional services by a licensed provider in a clinic setting, not requiring an appointment, and offering services outside traditional office hours.

Utilization Review Administrator: Company chosen by the SEIB to administer your Utilization Review Program such as Preadmission Certification and Individual Case Management. The Utilization Review Administrator is BCBS.

STATE EMPLOYEES' INSURANCE BOARD
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: 334.263.8341
Toll Free: 1.866.836.9737
Website: **www.alseib.org**

Claims Administrator
Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244
Customer Service: 1.800.824.0435
Rapid Response: 1.800.248.5123
Fraud Hot Line: 1.800.824.4391
Website: **www.bcbsal.com**

Utilization Management
Precertification: 1.800.551.2294
Case Management: 1.800.551.2294

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