
The State Employees' Supplemental Plan



State of Alabama

Effective January 1, 2025



**BlueCross BlueShield
of Alabama**

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' SUPPLEMENTAL 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' Supplemental 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 preauthorizations). 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 healthcare 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:
 - o Qualified sign language interpreters
 - o 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:
 - o Qualified interpreters
 - o 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: ढान दः ियद आप िहंदी बोलते, भाषा सहायता सेवाओं, िन: शु, आप के िलए उपलहः। कॉल । 1-855-216-3144 कॉल

(TTY: 711)**Laotian:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, 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

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Introduction

This summary of health care benefits available to you through the State Employees' Supplemental Plan (Plan) is designed to help you understand your coverage. This planbook 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 Plan and reserves the right to change the terms and conditions and/or end the Plan at any time and for any reason.

This Plan is established and maintained pursuant to Alabama Code Sections 36-29-19.2 and 36-29-19.8. It is designed for the express and limited purpose of providing supplemental benefits to eligible employees and non-Medicare retirees who can obtain group health coverage through a plan maintained by another employer (generally referred to throughout the remainder of this planbook as the "primary plan").

Participation in this Plan is voluntary, based on elections you make for yourself and your dependents in the time and manner described below in the section called Eligibility and Enrollment.

By electing to participate in this Plan, you are electing not to participate in the State Employees' Health Insurance Plan (SEHIP). Instead, you are electing to participate in a plan that supplements coverage under the primary plan. You and your family members should look to the primary plan as the principal source of health care benefits. Only after benefits have been determined under the primary plan will this Plan determine the level of supplemental benefits that are due to be paid.

Spousal carve-out warning: Before you opt out of the SEHIP and enroll in this Plan, you must review the provisions of your spouse's primary health insurance coverage to ensure that it does not disallow coverage for you because you are eligible for coverage through the SEHIP. If such a provision exists, no medical benefits will be available for you through your spouse's health insurance coverage or this Plan.

As you read this planbook, it is important for you to pay attention to terms that have defined meanings. To make the planbook more readable, the initial letters of defined terms are not capitalized. You are encouraged to begin your review of this planbook by going first to the definitions section and familiarizing yourself with the meaning of the terms used. For further information, contact one of the following:

State Employees' Insurance Board
201 South Union Street, Suite 200
PO Box 304900
Montgomery, Alabama 36130-4900
Phone: 334-263-8300
Toll-Free: 1-866-836-9737
www.alseib.org

or

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244
Customer Service: 1-800-824-0435
Rapid Response: 1-800-248-5123
Fraud Hotline: 1-800-824-4391
www.AlabamaBlue.com

Chapter 1

Active Employee Eligibility and Enrollment

Please visit 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 Motorsports 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.

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

This Plan is established and maintained pursuant to Alabama Code Sections 36-29-19.2 and 36-29-19.8. It is designed for the express and limited purpose of providing supplemental benefits to eligible employees and non-Medicare retirees who can obtain group health coverage through a plan maintained by another employer. You are not eligible for coverage if your primary coverage is with the State Employees' Health Insurance Plan (SEHIP), Public Education Employees Health Insurance Program (PEEHIP), Local Government Health Insurance Program (LGHIP), the Marketplace, TRICARE, or Medicare. In addition, you are not eligible for this Plan if your primary plan is a high deductible plan (i.e., a plan with in-network deductibles of \$1,650 or more for single coverage or \$3,300 or more for family coverage).

Eligible Dependent

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

1. Your spouse (excludes divorced or common-law spouse);
2. A child under age 26, only if the child is:
 - a) your son or daughter;
 - b) legally adopted by you or your spouse;
 - c) your stepchild; or
 - d) a dependent for whom the subscriber, or his or her spouse, has legal and physical custody granted by a court of competent jurisdiction.
3. Your incapacitated child - eligibility is determined by your primary insurance and documents must be sent to the SEIB for proof of eligibility.

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, regardless of what the divorce decree may state
- Dependents of retirees are not eligible for the Plan if they have Medicare as their primary coverage
- 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 are ineligible under your primary insurance coverage
- 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 (e.g., adding an ineligible person to coverage) or omission (e.g., failing to remove a person no longer eligible for coverage) of the subscriber results in or contributes to the payment of claims by the Plan 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

Before an employee can enroll in the Plan, he or she must decline coverage in the State Employees' Health Insurance Plan (SEHIP). Employees and dependents can enroll and coverage commences as stated below.

Employees

For new employees, an SEIB enrollment form (IB02) must be completed by the employee and his/her employer and submitted to the SEIB.

Dependents

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.

You may enroll a new dependent within 60 days of acquiring the new dependent and the effective date of coverage will be the date of marriage, birth, or adoption. Thereafter, dependents may be added to coverage only during the open enrollment period in November each year.

Re-enrollment into the State Employees' Health Insurance Plan

Employees may re-enroll in the SEHIP at any time. Coverage will be effective no later than the first day of the second month following receipt and approval of an enrollment form 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.

Survivor Enrollment

In the event of the death of an active 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.

Notice

Notice of any enrollment changes is the responsibility of the employee (e.g., status changes or address changes).

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 by facsimile.

Address Changes

All correspondence and notices required under the provisions of this Plan 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 PO 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 for active employees are processed electronically once they are changed on payroll with your agency.

Chapter 2

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, and does not have Medicare as his/her primary coverage.

Note: Dependents of retirees are not eligible for the Plan if they have Medicare as their primary coverage.

Eligible Dependent

Please see the Eligible Dependent Section in Chapter 1 for more information.

Enrollment/Continuation

Before a retiree can enroll in the Plan, he or she must decline coverage in the SEHIP. A retiree may enroll at any time and coverage will be effective no later than the first day of the second month following receipt and approval by the SEIB of an enrollment form.

Re-enrollment in the State Employees' Health Insurance Plan

Retirees may re-enroll in the SEHIP at any time. Coverage will be effective no later than the first day of the second month following receipt and approval of an enrollment form by the SEIB. Please be advised that there are no waiting periods for applicable premiums when you re-enroll.

Retiree Name Changes

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

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.

Chapter 3

Termination of Coverage

Coverage under this Plan 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, sickness, or due to leave of absence or temporary layoff, but only for a limited period. For details, contact the SEIB;
- When this Plan is discontinued;
- On the last day of the month in which you cancel coverage in the Plan;
- When you have Medicare as your primary coverage.

Coverage under this Plan will also 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 you have Medicare as your primary coverage.

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

Family & Medical Leave Act

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

Employees on Leave without Pay (LWOP)

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

Chapter 4

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 Plan 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.***

Important note: Since this Plan pays secondary benefits only, you should make sure that you have primary coverage through another group health plan or policy before buying COBRA coverage under this Plan. If you do not have such primary coverage, then this Plan will pay no benefits – notwithstanding your payment of COBRA premiums.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under this Plan 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 this Plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Note that your COBRA coverage will be identical to the coverage that you were receiving immediately before the qualifying event. Similar to coverage for active employees participating in this Plan, your COBRA coverage will pay supplemental benefits only.

Who are Qualified Beneficiaries?

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain circumstances, the covered employee. Under current law, to be a qualified beneficiary, an individual must generally be covered under this Plan 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 this Plan 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 this Plan 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 this Plan 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 this Plan as a dependent child.

What Coverage is Available?

If you choose continuation coverage, this Plan is required to offer you coverage that is identical at the time coverage is being provided to the coverage provided under the Plan to similarly situated employees or family members. As previously noted, this coverage is limited in scope and intended to supplement group coverage through another primary plan.

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
 - the 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 COBRA coverage. The 60-day period begins to run from the latter of (1) the date you would lose coverage under the Plan, 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 Plan 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 the SEIB learns of your loss of coverage, the Plan may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the Plan. The only way your coverage will continue is if you elect 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 this Plan.

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 to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

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

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

For this disability extension of COBRA coverage to apply, you must give the SEIB timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event; (2) the date on which coverage would be lost because of the initial qualifying event; (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 a New Dependent be Added to your COBRA Coverage?

You may add new dependents to your COBRA coverage under the circumstances permitted under the Plan. 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.

Note: Since the sole purpose of this Plan is to supplement coverage under a primary plan, if you cease to be covered under the primary plan, no benefits will be payable under this Plan.

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

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage.

The period of your COBRA continuation coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

How Much is COBRA Coverage?

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 on time.

When is my COBRA Coverage Premium Due?

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

When Does my COBRA End?

COBRA continuation coverage may be terminated for any of the following reasons:

- You are no longer covered under a primary plan.
- SEIB no longer provides group health coverage.
- The premium for your continuation coverage is not paid on time.
- You become covered after the date of the qualifying event 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 Plan. 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.

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. Learn more 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) 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 5

Benefits - Supplemental Plan

Annual Maximum

The annual maximum amount paid under the Plan is \$9,450 for individual coverage and \$18,900 for family coverage. The Plan limits reimbursement of deductibles to \$300 on inpatient hospital and the maximum deductible owed under your primary plan, not to exceed \$1,650 for single coverage and \$3,300 for family coverage.

Benefit Conditions

To qualify as Plan benefits, medical services and supplies must meet all of the following:

- They must be furnished after your coverage becomes effective;
- They must be covered for you and any of your dependents under a primary plan and you must have enrolled for coverage under that plan;
- Claims for services or supplies must have been filed with the primary plan, and the primary plan must have made its coverage determinations and notified you of them;
- The primary plan must have determined that the services or supplies were covered, medically necessary, not excluded, and in accordance with the primary plan's utilization review or similar guidelines;
- The primary plan must have made a benefit determination (that is, the primary plan has determined what it will pay), and BCBS must have been provided with a copy of that benefit determination;
- The service or supplies must have been furnished while coverage under the primary plan and this plan was in effect. If coverage ceases to be in effect under the primary plan, no benefits will be provided under this Plan unless you have purchased and are maintaining COBRA coverage through the primary plan, in which case this Plan will continue to pay supplemental benefits.

Inpatient Hospital Benefits

If you are admitted as a hospital inpatient and if the inpatient admission is covered under the primary plan and meets all medical necessity and utilization review criteria of the primary plan, this Plan will pay a benefit equal to the smaller amounts of:

- The sum of any coinsurance, deductibles, and/or copayments you owe under the primary plan with respect to such admission;
- \$300 per day for days 1-10 of the inpatient hospital admission and \$150 per day for days 11-90 of the hospital admission; or
- The allowed amount for the admission in question. The term "allowed amount" is defined and explained in the Definitions section.

For this purpose, an inpatient hospital admission means a continuous stay as an inpatient in a hospital not broken by more than the number of days specified by the primary plan for determining the length of a hospital admission.

Admissions for Mental and Nervous Disorders and Substance Abuse

If you are admitted as a hospital inpatient for treatment of a mental and nervous disorder or substance abuse and if the inpatient admission is covered under the primary plan and meets all medical necessity and utilization review criteria of the primary plan, this Plan will pay a benefit equal to the smaller of the amounts of:

- The sum of any coinsurance, deductibles, and/or copayments you owe under the primary plan with respect to such admission;
- \$150 per day for days 1-10 of the inpatient hospital admission and \$75 per day for days 11-90 of the hospital admission; or
- The allowed amount for the admission in question. The term “allowed amount” is defined and explained in the Definitions section.

Plan Year Maximums for Inpatient Hospital Benefits

During any one plan year, the Plan will not pay benefits for more than 90 days of inpatient hospital care regardless of whether the inpatient days relate to more than one admission or different types of admissions. In other words, the 90-day limitation is a combined limitation for medical, mental and nervous, and substance abuse admissions.

Other Covered Services

If you receive any other medical services or supplies and if the primary plan covers and makes payment for the services or supplies in question, this Plan will pay a benefit equal to the lesser of:

- The sum of any co-payments, deductibles, or coinsurance that you are required to pay with respect to the covered services or supplies; or
- The allowed amount for the service or supply in question. The term “allowed amount” is defined and explained in the Definitions section.

Exclusions

The Plan will not pay benefits in the following circumstances, even if the service or supply would otherwise be covered under the Plan and has been provided to a member by a licensed medical provider acting within the scope of his or her license.

- Services or supplies that are not covered under the primary plan.
- Services or supplies that are excluded under the primary plan including services or supplies that are excluded under the primary plan as a result of the application of a waiting period.
- Any liabilities that the patient is responsible for paying as a result of any penalties under the primary plan for failure to comply with the primary plan’s medical necessity, utilization review, precertification, or other similar requirements. This applies regardless of whether the provider waives the collection of the penalty.
- Any liabilities or penalties that the patient is responsible for paying because he or she received services or supplies outside the primary plan’s provider network.
- Services or supplies above any benefit limits or maximums under the primary plan.
- Services or supplies that are covered by Medicare as the primary plan.

Chapter 6

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 planbook explains some of HIPAA's requirements. Additional information is contained in the Plan's notice of privacy practices at the front of this planbook. 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 Plan needs to share your PHI with the plan sponsor (the State of Alabama). The Plan may disclose your PHI to the Plan sponsor under the following circumstances:

- The Plan 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 Plan.

The following restrictions apply to the Plan sponsor's use and disclosure of your protected health information:

- 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 Plan'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 planbook.
- The Plan sponsor will allow you or the Plan 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 Plan must follow in this regard. There are some exceptions.
- The Plan sponsor will amend, or allow the Plan 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 for 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 Plan 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 Plan 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 protected health information, the Plan sponsor will limit the use or disclosure of any PHI that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the Plan sponsor may use or disclose your 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 protected health information:

- The Plan sponsor will have in place appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the Plan sponsor described above have access to use or disclose your electronic PHI in accordance with HIPAA regulations.
- If the Plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the Plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by 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, healthcare operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the Plan, 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 7

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 Plan, to construe, interpret, and administer claims, and to perform every other act necessary or appropriate in connection with claims administration services under the Plan.

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

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, and 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 Plan, 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 Plan.

Obtaining, Use and Release of Information

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

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

Any or all of the provisions of this Plan may be amended by the SEIB 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 this Plan, make any agreement or promise, not specifically contained in the Plan, or waive any provision of the Plan.

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.

Chapter 8

Subrogation

Right of Subrogation

If BCBS pays or provides any benefits for you under this Plan, the Plan 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 Plan has paid or provided. The Plan may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, the Plan 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 Plan has paid Plan benefits. This means that you promise to repay the Plan from any money you recover that the Plan 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 Plan. And, if you are paid by any person or company besides the Plan, including the person who injured you, that person's insurer, or your own insurer, you must repay the Plan. In these and all other cases, you must repay the Plan.

The Plan has the right to be reimbursed or repaid first from any money you recover, even if you are not paid your entire claim for damages and you are not made whole for your loss. This means that you promise to repay the Plan 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 Plan first even if another person or company has paid for part of your loss. And it means that you promise to repay the Plan first even if the person who recovers the money is a minor. In these and all other cases, the Plan 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 Plan's reimbursement and subrogation rights in accordance with this Section. You may receive questionnaires requesting more information. Any member who has not responded within 30 days of receiving three questionnaires will have their claims suspended until they have complied with the questionnaire.

You or your attorney will notify BCBS before filing any suit or settling any claim to enable the Plan to participate in the suit or settlement to protect and enforce the Plan's rights under this section. If you do notify BCBS so that the Plan can and does recover the amount of Plan benefit payments for you, the Plan 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 Plan 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 Plan may suspend or terminate payment or provision of any further benefits for you under the Plan.

Chapter 9

Claims and Appeals

The following explains the rules under this Plan for filing claims and appeals with BCBS.

Filing of Claims Required

To file a claim with BCBS you must first file your claim with the primary plan and the primary plan must determine the amount of any deductible, copayment, or coinsurance. Only after the primary plan has made this determination, may you then submit a claim under this Plan. You must submit sufficient information to us to confirm that covered services or supplies were rendered, that the primary plan made a benefit determination, and that the primary plan calculated and applied against its benefit payment a deductible, copayment, or coinsurance. Once BCBS has received this information, they will then process your claim under this Plan and pay benefits as previously indicated.

Who Files Claims

As a general rule, you must file claims under this Plan. In some cases, BCBS has contracts with providers who will file claims with BCBS on your behalf.

Who Receives Payment

If you file the claims, BCBS will pay you. If your provider files the claim, BCBS will pay the provider.

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.

Processing of Claims

From time to time BCBS might need additional information to determine whether your claim is payable. 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.

Member Satisfaction

If you are dissatisfied with the handling of a claim by BCBS or have any questions or complaints, you may do one or more of the following:

- You may call or write the BCBS Customer Service Department. They will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
- You may file an appeal if you have received an adverse benefit determination.

Customer Service

If you have questions about your coverage or need additional information about how to file claims, you should contact BCBS. Blue Cross Customer Service (located in Birmingham) is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is 1-800-824-0435.

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

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

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

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

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

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 means that BCBS has denied some or your entire claim for benefits.

You have 180 days following an adverse benefit determination by BCBS within which to submit an appeal.

How to Appeal Adverse Benefit Determinations

If you wish to file an appeal of an adverse benefit determination, BCBS recommends that you use a form 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.

Conduct of 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 BCBS needs more information, they 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 Blue Cross Consideration of Your Appeal

BCBS will notify you of its decision within 60 days of the date on which you filed your appeal.

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); or
- 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 their decision. You must request this external review within 4 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.

Chapter 10

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. 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 11

Definitions

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

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

Blue Cross Blue Shield of Alabama (BCBS): The company chosen by the State Employees' Insurance Board, through a competitive bid, to process benefit claims filed by members.

COBRA: See the explanation in the "Continuation of Group Health Coverage" section of this planbook.

Coinsurance: The amount (normally expressed as a percentage of the allowed amount) that you are required to pay in conjunction with the benefits paid under the primary plan. A common example is an 80/20 plan, where the plan pays 80% of the provider's allowable charges and you pay the remaining 20%.

Copayment: An up-front payment (normally a fixed dollar amount) that you are required to make under the primary plan to receive covered services or supplies. A common example is a \$35 copayment that you are required to make at the time you receive services from a physician during an office visit.

Deductible: The portion of the primary plan's eligible benefits that you are required to pay before the primary plan makes a payment.

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

Effective Date: The date on which the coverage of each member begins as listed in the State Employees' Insurance Board records.

Employee: See the "Eligibility and Enrollment" section.

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

Hospital: A participating or non-participating hospital as defined in this section.

Inpatient: A registered bed patient in a hospital; provided that BCBS reserves the right in appropriate cases to reclassify inpatient stays as outpatient services.

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

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

It is important for you to remember that when BCBS makes determinations about the investigational nature of a service or supply BCBS is making them solely 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.

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

Member: An active/retired state employee or eligible dependent who has coverage under the Plan 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.

Plan Year: January 1 through December 31.

Retired Employee: A former employee who receives a monthly benefit check from the state of Alabama and is not entitled to Medicare.

Spousal Carve-out: A provision that makes you ineligible for your spouse's health insurance coverage if you are eligible for health insurance coverage through the SEHIP.

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.

State Employees' Supplemental Plan (Plan): A self-insured supplemental plan administered by the State Employees' Insurance Board.

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

STATE EMPLOYEES' INSURANCE BOARD

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

Claims Administrator

Blue Cross Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244
Customer Service: 1-800-824-0435
Rapid Response: 1-800-248-5123
Fraud Hot Line: 1-800-824-4391
Website: **AlabamaBlue.com**

Group Number 60913