
The State Employees' Health Insurance Plan



State of Alabama

Effective January 1, 2025



An Independent Licensee of the Blue Cross and Blue Shield Association

STATE OF ALABAMA
STATE EMPLOYEES' INSURANCE BOARD
PO Box 304900

MONTGOMERY, ALABAMA 36130-4900
334-263-8300 | 1-866-836-9737
STATE EMPLOYEES' HEALTH INSURANCE PLAN
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

The State Employees' Health Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

THE PLAN'S RESPONSIBILITIES

The Plan is required by federal law to keep your health information private, to give you notice of the Plan's legal duties and privacy practices, and to inform you about:

- the Plan's uses and disclosures of your protected health information;
- your privacy rights concerning your protected health information;
- the Plan's obligations concerning your protected health information;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

Effective Date of Notice: This notice is effective as of January 1, 2025.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION

This section of the notice describes uses and disclosures that the Plan may make of your health information for certain purposes without first obtaining your permission as well as instances in which we may request your written permission to use or disclose your health information. The Plan also requires its business associates to protect the privacy of your health information through written agreements.

Uses and disclosures related to payment, health care operations, and treatment. The Plan and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, the State of Alabama for purposes related to payment or health care operations.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity and appropriateness of care, and utilization review and precertifications). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

Health care operations include but are not limited to underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services, and auditing functions, including fraud and abuse programs, business planning and development, business management and general administrative activities. However, the Plan will not use protected genetic information for underwriting purposes. It also includes quality assessment and improvement and reviewing the competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to review the accuracy of benefit claim payments.

The Plan will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other uses and disclosures that do not require your written authorization. The Plan may disclose your health information:

- To persons and entities that provide services to the Plan and assure the Plan they will protect the information;
- If it constitutes summary health information, and it is used only for modifying, amending, or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan;
- If it constitutes de-identified information;
- If it relates to workers' compensation programs;
- If it is for judicial and administrative proceedings;
- If it is about decedents;
- If it is for law enforcement purposes;
- If it is for public health activities;
- If it is for health oversight activities;
- If it is about victims of abuse, neglect, or domestic violence;
- If it is for cadaveric organ, eye, or tissue donation purposes;
- If it is for certain limited research purposes;
- If it is to avert a serious threat to health or safety;
- If it is for specialized government functions;
- If it is for limited marketing activities.

Additional disclosures to others without your written authorization. The Plan may disclose your health information to a relative, a friend, or any other person you identify provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Officer at (334) 263-8300.

Uses and Disclosures Requiring Your Written Authorization. In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan written authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Officer at (334) 263-8300.

YOUR PRIVACY RIGHTS

This section of the notice describes your rights concerning your health information and a brief description of how you may exercise these rights.

Notice of Breach. You have a right to notice of a breach of protected health information (PHI).

Restrict Uses and Disclosures. You have the right to request that the Plan restricts use and disclosure of your health information for activities related to payment, health care operations, and treatment. The Plan will consider, but may not agree to, such requests. (Exception: the Plan must grant a restriction on PHI disclosed to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.)

Alternative Communication. The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult-dependent, you may want the Plan to send health information to a different address than that of the employee.

Inspect or Copy Health Information. You have a right to inspect or obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

You may request your records in an electronic format. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You may also be asked to pay a fee of \$1.00 per page based on the Plan's copying, mailing, and other preparation costs.

Amend Health Information. You have the right to request an amendment to health information that is in a "designated record set." You must provide a statement to support the request. The Plan may deny your request to amend your health information if the Plan did not create the health information, if the information is not part of the Plan's records, if the information was not available for inspection or if the information is accurate and complete.

Accounting of Certain Disclosures. You have the right to receive a list of certain disclosures of your health information. The accounting will not include: (1) disclosures made for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosure for national security purpose; and (6) disclosures incident to other permissible disclosures.

You may receive information about disclosures of your health information going back for six (6) years from the date of your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to access electronic records. You may request access to electronic copies of your health information, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic protected health information will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide an electronic copy.

Right to A Copy of Privacy Notice. You have the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

Complaints. You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Plan, contact the Plan's Privacy Officer at (334) 263-8300. You will not be penalized for filing a complaint.

How to exercise your rights in this notice

To exercise your rights listed in this notice, you should contact the Plan's Privacy Officer at (334) 263-8300.

THIS NOTICE IS SUBJECT TO CHANGE

The terms of this notice and the Plan's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plan. If any material changes are made, the Plan will distribute a new notice to participants and beneficiaries.

YOUR QUESTIONS AND COMMENTS

If you have questions regarding this notice, please contact the Plan's Privacy Officer at (334) 263-8300.

Revision 10-2024

Discrimination is Against the Law

The State Employees' Insurance Board (SEIB) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The SEIB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The SEIB:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact 1-855-216-3144 or TTY: 711.

If you believe that the SEIB has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Section 1557 Coordinator, 201 South Union Street, Montgomery, Alabama, 36104; Direct: (334) 263-8300; Fax (334) 263-8711; Email: 1557Grievance@alseib.org. You can file a grievance by mail, fax, email or in person. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711). 번으로 전화해 주십시오

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: هاتف الصم والبكم: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-216-3144 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS : 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો િન:શુદ્ધ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-216-3144 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ्यान दः ियद आप िहंदी बोलते, भाषा सहायता सेवाओं, िनः शु, आप के िलए उपलहः। कॉल । 1-855-216-3144 कॉल (TTY: 711)
Laotian: ບຸດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın..

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます 1-855-216-3144 (TTY: 711) まで、お電話にてご連絡ください

Effective January 1, 2025 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 AlabamaBlue.com.

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. Please see the benefit booklet for more information.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Precertification is required for inpatient admissions (except medical emergency, maternity, and as required by applicable Federal law); notification is required within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-551-2294 for precertification. Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury or medical emergency and covered as an out-of-network hospital.		
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance, subject to a \$250 per admission deductible and \$25 copay per day for days 2-5 per admission.	Covered at 80% of the allowance, subject to a \$250 per admission deductible.
OUTPATIENT HOSPITAL BENEFITS		
Precertification is required for certain outpatient hospital benefits, radiology services, and a select group of provider-administered drugs; visit AlabamaBlue.com and the benefit booklet for more information. Call 1-800-551-2294 for precertification. If precertification is not obtained, no benefits are available. Note: In Alabama, outpatient benefits for non-member hospitals are available only in cases of accidental injury or medical emergency and covered as an out-of-network hospital.		
Surgery	Covered at 100% of the allowance, subject to a \$250 facility copay. 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.
Emergency room -- Medical Emergency	Covered at 100% of the allowance, subject to a \$250 facility copay for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention). Claims with emergency room charges that do not meet medical emergency guidelines will be considered under Major Medical. Includes Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowance, subject to a \$250 facility copay for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention). Claims with emergency room charges that do not meet medical emergency guidelines will be considered under Major Medical. Includes Mental Health Disorders and Substance Abuse Services
Emergency room -- Accidental Injury	Covered at 100% of the allowance with no deductible or copay.	Covered at 100% of the allowance with no deductible or copay.
Urgent Care Facility	Covered at 100% of the allowance, subject to a \$75 copay.	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 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays and Tests	Diagnostic X-ray: Covered at 100% of the allowance with no deductible or copay. Advanced Imaging: Covered at 100% of the allowance, subject to a \$75 facility copay. One copay 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.
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance, subject to a \$25 copay.	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Precertification is required for a select group of provider-administered drugs; for more information visit AlabamaBlue.com/DrugList . Call 1-800-551-2294 for precertification. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HelpScript , cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Physician Office Visits, Office Surgery and Outpatient Consultations	Covered at 100% of the allowance, subject to a \$35 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Nurse Practitioner/Nurse Midwives, Physician Assistant Office Visits, Office Surgery and Outpatient Consultations	Covered at 100% of the allowance, subject to a \$35 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Emergency Room Physician	Covered at 100% of the allowance, subject to a \$35 office visit copay. Includes Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowance, subject to a \$35 office visit copay. Includes Mental Health Disorders and Substance Abuse Services
Emergency Room Nurse Practitioner / Physician Assistant	Covered at 100% of the allowance, subject to a \$35 office visit copay. Includes Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowance, subject to a \$35 office visit copay. Includes Mental Health Disorders and Substance Abuse Services
Telephone and Online Video Consultations Program A telephone and online video consultation service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. Telephone and online video consultations are available 24 hours a day, 7 days a week. To enroll, go to Teladoc.com/Alabama or call 1-855-477-4549.	Covered at 100% of the allowance with no deductible or copay.	Not covered.
Out of Office Surgery and Anesthesia	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Inpatient Visits	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic Lab and Pathology Exams	Covered at 100% of the allowance, subject to a \$7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays and Tests	Diagnostic X-ray: Covered at 100% of the allowance with no deductible or copay. Advanced Imaging: Covered at 100% of the allowance, subject to a \$75 facility copay. One copay 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.
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance with no deductible or copay. Note: For Provider administered drugs, HelpScript Rx program applicable to certain eligible prescription drugs.	Covered at 80% of the allowance, subject to the calendar year deductible.
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
ROUTINE PREVENTIVE CARE		
Routine Immunizations and Preventive Services	Covered at 100% of the allowance with no deductible or copay. See AlabamaBlue.com/preventiveservices for a listing of the specific immunizations and preventive services or call BCBS Customer Service at 1-800-824-0435 for a printed copy.	Covered at 80% of the allowance subject to the calendar year deductible. See AlabamaBlue.com/preventiveservices for a listing of the specific immunizations and preventive services or call BCBS Customer Service at 1-800-824-0435 for a printed copy.
Additional Routine Preventive Services	Covered at 100% of the allowance with no deductible or copay. In addition to the standard services, the following will apply: <ul style="list-style-type: none">• 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)• Blood 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 services, the following will apply: <ul style="list-style-type: none">• 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)• Blood 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 DISORDERS AND SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 100% of the allowance, subject to a \$250 per admission deductible and \$25 copay per day for days 2-5 per admission. Precertification is required.	Covered at 80% of the allowance, subject to a \$250 per admission deductible. Precertification is required.
Inpatient Provider Services	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Residential Treatment (Eating Disorders)	Covered at 100% of the allowance, subject to a \$250 per admission deductible and \$25 copay per day for days 2-5 per admission. Limited to eating disorders; precertification and ongoing medical necessity review required.	Covered at 80% of the allowance subject to a \$250 per admission deductible. Limited to eating disorders; precertification and ongoing medical necessity review required.
SEIB Approved Outpatient Provider Services	Covered at 100% of the allowance, subject to a \$35 copay per visit.	Covered at 80% of the allowance, subject to the calendar year deductible.
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)	Covered at 100% of the allowance, subject to a \$35 copay per visit. Precertification is required.	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required.
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible	\$300 per person each calendar year; maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	\$9,200 individual annual out-of-pocket maximum; \$18,400 family maximum. In-Network Services: Deductibles, copays and coinsurance for in-network services and out-of-network emergency services apply to the out-of-pocket maximum, including prescription drugs (excludes Medicare Rx plan). Out-of-Network Services: Deductibles, copays and coinsurance for out-of-network services do not apply to the out-of-pocket maximum.	
MAJOR MEDICAL SERVICES		
Precertification is required for certain major medical services and a select group of provider-administered drugs; please see benefit booklet. Call 1-800-551-2294 for precertification. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HelpScript , cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th 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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Habilitative and Rehabilitative Physical, Speech, and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits for each service per calendar year. <u>Precertification</u> is required after the 15 th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16 th and subsequent visits will be denied. Precertification is not required for home visits.	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits for each service per calendar year. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. <u>Precertification</u> is required after the 15 th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16 th and subsequent visits will be denied. Precertification is not required for home visits.
Applied Behavioral Analysis (ABA) Therapy	Covered for children 18 years or younger at 100% of the allowance, subject to a \$35 copay per visit. <u>Precertification</u> is required prior to rendering ABA therapy to determine medical necessity and every six months for continued therapy. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.	Covered for children 18 years or younger at 80% of the allowance, subject to the calendar year deductible. <u>Precertification</u> is required prior to rendering ABA therapy to determine medical necessity and every six months for continued therapy. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.
Physical, Speech, and Occupational Therapy related to the screening, diagnosis, and treatment of Autism Spectrum Disorder for children 18 years of age or under	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. Precertification is not required for home visits. For coverage related to the screening, diagnosis, and treatment of Autism Spectrum Disorder, precertification shall be based on the most recent treatment plan. BCBS may only request an updated treatment plan once every six months from the treating licensed physician or licensed psychologist to review medical necessity, unless BCBS and the treating licensed physician or licensed psychologist agree that a more frequent review is necessary for a particular patient. Coverage is limited to children 18 years of age or under.	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 15th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. Precertification is not required for home visits. For coverage related to the screening, diagnosis, and treatment of Autism Spectrum Disorder, precertification shall be based on the most recent treatment plan. BCBS may only request an updated treatment plan once every six months from the treating licensed physician or licensed psychologist to review medical necessity, unless BCBS and the treating licensed physician or licensed psychologist agree that a more frequent review is necessary for a particular patient. Coverage is limited to children 18 years of age or under.
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	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.
Ground Ambulance services	Covered at 80% of the allowance, subject to the calendar year deductible.	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.
Air Ambulance services	Covered at 80% of the allowance, subject to the calendar year deductible.	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.	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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<p>Home health and hospice care</p> <p>In-network home healthcare benefits consist of intermittent home nursing visits and home phototherapy for newborns ordered by your attending physician.</p> <p>In-network hospice benefits consist of physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management provided to a member certified by his physician to have less than six months to live.</p>	<p>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.</p>	<p>Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required; call 1-800-551-2294.</p> <p>In Alabama: No coverage for services rendered by a non-participating Home Health agency.</p>
<p>Home infusion</p> <p>Home infusion benefits include coverage of certain provider-administered drugs ordered by your attending physician and administered by a home infusion service provider in the home or in an infusion suite associated with the home infusion service provider.</p> <p>In-network benefits include coverage of the provider-administered drug and drug infusion-related administration services.</p> <p>See Provider-Administered Drugs paragraph under the Medical Necessity and Precertification section of your Benefit Booklet for precertification requirement of these drugs.</p>	<p>Covered at 100% of the allowance, subject to a \$25 copay when services are rendered by a participating Home Health agency; Precertification is required for a select group of provider-administered drugs; call 1-800-551-2294.</p>	<p>Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required for a select groups of provider-administered drugs; call 1-800-551-2294.</p> <p>In Alabama: No coverage for services rendered by a non-participating Home Health agency.</p>
<p>Diabetic Education</p>	<p>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 for precertification.</p>	<p>Not covered.</p>
<p>Medical Nutrition Therapy For Adults and Children, 6 hours per member per calendar year.</p>	<p>Covered at 100% of the allowance, subject to a \$20 office visit copay.</p>	<p>Covered at 80% of the allowance, subject to the calendar year deductible.</p>
HEALTH MANAGEMENT BENEFITS		
<p>Individual Case Management</p>	<p>Coordinates care in event of catastrophic or lengthy illness or injury; for more information, please call 1-800-551-2294 and press 3.</p>	
<p>Chronic Condition Management</p>	<p>Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease and other specialized conditions; for more information, please call 1-800-551-2294 and press 5.</p>	
<p>Baby Yourself®</p>	<p>A maternity program; the hospital deductible and daily copays may be waived on the maternity inpatient admission at delivery if the member enrolls in the Baby Yourself Program within the first two trimesters of pregnancy. For more information, please call 1-800-551-2294 and press 4. You can also enroll online at AlabamaBlue.com/BabyYourself.</p>	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<p align="center">PRESCRIPTION DRUGS – ACTIVE AND NON-MEDICARE MEMBERS</p> <p align="center">Prescription drug benefits are administered by Prime Therapeutics. For more information, call Member Services at 1-800-824-0435 or visit the website at myprime.com</p>		
Prescription Drugs	<p>Participating Pharmacy:</p> <p>Prescription drugs will be covered at 100%, subject to the following copays/coinsurance:</p> <ul style="list-style-type: none"> • Tier 1 - \$10 copay per prescription for 30-day or 60-day supply; \$20 copay per prescription for 90-day supply. If the drug is over \$50, the member will pay the tier 2 copay. • Tier 2 - 20% of the cost of the prescription with a minimum copay of \$45 and a maximum copay of \$85 per prescription; limited to 30, 60 or 90-day supply. • Tier 3 - 50% of the cost of the prescription with a minimum copay of \$65 and a maximum copay of \$125 per prescription; limited to 30-day supply. • Tier 4 - 50% of the cost of the prescription with a maximum copay of \$150 per prescription; limited to 30-day supply. • Tier 5 - Specialty Drugs- \$150 copay per prescription; limited to 30-day supply. Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs. 	<p>Non-Participating Pharmacy:</p> <p>Not covered</p>

***This is not a contract, benefit booklet or Summary Plan Description.
Benefits are subject to the terms, limitations and conditions of the group contract (including your benefit booklet).
Check your benefit booklet for more detailed coverage information.***

Note: Teladoc Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

For precertification call 1-800-551-2294
Call Blue Cross and Blue Shield of Alabama at 1-800-824-0435
Visit our website at www.alseib.org
 Group 13000
 Revised 1/2/2025 TS

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Introduction

This summary of health care benefits of the State Employees' Health Insurance Plan (SEHIP) is designed to help you understand your coverage. This plan book 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.

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.

Chapter 1

Overview of the Plan

Purpose of the Plan

The State Employees' Health Insurance Plan (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. Coverage is provided under this plan pursuant to applicable laws and is limited to those services, supplies and/or drugs that may be legally performed, prescribed or dispensed by a licensed health care provider, supplier or pharmacy.

The SEHIP complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

Using myBlueCross to Get More Information

By being a member of the SEHIP, you get exclusive access to myBlueCross – an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at www.AlabamaBlue.com/register. With myBlueCross, you have 24-hour access to personalized healthcare information, plus easy-to-use online tools that can help you save time and efficiently manage your healthcare:

- Download and print your benefits plan book or Summary of Benefits and Coverage
- Request replacement or additional ID cards
- View all your claim reports in one convenient place
- Find a doctor
- Track your health progress
- Take a health assessment quiz
- Get fitness, nutrition, and wellness tips
- Get prescription drug information

BlueCare Health Advocate

By being a member of the Plan, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist, help you make an appointment, research and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you, and much more. To find out more or to contact your BlueCare Health Advocate, call the BCBS Customer Service Department at the number on the back of your ID card.

Definitions

Near the end of this plan book, you will find a section called Definitions. This section identifies words and phrases that have specialized or particular meanings. To make this plan book 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 Plan 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.

Generally, after-hours care is provided by your physician. They may have a variety of ways of addressing your needs. You should call your physician for instructions on how to receive medical care after the physician's normal business hours, on weekends and holidays, or to receive non-emergency care for a condition that is not life-threatening but requires medical attention.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room.

Although you are not required to have a primary care physician, it is a good idea to establish a relationship with one. Having a primary care physician has many benefits, including:

- Seeing a physician who knows you and understands your medical history.
- Having someone you can count on as a key resource for your healthcare questions.
- Help when you need to coordinate care with specialists and other providers.

Typically, primary care physicians specialize in family medicine, internal medicine, or pediatrics. Find a physician in your area by visiting AlabamaBlue.com/FindADoctor.

If you need to see a specialist or behavioral health provider, you can contact their office directly to make an appointment. If you choose to see an in-network specialist or Blue Choice Behavioral Health provider, you will have the maximum benefits available for services covered under the Plan. If you choose to see an out-of-network specialist or non-Blue Choice behavioral health provider, your benefits could be lower.

Beginning of Coverage

The section of this plan book called Eligibility and Enrollment will explain what is required for you to be covered under the SEHIP and when your coverage begins.

Limitations and Exclusions

To maintain the cost of the SEHIP at an overall level that is reasonable to all Plan members, the SEHIP contains several provisions that limit benefits. There are also exclusions that you need to pay particular attention to, which can be found through the remainder of this plan book. You need to be aware of these limits and exclusions 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 has medical necessity standards to aid BCBS when it makes medical necessity determinations. BCBS publishes these standards at www.AlabamaBlue.com/providers/policies. The definition of medical necessity is found in the definitions section of this plan book.

In some cases, the SEHIP requires that you or your treating provider pre-certify the medical necessity of your care. Please note that pre-certification relates only to the medical necessity of care; it does not mean that your care will be covered under the Plan. Pre-certification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered. Later sections tell you when precertification is required and how to obtain precertification.

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 plan book, 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 certain out-of-network providers, 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. In most cases, if the out-of-network services are covered, 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. For 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 above 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 the Plan's Alabama in-network providers are:

- BlueCard PPO
- Participating Hospitals
- Preferred Outpatient Facilities
- Participating Ambulatory Surgical Centers
- Participating Renal Dialysis Providers
- Preferred Medical Doctors (PMD)
- Blue Choice Behavioral Health
- ABA Therapy Network
- Preferred Home Health Network
- Preferred Home Infusion Network

To locate Alabama in-network providers, go to AlabamaBlue.com/FindADoctor.

1. In the search box, you can select the category you would like to search under (doctor, hospital, dentist, pharmacy, etc.) or keep on All Categories to search all. Type in the provider's name to search or leave it blank to see all results.
2. In the "Network or Plan" section, use the drop-down menu to select a specific provider network (as noted above).

Search tip: If your search returns zero results, try expanding the number in the "Distance" drop-down.

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. 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 AlabamaBlue.com/FindADoctor and log into your *myBlueCross*. Search for a specific provider by typing their name in the Search Term box or click Search to see all in-network providers for your plan. 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 and/or Blue Shield plan where services are rendered. The local Blue Cross and/or Blue Shield plan will then forward the claims to us 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 plan or is not covered under the contract between the provider and Blue Cross and Blue Shield of Alabama or the local Blue Cross and/or Blue Shield plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the plan, such as Other Covered Services.

Continuity of Care

If you qualify as a continuing care patient, and your healthcare provider or facility is no longer in your network due to the termination of a contractual relationship, you may request to continue treatment with such provider

or facility until your treatment is complete or for 90 days from notification, whichever is shorter, at in-network cost-sharing rates under the plan. A continuing care patient is defined as an individual who:

- Is or was determined to be terminally ill and is receiving treatment for such illness;
- Is undergoing a course of treatment for a serious and complex condition;
- Is pregnant and undergoing a course of treatment for the pregnancy;
- Is undergoing a course of institutional or inpatient care; or
- Is scheduled to undergo non-elective surgery, including receipt of post-operative care, with respect to such a surgery.

Under these circumstances, the provider or facility cannot bill you for amounts in excess of the in-network allowed amounts under the plan. Continuity of care does not apply if your provider or facility was involuntarily terminated from your network for failure to meet applicable quality standards or for fraud.

If you have successfully transitioned to another in-network provider, if you have met or exceeded benefit limitations of the plan, or if care is not medically necessary, you will no longer be eligible for this continuity of care. If we deny your request for continuity of care, you may file an appeal following the procedures described in the Claims and Appeals section of this booklet.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than the SEHIP's copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there

may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, or submit a complaint online at <https://www.cms.gov/nosurprises>.

Visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

Visit <https://www.aldoj.gov> for more information about your rights under Alabama law.

Hospital Choice Network

Blue Cross and Blue Shield of Alabama has developed a Hospital Choice Network within the State of Alabama to evaluate cost, quality, and patient experience in member hospitals. Hospitals are categorized into either lower member cost-share or higher member cost-share, based on their performance.

Only Alabama general acute care hospitals are eligible for participation in the Hospital Choice Network. Rehabilitation hospitals, psychiatric hospitals, specialty facilities, out-of-state hospitals, VA hospitals, and long-term care hospitals are exempt from Hospital Choice Network scoring.

All hospitals are evaluated annually with changes made effective January 1. In addition, reviews are completed quarterly, allowing hospitals to improve their status. To review the evaluation criteria for all hospitals and/or the level of member cost-share for a particular hospital, please use the "Find a Doctor" tool on our website at AlabamaBlue.com. The member cost-share level will be included in the information provided for each hospital that participates in the Hospital Choice Network. For more information on the evaluation criteria, click on the name of the hospital and then click on the "Cost", "Quality" or "Patient Experience" tabs. If you have any questions, please call the customer service department number on the back of your ID card.

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 SEIB 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 in this plan book.

Termination of Coverage

Please see Chapter 4, "Termination of Coverage" for more information. If coverage terminates, no benefits will be provided thereafter in most cases, even if for a condition that began before the SEHIP or your coverage termination. Under certain circumstances, you may exercise your right to Continuity of Care if your SEHIP coverage with BCBS terminates. Continuity of Care is explained in detail earlier in this plan book. 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 plan book.

Your Rights

As a member of the Plan, you have the right to:

- Receive information about services, in-network providers, and your rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the Plan provides.
- Make recommendations regarding this member rights and responsibilities policy.

If you would like to voice a complaint, please call the customer service department number on the back of your ID card.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint. Or, you can submit a complaint online at <https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing>.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

Your Responsibilities

As a member of the Plan, you have the responsibility to:

- Supply information (to the extent possible) that is needed for payment of your care and that your providers need to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify, through

the benefits plan book provided to you, the coverage, or lack thereof, under your Plan.

- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Direct Deposit

Blue Cross and Blue Shield of Alabama offers Direct Deposit as an option for receiving payments electronically. Enrolling in Direct Deposit will provide you with faster and more secure payments as your funds will be deposited directly into your bank account. Direct Deposit eliminates the need for mobile deposit, trips to the bank, and the risk of your checks getting lost or stolen.

Please take a moment to consider this option. If you decide you would like to take advantage of Direct Deposit, you may do so by selecting one of the options below:

- Registering for or logging in to myBlueCross at AlabamaBlue.com and selecting Direct Deposit.
- Accessing myBlueCross through the Alabama Blue mobile app on your smartphone.

Chapter 2

Active Employee Eligibility and Enrollment

Visit our website at www.alseib.org to download forms.

Eligible Employees

The term "employee" includes only:

- 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 Alabama Sports Hall of Fame, the State Docks, St. Stephens Historical Commission, USS ALABAMA Battleship Commission, Red Mountain Greenway Commission, County Soil & Water Conservation Districts, and the Alabama Community College System.
- Part-time employees working at least ten hours per week if they agree to have the required premium paid through payroll deduction.
- Members of the Legislature and the Lieutenant Governor during their term of office.

Exclusion: You are not eligible for coverage if the SEIB determines that you are employed on a seasonal, temporary, intermittent, emergency, or contract basis unless you receive a W-2 and work an average of 30 hours per week, or 130 hours per month, during a designated measurement period as stipulated under the Affordable Care Act.

Eligible Dependent

The term "dependent" includes the following individuals:

- Your spouse (excludes divorced or common-law spouse);
- A child under age 26, only if the child is:
 - your son or daughter,
 - legally adopted by you or your spouse,
 - your stepchild, or
 - a dependent for whom you, or your spouse, has legal and physical custody granted by a court of competent jurisdiction.
- An incapacitated dependent child* over age 25 will be considered for coverage provided the dependent is:
 - unmarried,
 - permanently mentally or physically disabled or incapacitated,
 - had the condition prior to the dependent's 26th birthday,
 - incapable of self-sustaining employment,
 - dependent on you for 50% or more financial support,
 - otherwise eligible for coverage as a dependent except for age,
 - covered as a dependent on your Plan immediately prior to the child's 26th birthday, and
 - not eligible for any other group health insurance benefits.

*The above requirements must be met to be eligible for coverage as an incapacitated child. The SEIB shall decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by Medical Review conducted by BCBS. The SEIB reserves the right to periodically recertify incapacitation. Neither a reduction in work capacity nor the inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is employed, the extent of their earning capacity will be evaluated.

See the “Enrolling an Incapacitated Child” section for critical enrollment deadlines. If deadlines are not met and/or continuous coverage is not maintained on the child, an Incapacitated Child over the age of 25 is not eligible for coverage.

Ineligible Dependents

- Your spouse or other dependents if they are independently covered as a state employee unless they are employed as a professional civil engineer trainee with ALDOT and their employment is part of their educational training
- An ex-spouse or ex-stepchildren, regardless of what the divorce decree may state
- Your biological child if the child has been adopted by someone other than your spouse and you have been relieved of your parental rights and responsibilities
- Children age 26 and older
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements listed above under Eligible Dependent
- A child of a dependent child
- A daughter-in-law or son-in-law
- Grandchildren or other children related to the member by blood or marriage for which the member does not have legal and physical custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

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 an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for 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.

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, policies, and procedures. An SEIB Enrollment form (IB02) must be completed by the employee and his/her employer and submitted to the SEIB.

Employees eligible for coverage as a result of working, on average, 30 or more hours per week or 130 or more hours per month during a designated measurement period will be offered coverage to be effective on the first day of a designated stability period. To be enrolled, the employee must complete an SEIB Enrollment form and submit it 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 their 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. 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.

Enrolling an Incapacitated Child

If your child meets the other Incapacitated Child eligibility requirements listed above under Eligible Dependent, you must contact the SEIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the SEIB no more than 60 days after the child's 26th birthday. If you fail to submit the form and proof of incapacity within the required time period, or, if you do not maintain continuous coverage on the incapacitated child thereafter, your child is not eligible for future enrollment except in the following two situations:

1. When a new employee requests coverage for an incapacitated child within 60 days of employment;
or
2. When an employee's incapacitated child 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:
 - the employer ceases operations, or
 - termination of employment or reduction of hours of employment, or
 - employer stopped contributing to coverage,
 - b. a change form is submitted to the SEIB within 30 days of the incapacitated child's loss of other coverage, and
 - c. Medical Review approved incapacitation status.

In these two situations, your child must meet all Incapacitated Child eligibility requirements.

National Medical Support Notices

A National Medical Support Notice (Notice) is an order from a child support enforcement agency directing the Plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. If the SEIB receives a Notice from a child support enforcement agency directing the SEHIP to cover a child, the SEIB will determine whether the Notice is qualified. The SEIB has adopted procedures for determining whether such an order is a Notice. You have a right to obtain a copy of those procedures free of charge by contacting the SEIB.

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

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 Notice, all SEHIP provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the Notice 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.

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 (HIPAA) of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for employees and eligible dependents if:

- the employee declined to enroll in the SEHIP because of other employer group coverage; and
- the employee gains a new dependent through marriage, birth, or adoption; or
- the employee or dependent loses the other employer group coverage because:
 - COBRA coverage (if elected) is exhausted; or
 - loss of eligibility (including separation, divorce, death, termination of employment, or reduction of hours of employment); or
 - employer stopped contributing to coverage.

A request for special enrollment must be submitted to the SEIB within 60 days of the loss of other coverage or within 60 days of gaining a new dependent along with a completed enrollment form or status change form if only adding dependents. In addition, the following documentation must be submitted within 60 days of the qualifying event:

- proof of gaining a new dependent (e.g., marriage certificate, birth certificate, adoption papers) or
- 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 Plan

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

Re-employed state retirees must work an average of 10 hours or more per week to be eligible for re-employed state retiree coverage in the SEHIP. Re-employed state retirees, who work less than 10 hours per week on average, may continue their retiree coverage in the SEHIP, but will not be classified as re-employed state retirees for health insurance purposes.

To comply with the Medicare, Medicaid, and the SCHIP Extension 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 they are expected to work 10 hours or more on average per week. 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 active employee with family SEHIP coverage, the eligible dependents may continue coverage (survivor coverage) in the following circumstances:

- The eligible dependents may continue coverage by making the appropriate premium payments to the SEIB. The SEIB must be notified within 90 days of the date of death.
- Pursuant to Alabama Code Section 36-29-19.9, 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. The SEIB must be notified within 90 days of the date of death. Coverage provided pursuant to Alabama Code Section 36-29-19.9 shall cease upon remarriage or upon the attainment of alternate health insurance coverage.

To be eligible for survivor coverage, a dependent must be covered under the SEHIP immediately prior to the death of the employee. Dependents may not be added to survivor coverage after the death of the employee.

If a dependent with survivor coverage cancels coverage for any reason, the dependent is ineligible for survivor coverage at a later date.

Notice

Notice of any enrollment changes, including status changes or address changes, is the responsibility of the employee.

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 visiting our website at www.alseib.org by mail, or facsimile.

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 by visiting our website at www.alseib.org, or at P.O. Box 304900, Montgomery, Alabama 36130-4900. An address cannot be updated by BCBS or made from the information shown on claim forms.

Employee Name Changes

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

Premium Refunds

In the event you are entitled to a premium refund or any other refund from the SEIB and you die, become incompetent, or are a minor, the SEIB may pay your estate, your guardian, or any relative that, in its judgment, is entitled to the payment. Payment of the refund to one of these people will satisfy the SEIB's obligation to you.

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 and are updated on our website at www.alseib.org.

Spousal Surcharge Waiver

Employees and retirees whose spouses are enrolled in the SEHIP will be charged a \$50 per month surcharge. The SEIB will waive \$25 of the surcharge if the spouse is not eligible for other group health insurance coverage or the single monthly premium is \$255 or more.

To have \$25 of the spousal surcharge waived, you must complete the Spousal Surcharge Waiver Application (either IB25 for employees or IB28 for retirees) available on the SEIB's website and submit the completed form, with appropriate documentation, to the SEIB.

It is the responsibility of the member to notify the SEIB immediately should a covered spouse become eligible for coverage through his or her employer during the waiver period. Any employee or retiree who knowingly and willfully submits false information to the SEIB to obtain a waiver of a portion of the spousal surcharge or fails to immediately notify the SEIB that he or she is no longer eligible for a waiver of a portion of the spousal surcharge will be subject to disciplinary action, up to and including termination of coverage, and will be required to repay all surcharges.

Employees have 60 days from their enrollment date to apply for the spousal surcharge waiver. Covered spouses of active employees, non-Medicare retirees, and non-Medicare covered spouses of retirees have 60 days from their effective date of coverage to apply for the spousal surcharge waiver.

Non-Tobacco User Premium Discount

If you and/or your covered spouse have not used tobacco products in the last 12 consecutive months, you may be eligible for a non-tobacco premium discount. The non-tobacco premium discount will be applied as follows:

- If you, or your covered spouse, do not use tobacco products, your non-tobacco premium discount will be \$65 per month off the base premium.
- If you and your covered spouse do not use tobacco products, your monthly non-tobacco premium discount will be \$130 (\$65 for you and \$65 for your covered spouse) off the base premium.

To obtain the discount, you must submit a completed non-tobacco premium discount application (1B05) to the SEIB. When the SEIB approves the application, you and/or your covered spouse will receive the non-tobacco premium discount and will continue to receive the discount if you and/or your covered spouse remain tobacco-free.

If you and/or your covered spouse have used tobacco products within the last 12 consecutive months, eligibility for the non-tobacco premium discount may be obtained by completing the SEIB tobacco cessation program (See Chapter 20, Tobacco Cessation Program, for additional information). Upon completion of the Program, you must submit a completed annual tobacco user premium discount application (IB06), along with required documentation, to the SEIB. It is your responsibility to ensure the SEIB receives your application. If you continue to use tobacco products, you must complete the tobacco cessation program each year and submit a tobacco user premium discount application (IB06) each year in order to receive the non-tobacco premium discount.

A physician may recommend an alternative method for members and/or covered spouses who use tobacco products to qualify for the non-tobacco premium discount. Contact the SEIB Wellness Division at 1-866-838-3059 or 1-334-263-8431 and we will work with you (and, if you wish, with your physician) to find an alternative method with the same reward that is right for you in light of your health status.

Employees have 90 days from their enrollment date to apply for the discount. Covered spouses of active employees, non-Medicare retirees, and non-Medicare covered spouses of retirees have 90 days from their effective date of coverage to apply for the discount.

Wellness Premium Discount

All active employees, covered spouses of active employees, non-Medicare retirees and covered non-Medicare spouses of retirees enrolled in the SEHIP as their primary insurance plan are eligible for the Wellness Premium Discount by participating in the Achieve Wellness Program. To receive the \$50 per month discount, the following Achieve Wellness Program requirements **must be completed by October 31st of each plan year**:

- Annual wellness screening and, if you are considered to be at-risk, provider follow-up;
- The following preventive care tests, if required for you:
 - Diabetes eye exam once a year
 - Cervical Cancer Screening Pap test only once every 3 years
 - Breast Cancer Screening once every 2 years
 - Colon Cancer Screening- frequency is based on test. Refer to www.alseib.org/wellness.

Annual Wellness Screening

Every eligible participant must be screened annually between November 1 through October 31 at one of the following locations:

- Your worksite through the SEIB's worksite wellness screening program;
- Your local health department;
- A certified pharmacy location; and/or
- A healthcare provider, through the submission of a Provider Screening form.

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

- Blood pressure systolic reading is 160 or above or your diastolic reading is 100 or above;
- Total cholesterol reading is equal to or above 250;
- Glucose reading is equal to or above 200;
- Body mass index is equal to or above 40.

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 the SEHIP and only waives the office visit copay. You are responsible for all other applicable copays, such as lab test copays. Only one office visit copay waiver is allowed within a screening period regardless of how many times you are issued a referral. **This copay**

waiver is not applicable at an emergency room or urgent care center.

If the Annual Wellness Screening indicates that you are at risk, you may still meet the Annual Wellness Screening requirement by:

- Submitting a completed and signed office referral form indicating that you have been counseled by a healthcare provider regarding your risk(s) indicators; or
- Submitting a completed Provider Screening form from your healthcare provider.

An eligible individual may also meet the Annual Wellness Screening requirement if it is deemed that the eligible individual cannot participate in the wellness program due to pregnancy, disability, other infirmity as documented by the eligible individual's healthcare provider, or as otherwise determined by the SEIB.

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, for the Wellness Premium Discount to be effective on January 1 (provided that all other criteria are met), you should complete your Annual Wellness Screening no later than October 31 of the preceding year. New employees will have 90 days from their 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 have 90 days from their effective date of coverage to complete the Annual Wellness Screening requirement. It is your responsibility to ensure that the SEIB has received your Provider Screening form for you to complete the requirements for the wellness screening. For more information, call 1-866-838- 3059 or visit www.alseib.org.

Preventive Care tests

The Achieve Wellness Program is designed to identify certain national standards of care that have not been completed to support your overall health. If you are missing an identified preventive care test, BCBS will notify you. You will have until October 31 of each year to take the appropriate action for preventive care and keep your discount in place. If the appropriate action is not taken, the Wellness Premium Discount will be removed January 1 of the following year. Claims are reviewed monthly to identify those in compliance. The Wellness Premium Discount will be reinstated on the first day of the month following SEIB's notification of your compliance. The Preventive Care categories currently being monitored are:

- Diabetes eye exam once a year
- Cervical Cancer Screening Pap test only once every 3 years
- Breast Cancer Screening once every 2 years
- Colon Cancer Screening- frequency based on test. Refer to www.alseib.org/wellness.

Please visit **AlabamaBlue.com** and log in to *myBlueCross*. Select "Care Reminders" on the right navigation bar under *Manage My Health*. Your Care Reminders will list any overdue services based on national guidelines. You will also be able to see completed services and view upcoming services you will need in the next several months. Even though you may have several care reminders listed, only the Preventive Care tests listed above apply to the Achieve Wellness Program.

Reasonable Accommodation

If you are unable to participate in the Achieve Wellness Program, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the SEIB Wellness Division at 1-866-838-3059 or 1-334-263-8431.

Federal Poverty Level Discount

To qualify for the Federal Poverty Level Discount, active and retired employees must provide a current federal income tax return transcript for the immediately preceding year with a Federal Poverty Level Discount application (IB12) showing that the combined adjusted gross income for you and your spouse, if applicable, is less than or equal to 300% of the federal poverty level. If you are married and file taxes separately, you must also include a copy of your spouse's current (immediately preceding year) federal income tax return transcript. You must include all pages of the transcript(s).

The SEIB calculates any potential premium discount based on the adjusted gross income and the number of individuals in your household reported on the federal income tax return transcript(s). Request your free federal income tax return transcript from the Internal Revenue Service (IRS) at <https://www.irs.gov/individuals/get-transcript> or call 800-908-9946. Please allow 7-10 business days for delivery of your transcript(s).

Reminders:

- The discount will be effective the first day of the second month after the SEIB receives and approves your complete application and transcript(s).
- No refunds will be allowed for late or incomplete applications.
- You must re-apply for the discount every year. The discount expires on June 30th of the following year.
- The discount does not apply to members on COBRA or surviving dependent coverage.

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 does not apply to premium discounts.

Years of service are determined by the Retirement Systems of Alabama (RSA) in accordance with Alabama Code Section 36-29-1, et seq.

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 does not apply to premium discounts.

Years of creditable coverage in the SEHIP are determined by the SEIB in accordance with Alabama Code Section 36-29-1, et seq.

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 who 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 the 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 sliding scale premium effective for employees who 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:

- does not voluntarily terminate participation in the DROP within the first three years and
- 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

Members with a disability retirement on or after January 1, 2012, prior to becoming Medicare-eligible, are still subject to the retiree sliding scale premium components (premium based on years of creditable coverage (YOCC) in the SEHIP and age at retirement).

- These members will be exempt from the YOCC retiree sliding scale premium component for a 24-month period beginning on the first day of the second month after SEIB receives proof of application for SSDI benefits from the Social Security Administration. Therefore, these members should provide proof of application for SSDI benefits at the time they apply for retirement from the RSA.
- This exemption from the YOCC retiree sliding scale premium component will become permanent after SEIB receives proof of award of SSDI benefits.
- If proof of award of SSDI benefits is not received within the initial 24-month exemption window, SEIB will remove the exemption and apply the YOCC retiree sliding scale premium component. SEIB will reinstate the premium exemption prospectively on the first day of the second month after SEIB receives proof of award of SSDI benefits.
- Members who retire on a service retirement and later qualify for SSDI benefits cannot then become exempt from the YOCC retiree sliding scale premium component.

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

Chapter 4

Termination of Coverage

When Coverage Terminates

Coverage under the SEHIP will terminate:

- 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 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.
- On the last day of the month in which you decline coverage or opt-out of the SEHIP.
- When the SEHIP is discontinued.
- In the case of an employee who is eligible and receives insurance pursuant to the provisions of the Affordable Care Act based on working an average of 30 or more hours per week or 130 or more hours per month during a measurement period, coverage terminates on the first day after the applicable stability period if the employee does not average 30/130 or more hours per week/month during a subsequent measurement period.

Coverage under the SEHIP will terminate for a dependent:

- On the last day of the month in which such person ceased to be an eligible dependent.
- If the dependent becomes covered as an employee.
- When premium payments cease for coverage of a deceased active or deceased retired employee.
- When dependent premium payments cease.
- In the case of a dependent who receives insurance based on a member who is eligible and receives insurance pursuant to the provisions of the Affordable Care Act by working an average of 30 or more hours per week or 130 or more hours per month during a measurement period, coverage terminates on the first day after the applicable stability period if the employee does not average 30/130 or more hours per week/month during a subsequent measurement period.

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 the 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 of 1993 (FMLA) 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 the 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.

Who is a Qualified Beneficiary?

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, 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 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.

What Coverage is Available?

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

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the SEIB has been notified that a qualifying event has occurred.

- When Should Your Agency Notify the SEIB? Your agency is responsible for notifying the SEIB within 30 days of the following qualifying events:
 - end of employment;
 - reduction of hours of employment; or
 - death of an employee.
- When Should You Notify the SEIB? The employee or a family member has the responsibility to inform the SEIB within 60 days of the following qualifying events:
 - divorce;
 - legal separation; or
 - a child losing dependent status.

Written notice must be given to the SEIB within the applicable timeframe listed above from the date of the event or the date on 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.

How is COBRA Coverage Provided?

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, 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.

What will be the Length of COBRA 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 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 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, (3) the date of Social Security’s determination or (4) the date on which you, or the qualified beneficiary, is informed, through the furnishing of the SPD or COBRA general notice, of the responsibility to notify the Plan and the procedures for doing so. You must also notify the SEIB within 30 days of any revocation of Social Security disability benefits.

- **Extensions of COBRA for Second Qualifying Events** – If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the SEIB is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage had the first qualifying event not occurred. You must notify the SEIB within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Can New Dependents Be Added to Your COBRA Coverage?

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.

How Does the Family and Medical Leave Act Affect my COBRA Coverage?

If you are on a leave of absence covered by the 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.

How much is my COBRA Coverage Premium?

If you qualify for continuation coverage, you will be required to pay the group's premium plus a 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.

When is my COBRA Coverage Premium Due?

Your initial premium payment is due 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.

When Does my COBRA End?

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

- SEIB no longer provides group health coverage.
- The premium for your continuation coverage is not paid on time.
- You become covered by another group plan.
- You become entitled to Medicare.

- 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 to have full coverage.

Are there other coverage options besides COBRA Continuation Coverage?

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

Keep the SEIB Informed of Address Changes

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, visit the Centers for Medicare & Medicaid Services (CMS) website at [//www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/COBRA.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/COBRA.html) 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
PO 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 Fund.

Eligible Dependent

Please see the Eligible Dependent Section in Chapter 2 for more information.

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. To be eligible, you must provide a physical address to the SEIB.

If coverage is declined at the date of retirement, the SEIB will provide the retiree with a Declination of Coverage form that must be completed and returned to the SEIB to be eligible for special enrollment.

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

Open Enrollment

Retired employees who do not elect to continue their coverage under the SEHIP may enroll 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:

- The retired employee declined to enroll in the SEHIP because of other coverage and submitted a completed SEIB form declining coverage in the SEHIP; and
- The retiree gains a new dependent through marriage, birth, or adoption; or
- The retiree or dependent loses the other employer group coverage because:
 - COBRA coverage (if elected) is exhausted; or
 - loss of eligibility (including separation, divorce, death, termination of employment, or reduction of hours of employment); or
 - employer stopped contributing to coverage.

A request for special enrollment must be submitted to the SEIB within 60 days of the loss of other coverage or within 60 days of gaining a new dependent, along with a completed Enrollment form or Status Change form if only adding dependents. In addition, the following documentation must be submitted within 60 days of the qualifying event:

- proof of gaining a new dependent (e.g., marriage certificate, birth certificate, adoption papers); or
- 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 Plan

Eligible non-Medicare retirees who enroll in the Supplemental 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 must be notified within 90 days of the date of death.

Dependents may not be added to coverage after the death of the retired employee. To be eligible to continue coverage under this section, a dependent must be covered under the SEHIP immediately prior to the death of the retired employee.

If a dependent covered under this section cancels coverage for any reason, the dependent is ineligible for survivor coverage at a later date.

Re-Employed State Retiree

Re-employed state retirees must work an average of 10 hours or more per week to be eligible for re-employed state retiree coverage in the SEHIP. Re-employed state retirees who work less than 10 hours per week on average, may continue their retiree coverage in the SEHIP but will not be classified as re-employed state retirees for health insurance purposes.

To comply with the Medicare, Medicaid, and SCHIP Extension 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 they are expected to work an average of 10 hours or more per week. 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. Members who are eligible for Medicare are automatically enrolled in the Group Medicare Advantage Plan offered by the SEIB. The Medicare Advantage Plan will automatically go into effect unless you complete a Medicare Advantage Opt-Out form and return it to the SEIB within 21 days from the date of the opt-out notice. If you opt-out of the Group Medicare Advantage Plan offered by the SEIB and enroll in another Medicare Advantage Plan, you will not have any medical coverage through the SEIB.

Members enrolled in Medicare Advantage will receive information about the plan's benefits. A link to the Evidence of Coverage, a current drug formulary, participating pharmacy directory, and a provider finder is available at www.alseib.org.

A Medicare-eligible member should have both Medicare Parts A and B to have adequate coverage with the State of Alabama.

Who can opt-out of Medicare Advantage and enroll in the SEHIP?

In limited cases, certain members can opt-out of Medicare Advantage and enroll in SEHIP (Group 13000) secondary coverage without any prescription drug coverage. This is only available if the member:

- is in a skilled nursing facility, or
- has other Part D prescription drug coverage.

If you opt-out of the Medicare Advantage Plan and choose to enroll in SEHIP, SEHIP will be secondary to Medicare Part A and B and you will not have any prescription drug coverage through the SEHIP.

NOTE: Retiree pays the same premium as a Medicare retiree.

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

NOTE: The SEHIP is not a Medicare supplemental plan.

Medicare Part B

If a Medicare-eligible retired employee (retiree) is transitioning from active to retiree status and misses the Medicare enrollment period, then:

- The retiree may have coverage in the SEHIP, until the next Medicare Open Enrollment period, for benefits that would have been covered by Medicare Part B and for prescription drug coverage. The retiree will be required to pay the Early Retiree rate, plus the Medicare Part B premium to the SEHIP.
 - If the retiree does not pay this amount to the SEHIP, the retiree will not have any coverage in the SEHIP for benefits that would have been covered by Medicare Part B and will not have any prescription drug coverage. The SEHIP will only pay secondary to Medicare Part A.

Other than the transition period referenced above, if a retiree fails to maintain Medicare Part B coverage:

- The retiree will not have any coverage in the SEHIP for benefits that would have been covered by Medicare Part B and will not have any prescription drug coverage. The SEHIP will only pay secondary to Medicare Part A.

At any time, if a retiree's Medicare-eligible dependent fails to maintain Medicare Part B coverage, the Medicare-eligible dependent will not have any coverage in the SEHIP for benefits that would have been covered by Medicare Part B and will not have any prescription drug coverage. The SEHIP will only pay secondary to Medicare Part A.

Medicare Part D Prescription Drug Coverage

If you choose another Medicare Part D Plan, you will have no coverage through the Medicare Advantage Plan.

Keep in mind that if you opt-out of Medicare Advantage 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.

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

- you retired after September 30, 2005, and
- you become employed by another employer and are eligible for your other employer's group health insurance coverage, and
- 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 meet the above requirements and fail to enroll in your other employer's group health plan, the SEIB will:

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

Retiree Premiums

Please see Chapter 3 for more information.

Employee Name Change

Name changes must be made in writing and submitted to the SEIB.

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, including radiology procedures, and a select group of provider-administered drugs must be pre-certified by Blue Cross. Visit www.AlabamaBlue.com for a complete list of procedures or drugs that require precertification;
- Preferred Provider Organization (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 a preferred provider or not) who is recognized by BCBS as an approved provider for the type of service or supply being furnished. For example, BCBS reserves the right not to pay for some or all services or supplies furnished by certain persons who are not medical doctors (MDs), even if the services or supplies are within the scope of the provider's license. Call BCBS Customer Service if you have any questions about whether your provider is recognized by BCBS 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	\$9,200 for individual, \$18,400 for family. Certain benefits pay at 100% of the allowed amount thereafter.	Out-of-network services do not apply to the out-of-pocket maximum.

Calendar Year Deductible

In certain circumstances as and when required by Federal law, the cost-sharing amounts (deductibles, copayments, and coinsurance) that you are required to pay for out-of-network services will apply to the in-network calendar year deductible. Those services include:

- Medical or Accident emergency
- Air Ambulance
- Certain Non-emergency services performed by out-of-network providers at certain in-network facilities

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 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 toward 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:

- Most cost-sharing amounts (deductibles, copayments, and coinsurance) paid for any out-of-network services or supplies that may be covered under the plan (except for covered out-of-network mental health disorders and substance abuse services for medical emergencies);
- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies more than 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 more than 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).

In certain circumstances as and when required by Federal law, the cost-sharing amounts (deductibles, copayments, and coinsurance) that you are required to pay for out-of-network services will apply to the in-network calendar year out-of-pocket maximum. Those services include:

- Medical or Accident emergency
- Air Ambulance
- Certain non-emergency services performed by out-of-network providers at certain in-network facilities

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 toward 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 \$9,200, 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 \$18,400.

Pharmaceutical manufacturer coupons may be used to defray member cost-sharing obligations; however, any such coupon payments cannot be used or accumulated to reach the out-of-pocket maximum.

Other Cost-Sharing Provisions

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

- **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.
- **Amounts in excess of the allowed amount:** As a general rule, 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 us 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. As one example, certain out-of-network facility claims may 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 plan. This means you could be responsible for these charges if you use an out-of-network provider.
- **Provider Administered Specialty Drug Financial Assistance:** In most cases, only the amount you pay out-of-pocket for your provider administered specialty drugs will apply to your cost-sharing responsibilities or out-of-pocket limit. Except for certain specialty drugs, the dollar amount of any financial assistance provided to you by providers or manufacturers will not count towards coinsurance, copays, deductible cost-sharing responsibilities, or out-of-pocket limit.

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 Plan"). In some instances, you may obtain care from non-participating healthcare providers. 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 Plan, BCBS will remain responsible for fulfilling our contractual obligations. However, the Host Plan 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 Plan 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.

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 Negotiated Arrangements for National Accounts.

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 Plan.

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

- Member Liability Calculation

When covered healthcare services are provided outside of the 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's 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 BCBS will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

- Exceptions

In certain situations, BCBS may use other payment methods, such as billed covered charges, the payment BCBS would make if the healthcare services had been obtained within its service area, or a special negotiated payment to determine the amount they will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBS will make for the covered healthcare services as set forth in this paragraph.

D. Blue Cross Blue Shield Global® Core

If you are outside the United States, (hereinafter “BlueCard service area”), you may be able to take advantage of the Blue Cross Blue Shield Global® Core service center when accessing covered

healthcare services. The Blue Cross Blue Shield Global® Core is not served by a host plan.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. You must contact us to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

Physicians, urgent care centers, and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global® Core Claim**

When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure the timely processing of your claim. The claim form is available from BCBS, the service center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Chapter 9

Inpatient Hospital Benefits

Attention: Precertification is required for all hospital admissions, except for medical emergency services, maternity admissions, and as required by Federal law.

For medical emergency services, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

For precertification call 1-800-248-2342 (toll-free).

Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

(There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the plan.)

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. The SEIB may not 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 cesarean section, a 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 and it will be considered to be a separate hospital admission.

Deductible

For each certified hospital admission, the deductible for inpatient hospital benefits is \$250 (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 PPO or Participating Hospital

Inpatient hospital benefits consist of the following if provided during a hospital stay:

- Bed and board and general nursing care in a semiprivate room;

- Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them;
- Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
- Administration of anesthetics and all necessary equipment and supplies;
- Casts, splints, surgical dressings, treatment, and dressing trays;
- Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and X-rays;
- Physical therapy, hydrotherapy, radiation therapy, and chemotherapy;
- Oxygen and equipment to administer it;
- All drugs and medicines used by you if administered in the hospital;
- Regular nursery care and diaper service for a newborn baby while its mother has coverage; and,
- Blood transfusions administered by a hospital employee.

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 Bone Marrow Transplants

The organs for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney; and (6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on the BCBS list of approved facilities for that type of transplant and it must have BCBS' advance written approval. When BCBS approves a facility for transplant services it is limited to the specific types of transplants stated. Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical, and other services related to the transplant, including blood and blood plasma. Transplant benefits for cadaveric donor organ costs are limited to search, removal, storage, and transporting of the organ and removal team. Transplant benefits for living donor expenses are limited to:

- solid organs: testing for related and unrelated donors as pre-approved by us
- bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrowregistry
- prediagnostic testing expenses of the actual donor for the approved transplant
- hospital and surgical expenses for removal of the donor organ, and all such services provided to the donor during the admission
- transportation of the donated organ
- post-operative hospital, medical, laboratory, and other services for the donor related to the organ transplant are limited to up to 90 days of follow-up care after the date of donation.

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copays, coinsurance, and other plan limitations. For example, if the member's coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

There are no transplant benefits for: (1) any investigational/experimental artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this Plan; (6) donor costs if the recipient is not covered by this Plan; (7) recipient or donor lodging, food, or transportation costs, unless otherwise specifically stated in the Plan; (8) a condition or disease for which a transplant is considered investigational; (9) transplants (excluding kidney) performed in a facility, not on BCBS' approved list for that type or for which BCBS has not given written approval in advance.

Tissue, cell, and any other transplants not listed above are not included in this organ and bone marrow transplant benefit but may be covered under other applicable provisions of the Plan when determined to be medically necessary and not investigational. These transplants include but are not limited to heart valves, tendons, ligaments, meniscus, cornea, cartilage, skin, bone, and veins.

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. Precertification is required for certain outpatient hospital procedures, including radiology procedures, and provider-administered drugs. Some of the procedures are listed below and are subject to change. For a complete listing and precertification please call 1-800-551-2294.

- Charges to treat an accidental injury.
- Charges for outpatient surgery, **after you pay a \$250 copayment.**
- Charges for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention), **after a \$250 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 \$75 copayment.**
- Charges for hemodialysis in a hospital outpatient department or free-standing dialysis center are covered at 100% with no deductible or coinsurance.
- 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.**
- 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" which have a \$75 copay).

Certain outpatient surgical/diagnostic procedures, including radiology procedures and provider-administered drugs, require precertification. Contact BCBS at 1-800-551-2294 or www.AlabamaBlue.com before receiving services. Examples of procedures that require precertification are listed below. This is only a partial list of procedures and is subject to change.

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

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 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.

Precertification

Precertification is required for certain outpatient hospital benefits, physician benefits, and other covered services. The general categories or descriptions of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the filing of this plan book are set forth below. Examples are for illustrative purposes only. You can find more information about the specific services that require precertification at AlabamaBlue.com/Precert. This list will be updated no more than twice per calendar year. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services

Services that require precertification currently include:

- Certain advanced imaging (such as, for example, MRA, MRI, CT, CTA, and PET).
 - For precertification, call 1-866-803-8002 (toll-free).
- Intensive outpatient services and partial hospitalization.
 - For precertification, call 1-800-548-9859 (toll-free)
- Certain select procedures (such as, for example, implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, and surgery for obstructive sleep apnea).
 - For precertification, call 1-800-248-2342 (toll-free).
- Certain reconstructive procedures (such as, for example, blepharoplasty; rhinoplasty, and surgery for varicose veins).
 - For precertification, call 1-866-248-2342 (toll-free).
- Certain durable medical equipment.
 - For precertification, call 1-800-248-2342 (toll-free).
- Home health and hospice when services are rendered outside the state of Alabama.
 - For precertification, call 1-800-821-7231 (toll-free).
- Certain radiation therapy management services (such as, for example, proton beam therapy, cyberknife, and stereotactic radiosurgery).
 - For precertification, call 1-866-803-8002 (toll-free).
- Certain genetic laboratory testing (such as, for example, breast cancer (BRCA) testing and genetic carrier screening).
 - For precertification, call 1-866-803-8002 (toll-free).
- ABA therapy
 - For precertification, call 1-877-563-9347 (toll-free).

If precertification is not obtained, no benefits will be payable under the plan for the services.

You will be required to pay the billed charges for such services if we later determine that it was not medically necessary.

Chapter 11

Outpatient Diagnostic Procedures

Certain outpatient surgical/diagnostic procedures, including radiology procedures and provider-administered drugs, require precertification. Contact BCBS at 1-866-803-8002 (toll-free) or www.AlabamaBlue.com before receiving services. Examples of procedures that require precertification are listed below. This is only a partial list of procedures and is subject to change. It is your responsibility to make sure that your provider obtains prior authorization. Failure to comply may result in reduced benefits. If you do not obtain prior authorization of an outpatient diagnostic procedure listed below, BCBS will not pay for your outpatient procedure or any related charges. The following outpatient diagnostic procedures are subject to a **\$75** copay per test, limited to two copayments per date of service, and require prior authorization:

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

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

- Colonoscopy
- ERCP
- UGI endoscopy
- Thallium Scan

Chapter 12

Medical Utilization Management

Inpatient Hospitalization

It is your responsibility to notify BCBS about all admissions. 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. After 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 the filing of your appeal, such as the 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 BCBS within two years from the date the claims report is issued by BCBS.

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 the 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.

Baby Yourself Maternity Management Program

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 a case manager, call 1-800-551-2294.

If BCBS determines that you are a suitable candidate for individual case management, BCBS 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 LASIK).

Because individual case management is designed to provide the most appropriate benefits for each 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 make a written request 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 60 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.

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 BCBS.

"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, a 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, AL 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 as medically necessary. 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 four 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 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.

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.AlabamaBlue.com/preventiveservices for a listing of specific immunizations and preventive care services. 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)
- Blood 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.

Note: In some cases, routine immunizations and routine preventive services may be billed separately from your office or other facility visit. In that case, the applicable office visit or outpatient facility cost-sharing amounts may apply. In any case, applicable office visit or facility visit cost-sharing amounts may still apply when the primary purpose of your visit is not routine preventative services and/or routine immunizations.

Chapter 14

Preferred Provider Organization

When you use a Preferred Provider Organization (PPO) 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 PPO Program. Please call 1-800-810-BLUE (2583) or access the Blue Cross website at www.AlabamaBlue.com to find out if your provider is a PPO member.

Preferred Provider Benefits for Physicians, Nurse Practitioners, and Physician 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 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.

Certain outpatient surgical/diagnostic procedures, including radiology procedures and provider-administered drugs, require precertification. Contact BCBS at 1-800-551-2294 or AlabamaBlue.com before receiving services. Please note the list of procedures and/or drugs requiring precertification is subject to change.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, or physician's office. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

Provider-administered drug coverage is subject to Drug Coverage Guidelines found in the pharmacy section of AlabamaBlue.com. A drug may not be covered under the Plan because, for example, there are safety and/or efficacy concerns. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug.

- **Office Care Services** - the examination, diagnosis, and treatment of 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 **\$35** nurse practitioner or physician's assistant copay for each visit.
- **Surgical Care Services** - services for operations and cutting procedures and inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, heart catheterization, and of an assisting provider who assists in the performance of surgical procedures when medically necessary. Surgeries performed in the office are subject to a **\$35 copay**.
- **Maternity care--** includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- **Inpatient hospital visits** related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.
- **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 a **\$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 applicable copay (physician **\$35**, nurse practitioner or physician's assistant **\$35**) for each visit.

Teladoc® Benefits

Members have access to Teladoc®, which provides consultations with board-certified doctors via phone or video 24 hours a day/7 days a week. This service is available at zero copay and can be used to speak with a doctor about a variety of issues such as colds, flu, allergies, infections, and more. When necessary, the doctor can prescribe the appropriate medication needed for treatment. This benefit can be used in place of the emergency room or urgent care for non-emergency situations. To enroll, go to Teladoc.com/Alabama or call 1-855-477-4549. Teladoc® consultations are covered at 100% of the allowance with no deductible, coinsurance, or copayment.

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 an 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 (the Blue Choice Behavioral Health Network listing is available at www.AlabamaBlue.com) outpatient treatment for mental and nervous disorders will be covered at 100% of the fee schedule with a **\$35** copay per visit. (Other copayments may apply based on the services received.) Mental health day hospitalization, intensive day treatment, and supportive day treatment are covered at 100% of the fee schedule with a \$35 copay per visit. You can receive outpatient substance abuse sessions covered at 100% of the fee schedule with a \$35 copay per visit 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 100% of the allowance, subject to a \$250 per admission deductible and \$25 copay per day for days 2-5 per admission.

To be eligible for inpatient facility benefits, all inpatient admissions and stays (except medical emergencies that must have post-admission review) 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 PPO, contact the SEIB, BCBS Customer Service, or visit www.AlabamaBlue.com. 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 at 80% of the fee schedule, subject to the calendar year deductible. You will be responsible for 20% of the 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 the fee schedule after a **\$250** deductible per admission. You are responsible for 20% of

the 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 required 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 BCBS website at www.AlabamaBlue.com.

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 BCBS's payment (along with the 20% coinsurance due from the patient) as payment in full; the patient will not be balance-billed for any "overage" charges. All benefit payments will go to the participating chiropractor.

Precertification is required after the 18th visit. The participating chiropractor will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

Chapter 17

Prescription Drug Benefits

Prescription Drug Benefits (administered by Prime Therapeutics)

Except for the Provider-Administered Drugs referenced below, prescription drug benefits are administered by Prime Therapeutics (Prime) (1-800-824-0435).

To take advantage of the program, you should choose a participating pharmacy and show your BCBS/Prime 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 BCBS/Prime ID card to the pharmacist.

A participating pharmacy is any pharmacy that has contracted with Prime 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." Prescription drug coverage is limited to prescription products approved by the Federal Drug Administration (FDA) as evidenced by a New Drug Application (NDA), Abbreviated New Drug Application (ANDA), or Biologics License Application (BLA) on file with the FDA.

Under Alabama law, a pharmacist is required 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.

Prime 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 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 trial 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 a Tier 2 drug.

Eligible prescription drugs dispensed by a participating pharmacy will be covered as follows:

Active Employees and Non-Medicare Retirees

Tier 1 – Low-Cost Generics and Some Brand-Name Drugs

- \$10 copay for 30-day supply
 - \$10 copay for 60-day maintenance drug supply
 - \$20 copay for 90-day maintenance drug supply
- If the drug is over \$50, the member will pay the Tier 2 copay.

Tier 2 – High-Cost Generics and Preferred Brand Drugs

- **30-day Supply** - 20% of the cost of the prescription with a minimum copay of \$45 and a maximum copay of \$85 per prescription
- **60-day Maintenance Drug Supply** - 20% of the cost of the prescription with a minimum copay of \$45 and a maximum copay of \$85 per prescription
- **90-day Maintenance Drug Supply** - 20% of the cost of the prescription with a minimum copay of \$45 and a maximum copay of \$85 per prescription

Tier 3 – Non-Preferred Brand Drugs

- **30-day Supply** - 50% of the cost of the prescription with a minimum copay of \$65 and a maximum copay of \$125 per prescription

Tier 4 – Other Non-Preferred Drugs

- **30-day Supply** - 50% of the cost of the prescription with a maximum copay of \$150 per prescription

Tier 5 – Specialty Drugs

- **30-day Supply** - \$150 copay per prescription; Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs.

(Tiers 3, 4, and 5 prescriptions are only allowed in a 30-day supply even if they are classified as maintenance drugs.)

For a drug to be considered a maintenance drug, the drug must meet all the following maintenance drug criteria:

- The drug has a low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic response over a course of prolonged therapy.
- The drug's most common use is to treat a chronic disease state.
- The drug is administered continuously rather than intermittently.
- 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.
- The drug is a Tier 1 or Tier 2 drug.

The drug lists are also available at www.MyPrime.com. **Please note that the drug list and/or formulary are subject to change without notice.** Prime reserves the right to place limits on or require prior approval on certain medications.

Coverage for Fertility Drugs

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

Provider-Administered Drugs (administered by BCBS)

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis, in a hospital, other medical facility, or physician's office. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

Provider-administered drug coverage is subject to Drug Coverage Guidelines found in the pharmacy section of AlabamaBlue.com. A drug may not be covered under the Plan because, for example, there are safety and/or efficacy concerns. The guidelines in some instances also require you to obtain precertification as to the medical necessity of the drug. You can find a list of the provider-administered drugs that require precertification at AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. This list will be updated monthly. For precertification, call the Customer Service Department number on the back of your ID card. **If precertification is not obtained, no benefits will be payable under the plan for the provider-administered drug.**

HealthSmartRx: Smart RxAssist Program (administered by BCBS)

Many provider-administered drugs have manufacturer financial assistance programs to help patients with the cost of these high-cost drugs. Your benefit requires participation in the program to ensure you are paying the lowest possible cost for your eligible drugs. You can find a list of eligible drugs in this program at AlabamaBlue.com/Providers/HealthSmartRx. The copays may vary and be set to the maximum of any available manufacturer financial assistance (coupon).

The State Employees' Insurance Board is offering the Program so the member copayment will be less than the otherwise applicable copayment or reduced to zero. Please contact HealthSmartRx at 1-833-800-4032 to complete your required enrollment process. Only actual out-of-pocket payments will count toward your annual out-of-pocket maximum.

FlexAccess (administered by Prime Therapeutics)

The FlexAccess program is designed to help you save money on certain specialty medications by obtaining copay assistance from drug manufacturers when available. Once you start receiving the manufacturer-funded copay assistance through the FlexAccess program, your copay will be between \$0-\$35 per eligible prescription. You will continue to pay the reduced copay amount until the end of the calendar year even if your copay assistance funds run out prior to December 31st. While enrolled in the program, only your copay amount will apply toward your annual maximum out-of-pocket.

NOTE: Not all specialty medications are eligible for manufacturer copay assistance through the FlexAccess Program. For specialty medications that are not eligible through the FlexAccess program members will pay their applicable drug tier cost share.

Call FlexAccess at 1 (888) 302-3618 to see if your medication(s) is on the list of eligible medication(s) for manufacturer assistance. If your medication is eligible, they will provide you with next steps to enroll with the manufacturer to obtain funding.

Prescription Drug Appeal Process

You have the right to appeal any decision that denies payment for an item or service (in whole or in part). You may also submit written comments, documents, or other information relevant to the appeal.

You, your prescriber, or your authorized representative (someone you name to act for you, such as a family member, an attorney, or a friend) may file an appeal. Prime reserves the right to establish and implement reasonable procedures to determine whether an individual has been authorized to act as your representative.

You have the right to appeal a medication coverage decision within 180 calendar days from the date of the denial notification. You or your prescriber can get appeals information, including independent appeal rights, by calling Prime's appeals coordinator at 1-800-824-4035.

To file an appeal, please send any written comments, documents, or other relevant documentation with your appeal to the address listed below.

If you proceed with the appeals process, Prime will review the denial decision and provide you with a written determination within 30 calendar days of receiving your appeal.

If any of the following occurs, you may be able to request an external review of your claim by an independent third party, known as an independent review organization (IRO), which will review the denial and issue a final decision:

- You do not receive a timely decision
- Prime continues to deny the payment, coverage, or service requested after the final level of internal appeal
- Prime does not adhere to certain legal requirements regarding claims procedures.

External Review is not available for drugs that are not covered/excluded under the benefit.

If your situation meets the definition of urgent under the law, your review will be rushed. Generally, an urgent situation is one in which the standard time frame for a decision:

- Could seriously jeopardize your life or health or your ability to regain maximum function, based on a prudent layperson's judgment
- In the opinion of a practitioner with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

If you believe your situation is urgent, you may request an expedited appeal by calling Prime at 1-800- 824-4035.

You will be notified of the result of your expedited appeal within 72 hours of the receipt of the appeal request. If you are in an urgent situation, you may be allowed to proceed with an expedited external review at the same time as the internal appeals process under your plan.

External Review Process

An external review is a complete re-examination of your case by an independent review organization (IRO). External Review is not available for drugs that are not covered/excluded under the benefit.

You, your prescriber, or your authorized representative (someone you name to act for you, such as a family member, an attorney, or a friend) may request an external review. Prime reserves the right to establish and implement reasonable procedures to determine whether an individual has been authorized to act as your representative.

To file an external review, you must send Prime a letter within four months of receiving the final letter of denial (or if you meet the situation above regarding an urgent appeal) and explain the reason for your disagreement with this denial decision.

You are not required to bear any costs, including filing fees, when requesting a case to be sent for external review to an IRO.

Prime will forward your letter and the entire case file to the IRO within five business days of receiving your information, or within two business days for an expedited external review.

Upon receiving your information, the IRO will notify you whether your request is eligible and accepted for an external review. Once you receive this letter, you have 10 business days to submit (in writing) additional information for the IRO to consider in its review.

The IRO will provide you a written notice of the final external review decision within 45 calendar days after the IRO receives the request for the external review, or within 72 hours for urgent requests. If the IRO overturns the denial, Prime will authorize or pay for the services in question.

To file an external review and provide additional information about your request, please send any written comments, documents, or other relevant documentation with your request to the address listed below.

You may request an expedited external review by contacting Prime within four months of the date of notice of denial by calling 1-800-824-4035 or by faxing.

Chapter 18

Chronic Condition Management

The Plan offers wellness programs designed to assist you with the management of certain chronic conditions. We may identify your eligibility for one of these programs through medical claims, pharmacy claims, or your annual biometric screening results.

If eligible, we will provide program information to you at your wellness screening, or through electronic or regular mail. We encourage you to enroll at your wellness screening, but you can also enroll after reviewing the information provided via the contact information below.

The wellness programs provide information and most offer a health care professional specializing in your condition to help develop your health goals, such as losing weight, lowering your blood pressure, or reducing your blood sugar. We will help you reach your goals.

The wellness programs below are available to eligible members at no cost to you and are designed to assist you in managing your condition(s) and improving your quality of life.

Chronic Conditions	Program Description	Enrollment / Contact Information
Type 2 Diabetes	<p>Virta Health provides the opportunity for diabetes reversal—a reduction or elimination of diabetes medications and improved health.</p> <p>Virta addresses the root cause of diabetes: nutrition. They use carbohydrate restriction, a powerful tool for people with type 2 diabetes that lowers blood sugar while allowing people to eat to satisfaction.</p> <p>Virta is available for subscribers and spouses with Type 2 Diabetes.</p>	<p>Step 1 is to start the application process on Virta's website. https://www.virtahealth.com/sehip</p> <p>Step 2 is to be paired with a Virta Enrollment Advisor, who can answer questions related to:</p> <ul style="list-style-type: none"> • The Virta Treatment • Application process • Insurance coverage • International coverage • Admittance based on medical history <p>If you have questions or need general information, please email support@virtahealth.com or go to their website https://www.virtahealth.com/sehip</p>

Chronic Conditions	Program Description	Enrollment / Contact Information
<ul style="list-style-type: none"> • Coronary Artery Disease • Congestive Heart Failure • Chronic Kidney Disease • Chronic Obstructive Pulmonary Disease • Asthma • Hypertension • Musculoskeletal Pain • Diabetes • Prediabetes • Weight Management 	<p>The BCBS Disease Management program focuses on chronic health conditions that are sometimes debilitating but can be managed through early intervention, awareness of appropriate treatment, and lifestyle changes. Participants receive:</p> <ul style="list-style-type: none"> • 1:1 coaching via telephone with a Registered Nurse, Dietician, or other clinical resource • A health assessment, if needed, to assist in better managing the condition • Educational materials such as helpful self-monitoring charts, resource listings, self-care tips, and bi-annual newsletters <p>BCBS programs are available for members with one or several of the conditions listed.</p>	<p>Call BCBS at 1-833-964-1448 or email myBlueHealth@bcbsal.org</p>

Please note that the programs and information resources available may change from time to time.

Health Coaching

Blue Cross offers personalized health coaching to help you improve your health and well-being. Once enrolled, you'll receive one-on-one support from a team of specialists dedicated to helping you make healthier choices and reduce health risks.

Clinical Health Coaches focus on engaging members with obesity, prediabetes and hypertension. Your coach will work with you to set health goals, connect you with helpful community resources, explain medications and treatments, and create nutrition and exercise action plans. This support helps you feel your best, so you can keep enjoying the things you love.

Committing to making healthier choices can improve your health, reduce hospital visits, and potentially lower healthcare costs. Health coaches can guide you on how to eat better, quit smoking, improve sleep, and manage stress to improve health outcomes and quality of life.

Your Health Coaching Team Includes:

- Nurses
- Registered dietitians
- Certified Diabetes Care and Education Specialists®
- Licensed clinical social workers
- Counselors
- Nutritionists

Health coaches also provide resources and ongoing education to help you understand healthcare services and adjust your lifestyle to meet your health goals.

To enroll in the health coaching program, call **1-855-699-6168**, Monday-Friday, 7 a.m.–6 p.m. Central time. Participation is voluntary, confidential, and offered at no extra cost.

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 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 faxing or mailing 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**

**Email: wellness@alseib.org
Fax: 334.263.8631**

Medications, either by prescription or over the counter, are excluded from the program. Food and dietary supplements are excluded from the program.

You must file your claims for this benefit with the SEIB, not BCBS; however, BCBS will process the reimbursement.

Chapter 20

Tobacco Cessation Program

Tobacco Cessation Program

A Tobacco Cessation Program is provided by the SEIB for subscribers and their covered spouses. Program literature can be obtained through our Wellness Program and on our website. For more information about the program, call Alabama's Tobacco Quitline at 1-800-QUIT-NOW (1-800-784-8669) or visit www.quitnowalabama.com. The SEIB program offers free master's level counseling and coverage for all FSA-approved tobacco cessation medications (both prescription and OTC) for a 90-day treatment regimen when prescribed by a provider. This is available if you are in counseling with the Quitline and do not have medical contraindications.

This Program is separate from the preventive care benefits provided for tobacco cessation under the requirements of the Affordable Care Act. See the Routine Preventive Care Benefits section of the Summary of Benefits and/or go to AlabamaBlue.com/preventiveservices to see the benefits available for tobacco cessation.

Note: E-cigarettes are not eligible for reimbursement through the SEIB's tobacco cessation program or as an approved tobacco cessation product.

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, a maximum of three deductibles per family. Major medical deductibles and coinsurance apply to annual out-of-pocket maximums of \$9,200 for individuals and \$18,400 aggregate for families.

Only one deductible applies to covered major medical expenses incurred for the 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.
- Claims with emergency room charges that do not meet medical emergency guidelines.
- 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 above this maximum must be certified through case management. For more information, please call 1-800-551-2294.
- Prosthetic devices, such as an artificial arm, and orthopedic devices, such as a leg brace.
- Services by a physician to treat or replace natural teeth that are harmed by accidental injury, if the services are medically necessary and provided within 12 months of the accidental injury.
- Medical supplies such as oxygen, crutches, splints, casts, trusses and braces, syringes and needles (other than insulin supplies), 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. A provider must certify that the ambulance service was necessary if BCBS requests it.
- 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.
- Private duty nursing services of a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.) if: the services actually require the professional skills of an R.N. 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. To be covered, private duty nursing services **must** be pre-certified by BCBS through case management prior to services being provided. For more information, please 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. For more information, please call 1-800-551-2294.
- Physical therapy is covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-551-2294.
- Speech therapy is covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-551-2294.
- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-551-2294.
- Coverage for Autism Spectrum Disorder - The plan covers the screening, diagnosis, and treatment of Autism Spectrum Disorder for children 18 years of age or under. For coverage related to the screening, diagnosis, and treatment of Autism Spectrum Disorder, precertification shall be based on the most recent treatment plan. BCBS may only request an updated treatment plan once every six months from the treating licensed physician or licensed psychologist to review medical necessity, unless BCBS and the treating licensed physician or licensed psychologist agree that a more frequent review is necessary for a particular patient. Coverage is limited to children 18 years of age or under. Additional specific benefit limits include:
 - Applied Behavioral Analysis (ABA) Therapy
 - **In-Network (PPO)** - Covered at 100% of the allowance, subject to a \$35 copay per visit. Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For more information, please call 1-877-563-9347.
 - **Out of Network – (NON-PPO)** - Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For more information, please call 1-877-563-9347.
 - Physical therapy is covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-551-2294.

- Speech therapy is covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-551-2294.
- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, 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 (for deductibles, copayments, and coinsurance) up to a MAXIMUM OF **\$500** for care because of a single accident.

Covered services under this supplemental accident rider include:

- **\$35** PPO provider or **\$35** 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-rays 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 for 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 supplemental accident rider:

- PPO Services (except **\$35** PPO physician or **\$35** 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

Outpatient Treatment of Accidental Injury

Coinsurance, copayments, and deductible amounts for eligible medical expenses for services and supplies that are solely for the diagnosis and treatment of accidental bodily injury (excluding eye refractions and the fitting or furnishings of eyeglasses) are reimbursable up to \$500 per occurrence. Your provider must file a valid accident diagnosis code on the claim that is sent to BCBS following our policies. You may have to pay the normally applicable deductible and/or coinsurance amounts to the provider at the time of service and be reimbursed by BCBS for these amounts when the claim is filed and processed as a valid accident diagnosis code claim. Normal contract requirements apply to accident services. For example, services must not be considered investigational or experimental and must meet medical necessity criteria.

Chapter 23

Medical Exclusions

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

A

- Services, expenses, or supplies for **abortion** (except when necessary to prevent a serious health risk to the woman as permitted by applicable laws).
- 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 questions 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 an out-of-network hospital stay, except one for an emergency, unless BCBS has approved and **pre-certified** it before your admission. Services or expenses of an out-of-network hospital stay for an emergency if BCBS is not notified within 48 hours, or on its next business day after your admission, or if BCBS determines that the admission was not medically necessary.
- Services or expenses for which a **claim** is not properly submitted to BCBS.
- Services or expenses for a **claim not received within 365 days** 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 BCBS's satisfaction that surgery is reconstructive and not cosmetic. You must show BCBS history and physical exams, visual field measures, photographs, and medical records before and after surgery. BCBS 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, facelifts, buttock and thigh lifts, breast implants (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 performed. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this, they have a 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 **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.

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.
- **Eyeglasses** or contact lenses or related examinations or fittings, except under limited circumstances.
- 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 LASIK.

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).
- Prescription drugs not approved by the Federal Drug Administration (**FDA**).

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

- **Implantable devices** (and services, supplies, equipment and accessories ancillary to implantation of same), unless provided by an in-network provider or in-network third party vendor and covered by the terms of the applicable in-network contract or as otherwise required by law.
- Services or expenses for or related to the diagnosis or treatment of an **intellectual disability or intellectual developmental disorder**.
- **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's participation in an approved clinical trial and is prohibited from dropping coverage because a 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** and will not further improve the patient's health status or is not reasonable as to number, frequency, or duration (i.e. cleaning, meal preparation, personal care, hygiene assistance, etc.).

M

- Services or expenses BCBS determines 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.

N

- 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 for which payment for your coverage has not been made and that **nonpayment** results in termination of coverage.

O

- Unless otherwise expressly covered under this Plan, 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 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 (rehabilitative or habilitative)** for the 16th and subsequent visits that were not precertified.
- **Private duty nursing services** that have not been precertified.

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, unless the admission is determined to be medically necessary for acute inpatient rehabilitation.
- 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.
- **Replacement** or upgrade of existing properly functioning durable medical equipment (including prosthetics), even if the warranty has expired.
- Services or supplies furnished by a facility that is solely classified as a **residential treatment center**. This does not exclude covered services or supplies for treatment of an eating disorder furnished by a residential treatment center or covered substance abuse services or supplies furnished by a general hospital, psychiatric specialty hospital, or substance abuse facility.
- **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 Care" Chapter.
- **Routine physical examinations** except for the services described in "Routine Preventive Care."

S

- Services or expenses for, or related to **sex therapy** programs or treatment for **sex offenders**.
- **Services** or expenses for treatment while confined in a prison, jail, or other penal institution.
- Services or expenses of any kind for, or related to, reverse **sterilizations**.
- **Services** or supplies furnished by a **skilled nursing facility**.
- Services or expenses, including prescription drugs for, or related to, **sexual dysfunctions** or inadequacies.
- Services or supplies furnished by a **substance abuse residential facility**.

- Services, **supplies**, equipment, accessories, or other items which can be purchased at retail establishments or otherwise over-the-counter without a doctor's prescription that are not otherwise covered services under this plan, including but not limited to:
 - Hot and cold packs;
 - Standard batteries used to power medical or durable medical equipment; Solutions used to clean or prepare skin or minor wounds, including alcohol solution or wipes, povidone-iodine solution or wipes, hydrogen peroxide, and adhesive remover; Standard dressing supplies and bandages used to protect minor wounds such as band-aids, 4 x 4 gauze pads, tape, compression bandages, and eye patches; Elimination and incontinence supplies such as urinals, diapers, and bedpans; as well as blood pressure cuffs, sphygmometers, stethoscopes, and thermometers.

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 that are harmed by accidental injury covered under major medical.

- 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 unless otherwise required by law. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.
- **Transcutaneous Electrical Nerve Stimulation (TENS)** equipment and all related supplies including TENS units, conductive garments, application of electrodes, leads, electrodes, batteries, and skin preparation solutions.
- 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.

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- 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 a 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, whether 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 protected health information (PHI) is important to the SEIB. Under 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 PHI to treatment, payment, and health care operations. This section of this plan book explains some of HIPAA's requirements. Additional information is contained in the SEHIP's notice of privacy practices at the front of this plan book. You may also request a copy of this notice by contacting the SEIB.

Disclosures of Protected Health Information to the Plan Sponsor:

For your benefits to be properly administered, the SEHIP needs to share your PHI with the plan sponsor (the State of Alabama). The SEHIP may disclose your PHI to the plan sponsor under the following circumstances:

- The SEHIP may disclose your PHI to the plan sponsor for plan administrative purposes, as required by law, or as permitted under HIPAA regulations. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the SEHIP.

The following restrictions apply to the plan sponsor's use and disclosure of your PHI:

- The plan sponsor will only use or disclose your PHI for plan administrative purposes, as required by law, or as permitted under HIPAA regulations. See the SEHIP's privacy notice for more information about permitted uses and disclosures of PHI under HIPAA.
- If the plan sponsor discloses any of your PHI to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your PHI as required by HIPAA regulations.
- The plan sponsor will not use or disclose your PHI 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 PHI that is inconsistent with the uses or disclosures allowed in this section of this plan book.
- The plan sponsor will allow you or the SEHIP to inspect and copy any PHI about you that is in the plan sponsor's custody and control. 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 PHI to the extent permitted or required under HIPAA regulations.
- Concerning some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back six years. 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 PHI available to the SEHIP and the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your PHI in the plan sponsor's custody or control that the plan sponsor has received from the SEHIP or any business associate when the plan sponsor no longer needs your PHI to administer the Plan. If it is not feasible for the plan sponsor to

return or destroy your PHI, the plan sponsor will limit the use or disclosure of any PHI that it cannot feasibly return or destroy to those purposes that make the 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 PHI in accordance with 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 PHI 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, impose appropriate sanctions, and relieve any harmful effects to you.

Security of Your Personal Health Information:

The following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic PHI:

- The plan sponsor will have in place appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of your electronic PHI, 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 PHI in accordance with HIPAA regulations.
- If the plan sponsor discloses any of your electronic PHI 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 HIPAA regulations.

The plan sponsor will report to the SEIB any security incident of which it becomes aware in accordance with 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 PHI for treatment, payment, health care 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 to administer the Plan. If you or any provider refuses to provide records, information, or evidence we request within reason, we may deny your benefit payments. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law. Additionally, we may use or disclose your PHI for treatment, payment, or healthcare operations, or as permitted or authorized by law pursuant to the privacy regulations under HIPAA.

The privacy provisions of HIPAA 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 of 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
PO 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 incorrect, 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 the 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 the SEIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

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

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 BCBS's 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 nor 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 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 allowed amount paid by BCBS as benefits, you are responsible for the charges above 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 or 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.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS-NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

You may be eligible for assistance paying your employer's health plan premiums. Contact your State for more eligibility information. If you live in Alabama, visit **www.myalhipp.com** or call **1-855-692-5447**.

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
1-877-267-2323, Menu Option 4, Ext. 61565

Or visit **www.dol.gov/ebsa** **www.cms.hhs.gov**.

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 considering the existence of any other plan.

A secondary plan is one that takes into consideration the benefits of the primary plan before determining the 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:

Non-compliant 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 health care 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 health care expenses or health care 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 (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 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, prescription drugs, hearing aids, or another similar type of coverage or benefit, then it will have no secondary liability concerning 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 the 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.

Non-compliant Plan: The term “non-compliant plan” means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of non-compliant 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 considering the existence of any other plan. 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 section; or
- All plans that cover the person use the order of benefit determination rules required by this section, 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 to apply these rules and determine 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 with 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 with 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 these 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 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 can and does recover the amount of SEHIP benefit payments for you, the SEHIP will share proportionately with you in any attorney's fees charged to you by your attorney for obtaining the recovery. If you do not give us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

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

Medical Claims and Appeals

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

Filing of Claims Required

A claim prepared and submitted to BCBS must be received by BCBS 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 precertification of nursing services) that must be approved by BCBS in advance before they will be recognized as benefits. No communications with BCBS 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 BCBS 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 BCBS 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

BCBS's 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, BCBS 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. BCBS 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, become incompetent, or are a minor, BCBS may pay 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 are required for all hospital admissions and 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 plan book. 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 go to the BCBS Internet website at www.AlabamaBlue.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 plan book.

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.

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. Inform BCBS of the type of service or supply

for which you wish to file a claim (for example, hospital or physician), 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 365 days 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 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 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.

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 pre-certify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a preferred provider. 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 the 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 does 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 predeterminations, BCBS is not bound by the time frames and standards that apply to pre-service claims. 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 the 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 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 upon 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 hours-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 toll-free at 1-800-248-5123.

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 concerning a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make when you see your provider;
- the denial by BCBS of a pre-service claim;
- an adverse concurrent care determination (for example, BCBS denies your request to extend previously approved services); or
- a denial of your or your dependent's initial eligibility for coverage under the Plan or a retroactive rescission of coverage based on fraud or intentional misrepresentation of a material fact.

In all cases other than determinations by BCBS to limit or reduce previously approved care and determinations by the SEIB regarding initial eligibility or retroactive rescission, you have 180 days following an adverse benefit determination by BCBS within which to submit an appeal.

How to Appeal Adverse Eligibility and Rescission Determinations

Please see Chapter 29, "SEIB Appeals Process" for more information regarding appeal rights for eligibility and rescission determinations.

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 website at www.AlabamaBlue.com. 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
PO Box 12185
Birmingham, Alabama 35202-2185

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 strive 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) 220-7202.

If in writing, you should send your letter to:

For inpatient hospital care and admissions:

Blue Cross and Blue Shield of Alabama
Attention: Health Management – Appeals
PO 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 strive to resolve your questions or concerns.

Conduct of the Appeal

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

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 its decision. You must request this external review within four months of the date of your receipt of BCBS's 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
PO 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 give BCBS copies of this additional information to allow BCBS 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

Issues involving eligibility and enrollment should be addressed directly with the SEIB through the appeal process outlined below. However, all issues regarding benefit determinations should be addressed through the BCBS appeal process outlined in Chapter 28. The following issues will not be reviewed under the SEIB appeal process:

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

Note: Medical decisions will not be questioned.

All requests must be sent to the following address:

State Employees' Insurance Board
Attention: Legal Department
P.O. Box 304900
Montgomery, Alabama 36130-4900

Informal Review

If you feel an enrollment or eligibility decision was not in conformity with SEIB rules, policies, or procedures, you may request an informal review. In many cases, the issue can be resolved over the phone without the need for an administrative review or formal appeal. A request for an informal review must be received by the SEIB within 60 days from the date of an adverse decision by the SEIB. Untimely requests will be denied.

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 received by the SEIB within 60 days from the date of the informal review decision. Untimely requests will be denied. If the SEIB determines that an administrative review is appropriate, you will be sent an SEIB administrative review form to complete and return. A copy of the initial adverse determination and informal review decision must be submitted with the administrative review form. The administrative review committee will review the request, usually within 60 days. Oral arguments will not be considered unless approved by the SEIB. The administrative review committee will issue a decision in writing to all parties involved in the review.

Formal Appeal

If you do not agree with the administrative review decision, you may file a request for a formal appeal before the Board of Directors. Requests for a formal appeal must be received by the SEIB within 60 days following the date of the administrative review committee's decision. Untimely requests will be denied. Oral arguments will not be considered unless approved by the SEIB. If your request for a formal appeal is granted, generally, a decision will be issued within 90 days following approval of the request for a formal appeal. The number of days may be extended by notice from the SEIB. If you have not received a decision or notice of extension within 90 days, you may consider your appeal denied. The Board's decision is the final step in the SEIB appeal process and will exhaust all administrative remedies.

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

Chapter 30

Definitions

ABA Therapy: ABA therapy is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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 we recognize 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 us 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 plan book for a description of the contracting arrangements that exist outside the state of Alabama.

Out-of-Network Providers: In accordance with Blue Cross and Blue Shield of Alabama's applicable provider payment policies in effect at the time the service is rendered, the allowed amount for care rendered by out-of-network providers may be based on the negotiated rate payable to in-network providers for the care in the area, may be based on the average charge for the care in the area, or may be based on a percentage of what Medicare would typically pay for the care in the area (or, if no Medicare rates are available, an approximation of what Medicare would pay for care using various sources), or in accordance with applicable Federal law. 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;
- 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 certain out-of-network providers, 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 out-of-network emergency services for medical emergencies or for air ambulance services, the allowed amount will be determined in accordance with the requirements of the applicable Federal law.

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. To be considered an ambulatory surgical facility under the Plan, the facility must meet the conditions for participation in Medicare.

Applied Behavioral Analysis (ABA) Therapy: The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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.

Autism Spectrum Disorder: Any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis.

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 and/or Blue Shield plans by which a member of one Blue Cross and/or Blue Shield plan receives benefits available through another Blue Cross and/or Blue Shield 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 and to administer the utilization review program such as preadmission certification and individual case management. (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 "Continuation of Group Health Coverage (COBRA)" section of this plan book.

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 to provide 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 the 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 a 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 member begins as listed in the SEIB records.

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.

FDA Approved Drugs Guidelines: Prescription products approved by the Federal Drug Administration (FDA) as evidenced by a New Drug Application (NDA), Abbreviated New Drug Application (ANDA), or Biologics License Application (BLA) on file with the FDA.

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.

Habilitative Services: Healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living.

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 apply 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 Infusion Service Provider: A home infusion service provider is a state-licensed pharmacy that specializes in the provision of infusion therapies to patients in their home or other alternate sites associated with the home infusion provider such as a home infusion suite.

Home Plan: The Blue Cross Blue Shield Plan that 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 Blue Shield 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 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 to remember that when BCBS makes determinations about the investigational nature of a service or supply BCBS is making them solely to determine 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, concerning 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 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 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 where 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 to determine 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.

Medicare Advantage: A Medicare-approved PPO plan administered by UnitedHealthcare.

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 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.

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.

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 for psychiatric, alcoholism and other chemical dependency, rehabilitation, intellectual disability or intellectual developmental disorder, 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.

Open Enrollment: The annual open enrollment period is held each November 1 through November 30 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.

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.

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 BCBS for the furnishing of chiropractic services.

Participating Hospital: Any hospital with which 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.

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.

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.

Precertification: The procedures used to determine the medical necessity of the treatment prior to the service.

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.

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, Preferred Nurse Practitioner or Physician Assistant) 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 and Some Brand-Name Drugs; Tier 2: SEIB high-cost generics and preferred brand drugs; Tier 3: SEIB non-preferred brand drugs; Tier 4: other non-preferred drugs; and Tier 5: 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.

Rehabilitative services: Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

Residential treatment: Continuous 24-hour per day care provided at a live-in facility for mental health or substance abuse disorders

Residential Treatment (Eating Disorders): 24-hour level of care that is medically monitored, with 24-hour medical and nursing services and typically provides less intensive medical monitoring than inpatient care.

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.

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.

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, and 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.

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 provides outpatient substance abuse rehabilitation services.

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. Tele-consultations 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

PO Box 304900
Montgomery, Alabama 36130-4900
Phone: (334) 263-8300
Toll Free: 1-866-836-9737
Website: **www.alseib.org**

Medical Claims Administrator

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

Customer Service: 1-800-824-0435
Rapid Response: 1-800-248-5123
Fraud Hot Line: 1-800-824-4391
Website: **AlabamaBlue.com**

Utilization Management

Precertification: 1-800-551-2294
Case Management: 1-800-551-2294

Prescription Drug Administrator

Prime Therapeutics
2900 Ames Crossing Road, Suite 200
Eagan, MN 55121

Customer Service: 1-866-443-9233
Website: **MyPrime.com**

Provider-Administered Drug Administrator

HelpScript
1101 Wootton Parkway, Suite 1040
Rockville, MD 20852

Customer Service: 1-833-800-4032
Website: **AlabamaBlue.com/HelpScript**

Group Number 13000