# PEEHIP

**Public Education Employees' Health Insurance Plan**

*Administered by*

Blue Cross and Blue Shield of Alabama

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# OVERVIEW OF THE PLAN

As Plan Administrator for the Public Education Employee's Health Insurance Plan (PEEHIP), Blue Cross and Blue Shield of Alabama pledges to you that we will provide the best service we can in the administration of your group health care plan. This booklet summarizes your group's benefits. It also summarizes conditions, limitations, and exclusions to those benefits as well as sections explaining eligibility and defining certain words. Please be sure to read the entire booklet. This booklet is a "summary plan description" or "plan."

Blue Cross and Blue Shield of Alabama 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 us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer 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 Blue Cross and Blue Shield of Alabama not created under the original agreement.

If you have any questions please call our Customer Service at 800.327.3994.

For online information about your PEEHIP benefits, go to www.AlabamaBlue.com/peehip.

This site contains an interactive page which can be used to e-mail a Blue Cross and Blue Shield of Alabama PEEHIP Customer Service Representative. For online information on the benefits available to you as a PEEHIP member along with the corresponding rates, you may go to www.rsa-al.gov.

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact our customer service at 1-800-327-3994. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

***Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-800-327-3994. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.***

## Using myBlueCross to Get More Information

By being a member of the plan, you get exclusive access to ***my*BlueCross** – 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 ***my*BlueCross**, 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 benefit booklet 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.
- Get fitness, nutrition, and wellness tips.

## Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Public Education Employees' Health Insurance Board has elected to exempt the **Public Education Employees' Health Insurance Program** from the following requirements:

- Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from these federal requirements has been in effect October 1, 2005. The election has been renewed for every subsequent plan year.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage or proof of health coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

For more information regarding this notice, please contact PEEHIP.

## Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PEEHIP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a standard Medicare drug plan or keep your PEEHIP drug coverage.

Effective January 1, 2013, the PEEHIP prescription drug benefit for Medicare retirees and Medicare covered dependents changed to the PEEHIP Employer Group Waiver Plan (EGWP) which is PEEHIP's Medicare Prescription Part D Drug Plan called Medicare Generation Rx. All PEEHIP covered Medicare eligible retirees and Medicare covered dependents are automatically enrolled in Medicare Generation Rx unless you are enrolled in another Part D plan or you choose to opt-out. If you opt-out of this plan, you will have no prescription coverage through PEEHIP.

If you are considering joining a standard Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. However, if you choose to enroll in a standard Medicare Part D drug plan, you will lose the PEEHIP prescription drug coverage.

There are two important things you need to know about your current coverage and Medicare's standard prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a standard Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All standard Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PEEHIP has determined that the prescription drug coverage offered by PEEHIP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing PEEHIP coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a standard Medicare drug plan.

## When Can You Join a Medicare Drug Plan?

You can join a standard Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a standard Medicare drug plan.

## What Happens to Your Current PEEHIP Coverage If You Decide to Join a Standard Medicare Drug Plan?

If you do decide to join a standard Medicare drug plan and drop your PEEHIP drug plan, your current PEEHIP drug coverage will terminate on the date that you enroll in a standard Medicare drug plan. Please be aware that you and your covered dependents will lose the PEEHIP drug coverage and you will not be able to get this coverage back until you drop the standard Medicare Part D coverage. You cannot have PEEHIP prescription drug coverage and a standard Part D coverage at the same time.

If you enroll in a Medicare drug plan, you and your dependents will still be eligible for your current PEEHIP health benefits but will have no prescription drug coverage under PEEHIP.

## When Will You Pay a Higher Premium (Penalty) to Join a Standard Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PEEHIP and don't join a standard Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

## For More Information about This Notice or Your Current Prescription Drug Coverage

Contact the PEEHIP office at 877.517.0020 for further information. NOTE: You will receive this notice each year in the PEEHIP Advisor newsletter, and you may request a copy of this notice at any time.

## For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about standard Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICAR (800.633.4227). TTY users should call 877.486.2048.

An exception may apply to certain "low-income" individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and Part D (two separate steps). For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 800.772.1213 (TTY 800.325.0778).

**Remember:** Keep this important Creditable Coverage notice. If you decide to join one of the standard Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

## Access to Obstetrical and Gynecological (ObGyn) Care Notice

You do not need prior authorization from the Plan or from any other person (including a Primary Care Provider (PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Blue Cross and Blue Shield of Alabama network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to the Blue Cross and Blue Shield of Alabama website www.AlabamaBlue.com.

## Choice of Primary Care Physician Notice

The Plan generally allows the designation of a Primary Care Provider (PCP). You have the right to designate any PCP who participates in the Blue Cross and Blue Shield of Alabama network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to the Blue Cross and Blue Shield of Alabama website www.AlabamaBlue.com, for children, you may designate a pediatrician as the PCP.

## Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the patient and the patient's attending physician, and is subject to any applicable annual deductibles, coinsurance and/or copayment provisions.

## Health Insurance Portability and Accountability Act (HIPAA) 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 IT CAREFULLY.

The Public Education 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 is required by law to take reasonable steps to ensure the privacy of your health information and to inform you about:

- the Plan's uses and disclosures of your health information
- your privacy rights with respect to your health information
- the Plan's obligations with respect to your health information
- a breach of your PHI

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

Effective Date of Notice: This notice was effective as of September 23, 2013.

## How the Plan Uses and Discloses 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 their 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, PEEHIP, 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. It also includes quality assessment and improvement and reviewing competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to conduct a review of the accuracy of how benefit claims are being paid. However, in no event will Benefit Staff use PHI that is genetic information for underwriting purposes.

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 or if it:

- constitutes summary health information and 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
- constitutes de-identified information
- relates to workers' compensation programs
- is for judicial and administrative proceedings
- is about decedents
- is for law enforcement purposes
- is for public health activities
- is for health oversight activities
- is about victims of abuse, neglect or domestic violence

- is for cadaveric organ, eye or tissue donation purposes
- is for certain limited research purposes
- is to avert a serious threat to health or safety
- is for specialized government functions
- 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 Official.

***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 an 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 Official.

## YOUR PRIVACY RIGHTS

This section of the notice describes your rights with respect to your health information and a brief description of how you may exercise these rights. To exercise your rights, you must contact the Plan's Privacy Official at 877-517-0020.

### Restrict Uses and Disclosures

You have the right to request that the Plan restricts uses 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.

### 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. The Plan must accommodate your reasonable request to receive communication of PHI by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of the information through normal processes could endanger you in some way.

### Copy of Health Information

You have a right to 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. 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.” 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 the information is not accurate and complete.

### Right to Access Electronic Records

You may request access to electronic copies of your PHI, or you may request in writing or electronically

that another person receive an electronic copy of these records. The electronic PHI 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 a copy of the electronic PHI.

### List of Certain Disclosures

You have the right to receive a list of certain disclosures of your health information. The Plan or its business associates will provide you with one free accounting each year. For subsequent requests, you may be charged a reasonable fee.

### 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. You will not be penalized for filing a complaint.

### The Plan's Responsibilities

The Plan is required by a federal law to keep your health information private, to give you notice of the Plan's legal duties and privacy practices, and to follow the terms of the notice currently in effect.

### 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 PEEHIP's Privacy Official at 877-517-0020.

## Purpose of the Plan

The plan is intended to help you and your covered dependents pay for the costs of medical care. The plan does not pay for all of your medical care. For example, you may be required to contribute through payroll deduction before you obtain coverage under the plan. You may also be required to pay deductibles, copayments, and coinsurance.

## Definitions

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

## Receipt of Medical Care

Even if the 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.

## Beginning of Coverage

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

## Limitations and Exclusions

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

## Medical Necessity and Precertification

The plan will only pay for care that is medically necessary and not investigational, as determined by us. We develop medical necessity standards to aid us when we make medical necessity determinations. We publish these standards at www.AlabamaBlue.com/providers/policies The definition of medical necessity is found in the Definitions section of this booklet.

In some cases, the plan required that you or your treating physician precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification 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.

## In-Network Benefits

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

In-network providers are hospitals, physicians, pharmacies, and other healthcare providers or suppliers that contract with us 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)

To locate Alabama in-network medical providers and in-network inpatient mental health and substance abuse providers, go to www.AlabamaBlue.com. In-network outpatient mental health and substance abuse providers are located later in this book.

- First, click *Find a Doctor*.
- Second, select a healthcare provider type: doctor, hospital, dentist, pharmacy, other healthcare provider, or other facility or supplier.
- Third, enter a search location by using the zip code for the area you would like to search or by selecting a state.
- Fourth, use the drop-down menu in the *Network and Plans* filter to select a specific provider network (as noted above).

Search tip: If your search returns zero results, try expanding the number in the *Maximum miles for search* 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. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder website at http://provider.bcbs.com. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross 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.

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

Blue Cross and Blue Shield of Alabama 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 us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer 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 Blue Cross and Blue Shield of Alabama 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 us for reimbursement under the terms of the plan. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review. Thereafter, you may have the right to an independent external review. The provisions of the plan dealing with claims or appeals are found further on in this booklet.

## Changes in the Plan

From time to time it may be necessary to change the terms of the plan. The rules for changing the terms of the plan are described later in the section called Changes in the Plan.

## Termination of Coverage

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

# ELIGIBILITY AND ENROLLMENT

## Insurance Eligibility

### *Guidelines for Insurance Eligibility*

Full-time employees and permanent part-time employees are eligible for coverage with PEEHIP.

### *Full-Time Employees*

A full-time employee is any person employed on a full-time basis in any public institution of education within the state of Alabama as defined by Section 16-25A-1, Code of Alabama 1975. These institutions must provide instruction for any combination of grades K through 14 exclusively, under the auspices of the State Board of Education or the Alabama Institute for Deaf and Blind.

A full-time employee also includes any person who is not included in the definition of employee in Section 16-25A-1, but who is employed on a full-time basis by any board, agency, organization, or association which participates in the Teacher's Retirement System of Alabama and has by resolution pursuant to Section 16-25A-11 elected to have its employees participate in PEEHIP.

### *Permanent Part-Time Employees*

A part-time employee is any person employed on a permanent part-time basis in any public institution of education within the state of Alabama as defined by Section 16-25A-1, Code of Alabama 1975. These institutions must provide instruction for any combination of grades K through 14 exclusively, under the auspices of the State Board of Education or the Alabama Institute for Deaf and Blind.

A part-time employee also includes any person who is not included in the definition of employee in Section 16-25A-1, but who is employed on a permanent part-time basis by any board, agency, organization, or association which participates in the Teacher's Retirement System of Alabama and has by resolution pursuant to Section 16-25A-11 elected to have its employees participate in PEEHIP.

An eligible permanent part-time employee is not a substitute or a transient employee. A permanent part-time employee is eligible for PEEHIP if he or she agrees to payroll deduction for a pro rata portion of the premium cost for a full-time employee. The portion is based on the percentage of time the permanent part-time workers is employed.

## Eligible Dependents

### *Spouse*

The employee's spouse as defined by Alabama law to whom you are currently and legally married. PEEHIP requires a copy of a marriage certificate to verify eligibility and one additional current document to show proof of current marital status. Excludes a divorced spouse and a common law spouse.

### *Children*

PEEHIP offers dependent coverage to children up to age 26. Appropriate documentation will be required by PEEHIP before dependents can be enrolled. In accordance with the federal Health Care Reform Legislation, the following children are eligible for PEEHIP coverage:

1. A married or unmarried child under the age of 26 if the child is your biological child, legally adopted child, stepchild or foster child without conditions of residency, student status, or dependency. A foster child is any child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

2. The eligibility requirements for any other children such as grandchildren, for example, must meet the same requirements as foster children and must be placed with you by decree or other order of any court of competent jurisdiction, for example, legal custody or legal guardianship. PEEHIP is not required and will not provide coverage for a child of a child receiving dependent coverage. Also, maternity benefits and delivery charges are not covered for children of any age regardless of marital status.

3. An unmarried incapacitated child 26 years of age or older who:

    - is permanently incapable of self-sustaining employment because of a physical or mental handicap, is chiefly dependent on the member for support, and
    - was disabled prior to the time the child attained age 26, and the child had to be covered as a dependent on the member's PEEHIP policy before reaching the limiting age of 26.Two exceptions:
    - New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment.
    - Existing member requests hospital medical coverage of the incapacitated child over the age of 2 within 45 days of the qualifying life event of loss of other hospital medical group coverage

The employee must contact PEEHIP and request an Incapacitated Dependent form. Proof of the child's condition and dependence must be submitted to PEEHIP within 45 days after the date the child would otherwise cease to be covered because of age. PEEHIP may require proof of the continuation of such condition and dependence. If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once he or she reaches the limiting age of 26 as an incapacitated child. For example, approved permanently incapacitated children can continue on any PEEHIP plans they are on at the time they age out, but they are not eligible to be covered on other PEEHIP plans once they reach the limiting age of 26. If the child is approved as incapacitated child and allowed to stay on the PEEHIP Hospital Medical Plan, the child cannot change plans and be covered on other PEEHIP plans, such as VIVA or the Optional Plans if he or she has already reached the limiting age of 26.

***Ineligible Employees***

The following employees are not eligible to participate in PEEHIP:

- A seasonal, transient, intermittent, substitute or adjunct employee who is hired on an occasional or as needed basis.
- An adjunct instructor who is hired on a quarter-to-quarter or semester-to-semester basis and/or only teaches when a given class is in demand.
- Board attorneys and local school board members if they are not permanent employees of the institution.
- Contracted employees who may be on the payroll but are not actively employed by the school system.
- Extended day workers hired on an hourly or as needed basis.

***Ineligible Family Members (Dependents)***

- An ex-spouse regardless of what the divorce decree may state
- Ex-stepchildren regardless of what the divorce decree may state
- A common law spouse or domestic partner

- Children age 26 and older
- Disabled children over 26 who were never enrolled or were deleted from coverage
- An employee who is eligible for PEEHIP as a subscriber cannot be covered as a dependent child on another PEEHIP policy.
- A child of a dependent child cannot both be covered on the same policy
- A daughter-in-law or son-in-law
- Grandchildren or other children related to you by blood or marriage for which you do not have legal guardianship or legal custody who are not foster children or adopted children and temporarily disabled dependent children who have aged out.
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

**PEEHIP is not bound by a court order to insure dependents who do not meet PEEHIP guidelines**

***COBRA for Dependents***

When a child or spouse is no longer eligible for coverage, he or she may be eligible to continue health insurance coverage under COBRA. To elect coverage under COBRA, the member or dependent must notify PEEHIP within 60 days from the date the dependent is no longer eligible for coverage.

**When can I enroll or make changes in coverage?**

**Open Enrollment**

The Open Enrollment period begins July 1 and ends August 31 for changes to be effective October 1. Each year, all PEEHIP eligible active and retired members are sent an Open Enrollment one-page notice to their home address. In addition, the complete Open Enrollment packet is available on the PEEHIP Open Enrollment web page by July 1, every year. Active and retired members can view and/or download a copy of the Open Enrollment packet from the PEEHIP Open Enrollment web page at http://www.rsa-al.gov/index.php/members/peehip/open-enrollment/.

Members can make their insurance changes through Member Online Services (MOS) at www.rsa-al.gov. For those members who do not have internet access and cannot download the information, an Open Enrollment packet can be mailed if the member contacts RSA Member Services at 877.517.0020.

**Open Enrollment will end by the following deadlines:**

- The deadline for submitting online Open Enrollment changes is midnight of September 10. After September 10, online Open Enrollment changes will not be accepted and the Open Enrollment link will be closed.
- The deadline for submitting paper Open Enrollment forms is August 31. Any paper forms postmarked after August 31 will not be accepted.
- The deadline for enrollment or re-enrolling in a **Flexible Spending Account** online or on paper is September 30.
- No changes in coverage or tobacco status can be made from a phone call.

No Open Enrollment changes can be made after these deadlines

**Current Employees**

Open Enrollment for all current employees takes place in July and August for coverage to be effective October 1 of each year. Employees can add new types of coverage, dependent coverage or change coverage types during this Open Enrollment period.

### New Employees

New employees can enroll in coverage within 30 days of their hire date and have the option of their coverage being effective their date of hire or the first day of the month following their date of hire. Or, new employees can enroll in coverage during Open Enrollment of July 1 - August 31, and the coverage will be effective October 1. New employees must enroll online through Member Online Services and the enrollment must be completed within 30 days of the new employee's employment date. The New Employee enrollment link within MOS is only available up until the 30th day after the employment date, and then it is removed. If online enrollment is not completed within the deadline, the new employee is only permitted to enroll in single Hospital Medical coverage and a paper enrollment form must be submitted and the effective date will be the date the form is completed and received by PEEHIP. The employee must wait until Open Enrollment to enroll in family medical coverage and/or to enroll in optional coverage plans (dental, vision, cancer, and indemnity).

### Transfers

Employees who transfer from one system to another system are considered current employees and are NOT considered new employees for insurance enrollment purposes, therefore, must keep existing PEEHIP coverage and cannot make insurance changes until the Open Enrollment period for an October 1 effective date.

## Enrollment Documentation Required by PEEHIP

Every member who has a dependent enrolled on his or her PEEHIP coverage(s) will be required to certify to PEEHIP their dependent's eligibility. Certification will require appropriate documents to support your dependent's eligibility. **Black out Social Security numbers, account numbers, income, or statement balances prior to sending your documents to PEEHIP**. Under no circumstances does PEEHIP solicit this type of information from members.

Please mail, email, or fax your documents to PEEHIP.

Enrollments cannot be processed without the appropriate documentation. PEEHIP is not bound by a court order to insure dependents who do not meet PEEHIP guidelines. **To avoid enrollment deadlines, submit your enrollment even if you do not have all of the appropriate documentation at the time of enrollment.**

### *Spouse*

A spouse is defined as the employee's lawful spouse as defined by Alabama law to whom you are currently and legally married. Ex-spouses and common-law spouses are not eligible dependents even if a member continues to pay for family coverage. The ex-spouse must be deleted from coverage effective the first day of the month following the date of divorce. Eligibility documents required for spouses are:

- Marriage certificate
- **AND one** of the following documents to show marriage is still current:
    - Page 1 and signature page of member's most current Federal Income Tax Return (1040, 1040A or 1040EZ) as filed with the IRS listing the spouse
    - Page 1 and Certificate of Electronic Filing or transmission page (if electronically completed or completed by a tax professional) of member's most current Federal Income Tax Return (1040, 1040A, or 1040EZ) **as filed with the IRS** listing the spouse
    - Transcript of member's most current Federal Income Tax Return (1040, 1040A, or 1040EZ) listing the spouse
    - Current mortgage statement, home equity loan, or lease agreement listing both member and spouse
    - Current property tax documents listing both member and spouse

- Automobile registration that is currently in effect listing both member and spouse
- Current utility bill listing both member and spouse
- Current utility bill listing the spouse at the same address as the member

**Note:** *"Current" is defined as within the last six months.*

***Separated Spouse***

A separated spouse is defined as a legally separated spouse. Required document for

separated spouse is:

- Notice of Legal Separation (court documents signed by a judge)

***Biological Child***

A biological child is defined as a member's biological child who is under age 26. Required document for a biological child is:

- Birth certificate (issued by a state, county or vital records office)

***Foster Child***

A foster child is defined as a child under age 26 who is placed with a member by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Required documents for foster children are:

- Placement authorization signed by a judge, OR
- Final Court Order with residing judge's signature and seal

***Adopted Child***

An adopted child is defined as a member's legally adopted child under age 26. Required documents for adopted children are:

- Certificate of Adoption,
- Papers from the adoption agency showing intent to adopt
- Court documents signed by a judge showing the member has adopted the child,
- International adoption papers from country of adoption; OR,
- Birth Certificate (issued by a state, county, or vital records office naming the adopted parents)

***Step Child***

A step child is defined as a child under age 26 who is the natural offspring or adopted child of the covered member's spouse. Required documents for step children are:

- Birth Certificate of step child showing member's spouse's name

  **AND**

- Marriage certificate showing step child's biological parent is married to member if the spouse is not covered under the PEEHIP plan, in addition to the above documents you must submit proof that your marriage is still current. Please refer to the Spouse category for a list of acceptable documentation.

***Incapacitated Child***

An incapacitated child is defined as an unmarried incapacitated child 26 years of age or older who:

- is permanently incapable of self-sustaining employment because of a physical or mental handicap
- is chiefly dependent on the member for support, and
- was disabled prior to the time the child attained age 26, and the child had to be covered as a dependent on the member's PEEHIP policy before reaching the limiting age

Two Exceptions:

1. New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment; or.
2. Existing member requests hospital medical coverage of an incapacitated child over the age of 26 within 45 days of the qualifying life event of loss of other hospital medical group coverage. If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once he or she reaches the limiting age of 26 as an incapacitated child. Required documents for incapacitated children are:

    - Incapacitated Dependent form. Proof of the child's condition and dependence must have been submitted to PEEHIP within 45 days after the date the child would otherwise have ceased to be covered because of age. PEEHIP may require proof of continuation of such condition and dependence. If the child is approved as an incapacitated child and allowed to stay on the PEEHIP hospital medical plan, the child cannot change plans and be covered on other PEEHIP plans, such as an HMO or Optional plans if he or she has already reached the limiting age of 26.
    - Proof of the required document(s) for one of the dependent categories as noted above to show the child is your biological child, adopted, or step child

    **AND**

    - Medicare Card if eligible

***Other child***

Any other children, such as grandchildren, for example, must meet the same requirements as foster children and must be placed with you by decree or other order of a court of competent jurisdiction, for example, legal custody, legal guardianship. Required documents for other children are:

- Placement Authorization signed by a judge

**OR**

- Final Court Order with presiding judge's signature and seal

## Dependent Eligibility Audit

PEEHIP has limited funds to cover the high cost of claims and coverage of its eligible members and their dependents who are enrolled in PEEHIP coverages. PEEHIP must use its limited funds appropriately and this entails monitoring compliance with eligibility policies to prevent fraud, waste and abuse. Therefore, PEEHIP continues to ensure compliance with its dependent eligibility policies by performing audits and monitoring compliance. If you are covering an ineligible dependent, you must notify PEEHIP and disenroll the dependent immediately. If you know of someone who is covering an ineligible dependent, please notify PEEHIP by phone 877.517.0020, fax 877.517.0021, email peehipinfo@rsa-al.gov or mail PEEHIP, P.O. Box 302150, Montgomery, AL 36130-2150.Covering ineligible dependents unnecessarily raises costs for all eligible PEEHIP members. Help PEEHIP prevent fraud, waste and abuse through compliance with its dependent eligibility policies.

## Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects Americans who move from one job to another, and have a loss of coverage. HIPAA applies to the PEEHIP Hospital Medical Plan and the VIVA plan. HIPAA does not apply to the four Optional Plans administered by Southland Benefit Solutions Insurance Corporation. HIPAA provides for increased health coverage portability for our members and special enrollment periods. HIPAA provides for other benefits such as guaranteed availability and renewability of health insurance coverage.

## Pre-Existing Conditions

**Beginning October 1, 2014 and pursuant to the federal healthcare reform laws, all members and dependents regardless of age that are added to PEEHIP coverage on or after October 1, 2014, will no longer have waiting periods applied on pre-existing conditions.**

### Credit Must Be Given for Creditable Coverage

When medical coverage is cancelled on a PEEHIP member or dependent, Blue Cross and Blue Shield of Alabama or VIVA Health Plan will mail a proof or Certificate of Creditable Coverage to the member's address on file. This certificate provides evidence of prior health coverage and can be used to demonstrate creditable coverage to the member's new plan or issuer. The certificate can be furnished automatically to members and upon request by an individual within 24 months after coverage ends. PEEHIP and the VIVA plan will accept the Certificates of Creditable Coverage from other plans.

## Special Enrollment Outside of Open Enrollment

HIPAA requires group health plans to provide special enrollment periods during which certain individuals who previously declined health coverage are allowed to enroll. A special enrollee is not treated as a late enrollee. Examples of coverage loss situations that qualify for special enrollment:

- An individual with other insurance coverage loses that coverage.
- A person becomes a dependent through marriage.
- A birth of a dependent child.
- An adoption, placement of adoption, or legal custody of a child under the age of 18.
- Loss of coverage because of layoffs
- Company discontinuing insurance coverage completely
- Company changing insurance carriers (not just a change in benefits and premiums) and no longer offering the previous carrier. This does not apply to a self-insured plan that is only changing insurance administrators.
- Loss of coverage because dependent is fired
- Loss of coverage due to divorce
- Exhaustion of COBRA continuation coverage
- Loss of coverage due to employment strike
- Loss of coverage because of voluntary resignation or voluntary change in employment

These individuals are not required to wait until the Open Enrollment period to enroll in the Hospital Medical Plan. This special enrollment period is available to employees and their dependents who meet certain requirements:

1. The employee or dependent must otherwise be eligible for coverage under the terms of their plan.
2. When the PEEHIP coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage.
3. If the other coverage is COBRA continuation of coverage, the special enrollment can only be requested after exhausting COBRA continuation of coverage.
4. If the other coverage is not COBRA continuation of coverage, special enrollment can only be requested after losing eligibility for the other coverage or after cessation of employer contributions

for the other coverage. In each case, the employee has 45 days to request special enrollment.

**An individual does not have a special enrollment right if the individual loses the other coverage in certain situations. Examples of coverage loss situations that do not qualify for special enrollment:**

1. As a result of the individual's failure to pay premiums.
2. For cause (such as making a fraudulent claim).
3. If other coverage has an increase in premiums or a change in benefits.
4. If employer changes to the Marketplace Exchange plans and continues to subsidize the premium.
5. Loss of coverage because an eligible dependent was voluntarily dropped during another plan's open enrollment period

These examples do not qualify as a loss of coverage under the HIPAA Federal guidelines.

The special enrollment for new dependents can occur if a person has a new dependent by birth, marriage, adoption or placement for adoption or legal custody. The election to enroll must be made within 45 days following the qualifying life event and can be made online.

**If the request is not made within 45 days of the loss of coverage, the special enrollment benefit does not apply. In addition, the coverage effective date must be within 45 days of the loss of coverage.**

When requesting special enrollment in Hospital Medical coverage due to loss of coverage, the member must submit to PEEHIP a completed new enrollment and status change form and attach a letter on company letterhead from the employer through which coverage was lost and the letter must state the reason for the loss of coverage, the employment and termination dates, and the date the coverage ended. The new enrollment and Status change form can be downloaded from the PEEHIP website. Special enrollment due to loss of coverage cannot be made online.

If the loss of coverage is due to divorce, the member must indicate on the form and give the exact date of divorce and provide a copy of the divorce decree signed by a judge of a court of competent jurisdiction.

If PEEHIP is not notified within 45 days, the member is required to wait and enroll during the Open Enrollment period of July 1 – August 31 for an October 1 effective date of coverage. Members are only allowed to enroll in the Hospital Medical plan when there has been a loss of coverage and must wait until Open Enrollment to enroll in the Optional Plans. The member cannot enroll in dental or vision coverage outside of open enrollment even if it was part of the plan in which they lost coverage.

A member is eligible to drop any of the Optional Plans when he or she enrolls in Hospital Medical coverage due to a loss of previous coverage if he or she had the Optional Plan(s) for at least one year.

## Newly Acquired Dependents and Single Coverage

## Marriage

A member enrolled in single coverage who marries and wishes to acquire family coverage can request coverage within 45 days of the marriage. You must mail a copy of the marriage certificate to PEEHIP after adding the new spouse to coverage through Member Online Services at www.rsa-al.gov. The effective date of coverage can be the date of marriage or the first day of the following month. Prior notification is not required.

If you do not enroll your new spouse through the online system or in writing within 45 days of the date of marriage, the policy cannot be changed to family and the new spouse cannot be added until the Open

Enrollment Period. Members will be required to make payment for the additional family premium at time of enrollment.

## Birth, Adoption, or Legal Custody of a Child

Members enrolled in single coverage who desire family coverage due to the birth, adoption, or legal custody of a child can request coverage within 45 days of the qualifying life event. You must provide a copy of the birth certificate, adoption or custody papers and the child's Social Security number after adding your child through the Member Online Services (MOS) system at www.rsa-al.gov. Click the QLE link after logging into MOS. You can also submit written notification to PEEHIP within 45 days of the date of qualifying life event. The effective date of coverage can be the date of birth or the first day of the following month.

If PEEHIP does not receive your online enrollment or written notification within 45 days of the qualifying life event, the policy cannot be changed to family and the new dependent cannot be added until the Open Enrollment period. If a newborn is not covered on the date of birth, claims for the newborn at the time of birth will not be paid. When adding family coverage, a member can add all eligible dependents to the policy. A member who is only enrolled in the four Optional Plans cannot enroll in the Hospital Medical Plan due to any of these qualifying life events.

**Members will be required to make payment for the additional family premium at time of enrollment.**

## Newly Acquired Dependents and Family Coverage

If a member is enrolled in family coverage, the member can enroll a new dependent(s) by using the Member Online System at www.rsa-al.gov or by completing and mailing a new enrollment and status change form to PEEHIP within 45 days of acquiring the dependent(s). Prior notification is not required. Application for dependent coverage must be made by the employee and approved and processed by PEEHIP prior to the payment of any claims.

## Cancelling or Changing Coverage Outside of Open Enrollment

### *Active Members*

All active members pay their premiums using pre-tax dollars. Therefore, active members must have an IRS qualifying life event (QLE) before they can be allowed to cancel their Hospital Medical Plan, change their coverage, or drop/add dependents outside of the Open Enrollment period. Also, the request to cancel or change coverage must be within 45 days of the IRS qualifying event.

Examples of IRS qualifying events are:

- Adoption of child
- Birth of a child
- Death of a spouse or dependent
- Dependent loss of coverage
- Divorce or annulment
- Legal custody of child
- Marriage
- Marriage of dependent child
- Termination of spouse/dependent employment and loss of insurance coverage

- Commencement of spouse/dependent employment
- Medicaid and Medicare entitlement
- FMLA/LOA
- Spouse's employer has a different open enrollment period

Appropriate documentation must be received and approved before the change can be made.

A member is not eligible to drop the medical plan when they change from full-time to part-time status.

If all dependents on the policy are ineligible, the coverage will automatically change to an individual plan effective the first of the month following the cancellation of the last remaining dependent. When a policy is cancelled, the coverage remains in effect through the last day of the month. Policies cannot be cancelled in the middle of a month.

### *Retired Members*

A retired member's premiums are not paid with pre-taxed dollars; therefore, a retired member can drop the hospital medical coverage, drop a dependent(s) from hospital medical coverage, or change from family to single hospital medical coverage outside of Open Enrollment on a prospective basis, by submitting a written request to PEEHIP. The cancellation of coverage will be the first day of the month following receipt of the written notification. A retired member cannot make changes to the optional coverage plans until the Open Enrollment period.

## *An Ex-Spouse and Ex-Stepchildren Must be Removed from Coverage*

Ex-spouses and ex-stepchildren are not eligible dependents even if a member continues to pay for family coverage and regardless of what the divorce decree states. The ex-spouse and ex-stepchildren must be deleted from coverage effective the first day of the month following the date of divorce. The member will be responsible for an ex-spouse's and ex-stepchildren's claims when they are not removed from coverage.

Active and retired members can use the online system to report a divorce and remove the Ex-Spouse from coverage effective the 1st day of the month following the divorce:

1. Click the "View/Change Contact Information" link once you have logged in to Member Online Services (MOS). Select the "Update my marital status" option, select "divorce" from the drop box, and then provide the date the divorce was final. This is generally the date the judge signed the Final Order of the Divorce Decree. Be sure to get a Confirmation page to ensure this change was saved and submitted to PEEHIP. This will remove the ex-spouse from your coverage.
2. If you do not have access to a computer, you must timely notify PEEHIP of your divorce by completing and mailing or faxing a new enrollment and status change form and a copy of your divorce decree to PEEHIP.

### Updating Information

### Name and Social Security Number Changes

Currently, PEEHIP determines a member's name for insurance purposes from the TRS FORM 100 ENROLLMENT form, or the enrollment through Member Online Services (MOS) or the New Enrollment and Status Change form.

Also, PEEHIP updates names from information received from the Social Security office. Therefore, the name on all insurance and TRS forms must be the same as the name on the Social Security card.

PEEHIP requires a copy of the member's Social Security card before a name or Social Security number change can be made. Also, active employees must provide a correct Social Security card to their employer to correct their TRS and PEEHIP accounts. The disclosure of your Social Security number is

mandatory for PEEHIP coverage so that PEEHIP may ensure compliance with the federal Medicare Secondary Payer rules created by 42 USC 1395y(b). Your Social Security number will be used by PEEHIP for the purpose of coordination of benefits.

### Address Changes

To change an address, use the secure online process from the RSA website at www.rsa-al.gov . Select the **Member Online Services** option on the left side of the home page and follow the instructions. This address change will automatically transmit to the insurance carriers and also update your address with the Teachers' Retirement System and RSA-1 if you are a participant in those accounts. However, the address change you make through the RSA online system will not change your address with your employer. You must contact your employer to have your address changed in their system.

Alternatively, you can change your address in writing, by completing an ADDRESS CHANGE NOTIFICATION form which can be downloaded from the RSA Web site. PEEHIP will also accept a letter with the old address, new address, insured's name and Social Security number.

The PEEHIP department cannot accept an address change by phone. All address changes should be made online or on the address change cards provided by the U.S. Postal Service or the ADDRESS CHANGE NOTIFICATION form provided by RSA. The card must then be mailed to PEEHIP for the actual change to occur.

## National Medical Child Support Orders

If the group receives an order from a court or administrative agency directing the plan to cover a child, the group will determine whether the order is a National Medical Child Support Order (NMCSO). A NMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The group has adopted procedures for determining whether such an order is a NMCSO.

The plan will cover an employee's child if required to do so by a NMCSO. If the group determines that an order is a NMCSO, Blue Cross will enroll the child for coverage effective as of a date specified by the group, but not earlier than the later of the following:

- If Blue Cross receives a copy of the order within 30 days of the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.
- If Blue Cross receives a copy of the order later than 30 days after the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order is received. PEEHIP will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the group may increase the employee's payroll deductions. During the period the child is covered under the plan as a result of a NMCSO, all plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the NMCSO is in effect Blue Cross will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. Blue Cross will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the plan. Upon request, Blue Cross will also send claim reports directly to the child's custodial parent or legal guardian.

## Relationship to Medicare and Provision for Medicare Eligibles

You must notify PEEHIP when you or any of your covered dependents become eligible for Medicare.

## Active Employees

PEEHIP is required by the Age Discrimination in Employment Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, to offer its active employees over age 65 coverage under its group health plan under the same condition as any employees under age 65. As a result of an accompanying amendment to the Social Security Act, Medicare is secondary to benefits payable under an employer-sponsored health insurance plan for employees over age 65 and their spouses over age 65. If the service is also covered by Medicare, the claim can be submitted to Medicare which may pay all or a portion of the unpaid balance of the claim subject to Medicare limitations.

As a result of these changes, PEEHIP does not provide an active member or his or her spouse with benefits which supplement Medicare. The member has the right to elect coverage under PEEHIP on the same basis as any other employee.

If a member chooses to be covered under PEEHIP, the plan will be the primary payer for those items and services covered by Medicare. (Note that Medicare covers hospitalization, post-hospital nursing home care, home health services.) This means that the plan will pay the covered claims and those of the member's Medicare-eligible spouse first, up to the limits contained in the plan, and Medicare may pay all or a portion of the unpaid balance of the claims, if any, subject to Medicare limitations. If the member's spouse is not eligible for Medicare, the plan will be the sole source of payment for the spouse's claims.

Since PEEHIP also covers items and services not covered by Medicare, PEEHIP will be the sole source of payment of medical claims for these services.

Because of the cost of Medicare Part B, a member age 65 or older may decide to defer enrolling for Part B until he or she actually reaches retirement, at which point Medicare will become the primary payer and the member must enroll in Medicare Part B effective the date of retirement. However, a member and his or her Medicare-eligible spouse can enroll in Medicare Part B only during certain times allowed by Medicare. Medicare-eligible members should enroll in Part A and Part B no later than the date of retirement of the policyholder.

The Social Security Administration handles Medicare enrollments. Therefore, if you have questions about when to enroll in Medicare Part B, you should contact the Social Security Administration at 800.772.1213. A Medicare-eligible retiree and/or spouse must have both Medicare Part A and Part B to have adequate coverage with PEEHIP. If you do not have Part B, PEEHIP will only pay 20% of the Medicare allowable fee (subject to a $30 copay on office visits, emergency room visits and outpatient consultations) as if you had Part B.

## If I Work After Age 65 or Become Eligible For Medicare, am I Still Covered?

If you continue to be actively employed when you are age 65 or older and are insured on a PEEHIP active contract, you and your spouse will continue to be covered for the same benefits available to employees under age 65. In this case, your PEEHIP plan will pay all eligible expenses first. If you are enrolled in Medicare, Medicare will pay for Medicare-eligible expenses, if any, not paid by the group benefits plan.

If both you and your spouse are over age 65, you may elect to withdraw completely from the PEEHIP plan and purchase a Medicare Supplement contract. This means that you will have no benefits under the PEEHIP plan. In addition, the employer is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract.

## Other Medicare Rules

*Disabled Individuals:* If you or your dependent is eligible for Medicare due to disability and also covered under the plan by virtue of your current employment status with the employer, the plan will be primary and Medicare will be secondary.

*End-Stage Renal Disease:* If you are eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), the plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility. Thereafter, Medicare will be primary and the plan will be secondary.

If you have any questions about coordination of your coverage with Medicare, please contact PEEHIP for further information.

PEEHIP members who retired on disability after September 30, 2005, but are also eligible for service retirement, are subject to the Sliding Scale for PEEHIP premiums.

Medicare rules require a Medicare-eligible, active PEEHIP member who is covered on their spouse's PEEHIP retired contract to have Medicare as the primary payer on the active PEEHIP member. The active, Medicare-eligible member must have Medicare Part A and Part B coverage.

If the active member does not want Medicare as his or her primary payer and does not want to enroll in Medicare Part B until retirement, he or she will have to enroll in a PEEHIP active contract and will not be able to remain on the retired contract with the retired PEEHIP-eligible spouse. Most of the time, in this situation, active members must wait and enroll in their own PEEHIP medical policy during the Open Enrollment period or their spouse's date of retirement. When the active Medicare-eligible member retires, he or she will need to enroll in Medicare Part B. The effective date of Medicare Part B needs to be the date of retirement to avoid a lapse in coverage.

## Retired Employees

Retired employees are not affected by the TEFRA amendment to the Age Discrimination in Employment Act; therefore, upon retirement and Medicare eligibility the member's coverage under PEEHIP will complement his or her Medicare coverage. Medicare will be the primary payer and PEEHIP will be the secondary payer for retirees and dependents eligible for Medicare. Medicare approved admissions will not be subject to the Preadmission Certification requirements.

PEEHIP remains primary for retirees until the retiree is Medicare-eligible. A Medicare-eligible retiree and/or spouse must have both Medicare Part A and Part B to have adequate coverage with PEEHIP.

After Medicare pays 80% of the approved amount after the Part B deductible, PEEHIP will pay the remainder of the Medicare approved amount without a Major Medical deductible (subject to applicable copays for office visits, emergency room visits and outpatient consultations) on PEEHIP approved services. In rare situations some services are covered by Medicare and are not by PEEHIP. In the rare situation that a service is not covered by Medicare but is covered by PEEHIP, PEEHIP will be primary and all PEEHIP deductible and copayment amounts will apply as will all PEEHIP precertification requirements.

Medicare-eligible members and Medicare-eligible dependents should not enroll in a separate standard Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. All retired Medicare-eligible members and Medicare-eligible dependents on retired contracts are enrolled in the Medicare GenerationRx Medicare Part D program offered by PEEHIP unless they are enrolled in a separate standard Medicare Part D plan or they choose not to participate.

## Termination of Coverage

Plan coverage ends as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

- The date on which the employee fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the Leaves of Absence rules below);
- For spouses and stepchildren, the date of divorce or other termination of marriage;
- For children, the date a child ceases to be a dependent;
- For the employee and his or her dependents, the first day of the month following the date of the employee's or dependent's death;
- You fail to pay your group any contribution amount due within 30 days after the day due;
- Upon discovery of fraud or intentional misrepresentation of a material fact by you.
- October 1 for Open Enrollment cancellation requests;
- For the employee and/or his/her dependents, the first day of the month following the request to cancel

coverage due to a qualifying life event;

- First day of the month following receipt of a written cancellation request outside of Open Enrollment from retirees whose premiums are not paid with pre-taxed dollars. The cancellation applies to the medical coverage and not the optional plans;
- The first day of the month following written or online notification from retirees who retired after September 30, 2005, and who become employed by an employer that provides employees at least 50% of the cost of single health insurance coverage and that qualify to receive other employer group health insurance coverage through that employer pursuant to Section 16-25A-5.2(1);
- For children covered under a parent's PEEHIP plan, the first day of the month in which the child becomes eligible for PEEHIP coverage as a new employee. or
- On 30-days advance written notice from your group to us.

All the dates of termination assume that payment for coverage for you and your dependents, in the proper amount, has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid. Blue Cross and Blue Shield of Alabama will mail a Certificate of Creditable Coverage to each member upon cancellation of coverage.

### Leaves of Absence

If you qualify for an approved leave of absence under the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to employers who employ 50 or more employees. You should contact your employer or group to determine whether a leave qualifies as FMLA leave.

You may also continue your coverage under the plan for up to two years during an employer-approved leave of absence.

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should contact your employer about your rights to continue coverage under the plan.

A member who goes on an authorized leave of absence without pay can continue group health coverage for up to two years of authorized leave before he or she would be required to enroll in continuation of coverage under the COBRA provisions. A member on an approved leave of absence can continue the health insurance coverage for two years and then can continue the health insurance coverage for an additional 18 months under the COBRA provisions.

## COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires PEEHIP and most other group health plans to offer employees and their families the opportunity for a temporary extension of health coverage. The continuation of coverage is offered at group rates in certain instances where coverage under PEEHIP would otherwise end.

All public education employees of the State of Alabama who are covered under the PEEHIP group health insurance have the right to choose continuation of coverage if the employee loses group health coverage due to a reduction in hours of employment or because of a resignation or termination of employment (for reasons other than gross misconduct on the part of the employee).

Each public education institution has the responsibility by law to notify the PEEHIP office immediately when an employee loses group health coverage due to the employee's:

- death;
- termination of employment; or,
- reduction in hours.

COBRA also provides that you may have other health coverage alternatives for you and your family that may be available to you through the Health Insurance Marketplace. You may be able to buy coverage through the Health Insurance Marketplace and could be eligible for a new kind of tax credit that lowers your monthly premiums right away. You can see what your premiums, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

## COBRA Compliance

The sanctions imposed under the auspices of COBRA can be quite severe, making a determination of compliance greatly important. It is the employer's responsibility to notify PEEHIP within a maximum of 30 days of an employee's termination, death or reduction in hours. The employer must notify the PEEHIP office by entering a termination date in the employer portal before the next payroll cycle. Employers must key the termination date in the employer portal for each employee who loses insurance coverage due to resignation or termination of employment or reduction in hours, even if the employee does not want to continue the coverage. Employers are subject to a penalty of $100 per day for every day that they are past the 30-day notification deadline.

It is the employee's or dependent's responsibility to notify PEEHIP within a maximum of 60 days when the dependent needs continuation coverage under COBRA.

COBRA allows the employer a maximum of 30 days to notify PEEHIP of the above named qualifying events. However, the employer's immediate notification to PEEHIP will help reduce the amount of time the plan is exposed to adverse risk and potential premium increases.

## Termination for Gross Misconduct

If an employer terminates an employee for gross misconduct, then PEEHIP is not required to provide continuation of coverage under the provisions of COBRA. However, the employer must still notify the PEEHIP office of the termination by entering the termination information via the employer portal.

## Eligibility

Under COBRA, the employee, ex-spouse or dependent family member has the responsibility to inform PEEHIP within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan and must obtain a Continuation of Coverage Application form. PEEHIP may be notified by phone or in writing.

A dependent's coverage ends on the last day of the month in which the dependent becomes ineligible by turning age 26 or by divorce or legal separation.

When PEEHIP is notified of a qualifying event, PEEHIP will in turn notify the eligible member that he or she has the right to choose continuation of coverage. It is important to note that the eligible member has 60 days from the date he or she would lose coverage because of one of the qualifying events to inform PEEHIP that he or she wants continuation of coverage.

If the eligible member does not choose continuation of coverage, his or her PEEHIP group health insurance coverage will end the last day of the month in which the member becomes ineligible.

If a member and/or dependent become entitled to Medicare after electing COBRA coverage, he or she is no longer eligible to continue the COBRA coverage. However, dependents on the contract will be allowed to continue COBRA coverage up to a total of 36 months from the date of the original qualifying event.

## Continuation of Coverage

If the eligible member chooses continuation of coverage, PEEHIP is required to give the member coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members and is the same coverage he or she had prior to the qualifying event.

COBRA requires that the eligible member be afforded the opportunity to maintain continuation of coverage for 18 months due to a termination of employment or reduction in hours. COBRA requires that eligible dependents who become ineligible for reasons such as aging out or divorce be afforded an opportunity to maintain coverage for 36 months.

COBRA members have the same rights such as adding a newborn child or a new spouse within 45 days of the date of birth or marriage as other employed or retired members.

COBRA also provides that a member's continuation of coverage may be cut short for any of the following five reasons:

- PEEHIP no longer provides group health coverage to any of its employees.
- The premium for continuation of coverage is not paid by the member when payment is due, or the premium payment is insufficient.
- The member becomes covered under another group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition.
- The member or dependent becomes entitled to Medicare after COBRA benefits begin.
- The member becomes divorced from a covered member and subsequently remarries and is covered under the new spouse's group health plan, which does not contain any exclusions or limitations with respect to pre-existing conditions.

An eligible member does not have to show that he or she is insurable to choose continuation of coverage. However, under COBRA, he or she is required to pay the full monthly premium for continuation of coverage.

If a member who is on COBRA dies before the 18 months has lapsed and the member's family is covered under COBRA, the eligible covered family members can continue the COBRA coverage up to a total of 36 months from the date of the original qualifying event.

## Dependent Coverage

A spouse of an employee covered by PEEHIP has the right to choose continuation of coverage if the spouse loses group health coverage under the Plan for any of the following reasons:

- death of the employee
- termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment
- divorce or legal separation

- employee's eligibility for Medicare

In the case of a dependent child of an employee covered by PEEHIP, he or she has the right to continuation of coverage if group health coverage under the Plan is lost for any of the following reasons:

- death of a parent
- termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer
- parents' divorce or legal separation
- parent becomes eligible for Medicare
- dependent ceases to be a dependent child under the Plan

## Members on COBRA Who Return to Work

When a member who is enrolled in PEEHIP under COBRA returns to work and does not have a break in coverage, the member is not allowed to change coverage until the Open Enrollment period.

If a member chooses not to continue their insurance coverage under COBRA and has a break in coverage, the member must complete a new enrollment application when he or she is re-employed in public education.

Exception: Employees enrolled in one or more Optional plan while on COBRA can add the remaining Optional plans when he or she becomes eligible for a full employer contribution. However, employees enrolled in one or more Optional plan while on COBRA cannot enroll in a Hospital Medical plan until Open Enrollment.

## Can COBRA Coverage be Extended for Covered Members who Become Disabled?

Yes. In certain circumstances, COBRA can be extended for covered members who become disabled. 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 PEEHIP office, 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 PEEHIP office timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the PEEHIP office within 30 days of any revocation of Social Security disability benefits. See the section called Notice Procedures for more information about the notice procedures you must use to give this notice.

## Extensions of COBRA for Second Qualifying Events

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

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

For this 18-month extension to apply, you must give the PEEHIP office timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the section Notice Procedures for more information about the notice procedures you must use to give this notice.

## Notice Procedures

*If you do not follow these notice procedures or if you do not give the PEEHIP office notice within the required 60-day notice period, you will not be entitled to COBRA or an extension of COBRA as a result of an initial qualifying event of divorce or loss of dependent child status, a second qualifying event or Social Security's disability determination.*

Any notices of initial qualifying events of divorce or loss of dependent child status, second qualifying events or Social Security disability determinations that you give must be in writing. Your notice must be received by the PEEHIP office no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the plan and for your notice of a second qualifying event, you must mail or hand-deliver your notice to the PEEHIP office. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, you may ask the PEEHIP office for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

## Medicare and COBRA Coverage

You should consider whether it is beneficial to purchase COBRA coverage. After you terminate employment, or retire, your COBRA coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Medicare.

If you think you will need both Medicare and COBRA after your termination of employment, you should enroll in Medicare on or before the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your termination of employment, or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months from the date of your termination of employment. If you do not enroll in Medicare on or before the date on which you make your election to buy COBRA coverage, your COBRA benefits will end when your Medicare coverage begins. Your covered dependents will have the opportunity to continue their own COBRA coverage.

If you do not want both Medicare and COBRA for yourself, your covered family members will still have the option to buy COBRA when you terminate employment. However, if your covered family members

become enrolled in Medicare after electing COBRA, their COBRA coverage will end. See the Early Termination of COBRA section of this booklet for more information about this.

# WELLNESS PROGRAM

**(Administered by ActiveHealth and the Alabama Department of Public Health)**

## Wellness Program Overview

The PEEHIP Team Up for Health Wellness Program offers ways for members to better understand their health risks and opportunities for health improvement. These wellness benefits are designed to improve health outcomes and save lives. By participating in the program, eligible members earn a waiver of the $50 monthly wellness premium effective October 2015.

## Eligible Members

All active and retired members and dependents (age 18 and up) covered by the PEEHIP Hospital Medical Plan, HMO or Optional Plans can receive one free annual wellness screening by the Alabama Public Health Department nurses at different sites during the year.
The following members enrolled in the PEEHIP Blue Cross Blue Shield hospital medical (group #14000) plan are eligible for the additional Wellness Program benefits provided by ActiveHealth, and are required to participate in a minimum set of activities in order to earn a waiver of the $50 monthly wellness premium.

- Active employees and their covered spouses
- Non-Medicare eligible retirees
- Non-Medicare eligible spouses covered on retiree contracts

## Wellness Benefits Provided

PEEHIP, in partnership with ActiveHealth and the Alabama Department of Public Health (ADPH), offers the wellness services below effective January 1, 2015:

- Wellness Screenings – available prior to January 1, 2015, screenings continue to be offered free once per year by ADPH nurses at worksites. Flu shots are also available to all PEEHIP members and school aged children.
- Health Questionnaire (HQ) – provides an assessment of members' overall health and helps find ways for improvement
- Wellness Coaching – connects members with registered dietitians, nutritionists, exercise physiologists, or other licensed counselors who can help members to build a plan for achieving healthier lifestyles.
- Disease Management – provided by ActiveHealth effective January 1, 2015 for subscribers and their covered spouses. Disease Management for covered children is provided by Blue Cross Blue Shield. Disease Management provides support from licensed nurses to help manage long-term chronic health conditions.
- 24-Hour Nurseline – members can speak with a registered nurse 24 hours per day, 7 days per week to inquire about any health related matter.
- Care Considerations – ActiveHealth continuously analyzes healthcare information to look for opportunities to recommend certain tests or medications or treatments. All Care Considerations encourage members to first speak with their doctor about the recommendation.
- MyActiveHealth Personal Health and Wellness Website – provides a wide variety of tools including the HQ, online coaching topics, personal health record, videos, quizzes, and other interactive tools to help members achieve health goals.
- Tobacco Cessation – Alabama Tobacco Quitline is a free service from ADPH for all Alabamians. AL Quitline offers live and online counseling, and is available toll free at 1-800-784-8669 or www.quitnowalabama.com. ActiveHealth also offers a free tobacco cessation program with live and online counseling to those members listed above who are eligible for their services. For more information, call 1-855-294-6580.

For more information on the services provided by the PEEHIP Wellness Program, visit http://www.rsa-al.gov/index.php/members/peehip/health-wellness/.

## Wellness Premium Waiver

Those members listed above who are eligible for the additional wellness program benefits provided by ActiveHealth are required to participate in the activities below by August 31, 2016 in order to earn a waiver of the $50 monthly wellness premium effective October 2016.

Required for all eligible:

- Wellness Screening – Restarting every August 1, one annual screening is offered by Alabama Department of Public Health nurses and is available at worksites and local county health departments. Screenings are also available once per calendar year restarting every January 1 from primary care physicians by using PEEHIP's Healthcare Provider Screening form. Wellness screenings obtained at a doctor's office are normally classified as a routine office visit, and under the PEEHIP Blue Cross Blue Shield benefits, only one routine office visit is covered per calendar year. Any additional routine office visits obtained in one calendar year will not be covered. Health Questionnaire – available at www.MyActiveHealth.com/PEEHIP or by phone at 1-855-294-6580.

  Required only if invited to participate by ActiveHealth via notification letter:
  Health coaching via wellness coaching or disease management – available online at www.MyActiveHealth.com/PEEHIP or by phone at 1-855-294-6580 or onsite via a health coaching seminar. Only one health coaching option is necessary. For onsite seminars, check with your payroll/insurance coordinator.

- Some PEEHIP members are identified as candidates for a higher level of care than regular Health Coaching. These members will be required to complete at least 4 telephonic health coaching calls before August 31, 2016 in order to earn the wellness premium waiver. These members with a specific 4 coaching call requirement were notified of their specific requirement by mail in October 2015, and their ActiveHealth nurse will work with them to develop a call schedule that is most convenient and helpful to them.

In order to ensure you receive all important communications from PEEHIP, Blue Cross Blue Shield, and all of PEEHIP's healthcare partners, it is highly important that you keep your contact information up to date with all parties. To do this, visit PEEHIP's Member Online Services (MOS) at https://mso.rsa-al.gov and click the "View/Change Contact Information" link to provide PEEHIP with your current information. To update your information with BCBS, visit www.AlabamaBlue.com .

# COST SHARING

## Effective 10/1/2015 – 12/31/2015

| | |
|---|---|
| Calendar Year Deductible | $300<br><br>($900 aggregate per family) |
| Calendar Year Major Medical Out-of-Pocket Maximum<br>(In-network Other Covered Services are the only expenses applicable to the calendar year major medical out-of-pocket maximum) | $400 per person (applicable to Other Covered Services) plus the $300 calendar year deductible |
| Calendar Year Overall Out-of-Pocket Maximum<br>(All In-Network deductibles, copayments and coinsurance, excluding prescription drugs, for In-Network services apply to the overall out-of-pocket maximum) | $6,600 per person<br>$13,200 per family |
| Lifetime Dollar Maximum on Essential Health Benefits | Unlimited |

## Effective 01/01/2016

| | |
|---|---|
| Calendar Year Deductible | $300<br><br>($900 aggregate per family) |
| Calendar Year Major Medical Out-of-Pocket Maximum<br>(In-network Other Covered Services are the only expenses applicable to the calendar year major medical out-of-pocket maximum) | $400 per person (applicable to Other Covered Services) plus the $300 calendar year deductible |
| Calendar Year Overall Out-of-Pocket Maximum<br>(All In-Network deductibles, copayments and coinsurance, excluding prescription drugs, for In-Network services apply to the overall out-of-pocket maximum) | $6,850 per person<br>$13,700 per family |
| Lifetime Dollar Maximum on Essential Health Benefits | Unlimited |

## Calendar Year Deductible

The calendar year deductible is specified in the table above. Other parts of this booklet will tell you when benefits are subject to the calendar year deductible. The calendar year deductible is the amount you or your family must pay for some medical expenses covered by the plan before your healthcare benefits for those medical expenses begin.

Here are some special rules concerning application of the calendar year deductible:

- The individual calendar year deductible must be satisfied on a per member per calendar year basis, subject to the family calendar year deductible.

- The family calendar year deductible is an aggregate dollar amount. This means that all amounts applied toward the individual calendar year deductible will count toward the family calendar year amount. Once the family calendar year deductible is met, no further family members must satisfy the individual calendar year deductible.
- When covered charges are applied towards the deductible for services rendered in October, November, or December, we will credit those covered charges towards the calendar year deductible for the following year. (Effective January 1, 2016 this is no longer applicable)
- Only one individual calendar year deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- In all cases, the deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

## Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is specified in the table above. The calendar year out-of-pocket maximum generally applies to services or supplies that are subject to the calendar year deductible. There may be exceptions to this, depending upon specifications from your group. You may also call Customer Service if you have questions about payments that count towards the calendar year out-of-pocket maximum. Once the maximum has been reached, covered expenses of the type that count towards the maximum will be paid at 100% of the allowed amount.

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

- Out-of-network coinsurance on most services;
- The calendar year deductible;
- Per admission deductibles;
- Copayments;
- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges);
- Amounts paid for services or supplies in excess of any plan limits (for example, a limit on the number of covered visits for a particular type of provider);
- Amounts paid as a penalty (for example, failure to precertify); and,
- Facility and physician expenses for outpatient mental health and substance abuse.

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

## Other Cost Sharing Provisions

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

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

- **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, 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 will be responsible for these charges if you use an out-of-network provider.

## Out-of-Area Services

Blue Cross and Blue Shield of Alabama 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 our 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 Blue Cross and Blue Shield of Alabama and other Blue Cross and Blue Shield Licensees.

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

### A. BlueCard® Program

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

Whenever you access covered healthcare services outside our 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 Blue Cross and Blue Shield of Alabama.

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

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

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

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

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

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

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

1. Member Liability Calculation

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

2. Exceptions

In some exception cases, we may pay such claims based on the payment we would make if we were paying a non-participating provider inside of our service area, as described elsewhere in this benefit booklet, where the Host Blue's corresponding payment would be more than our in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In other exception cases, Blue Cross and Blue Shield of Alabama may use other payment bases, such as billed covered charges, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

# HEALTH BENEFITS

**Attention:** Benefit levels for mental health disorders and substance abuse are set forth in the Mental Health and Substance Abuse Benefits section of this booklet.

## Inpatient Hospital Benefits

**Attention:** Preadmission certification is required for all hospital admissions except emergency hospital admissions and maternity admissions.

For emergency hospital admissions, 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.

Preadmission certification does not mean that your admission is covered. It only means that Blue Cross and Blue Shield of Alabama has approved the medical necessity of the admission.

In many cases your provider will initiate the preadmission certification process for you. You should be sure to check with your admitting physician or the hospital admitting office to confirm whether preadmission certification has been obtained. It is your responsibility to ensure that you or your provider obtains preadmission certification.

**For preadmission certification call 1-800-248-2342 (toll-free).**

Generally, if preadmission certification 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, the benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on the retrospective review by the plan.

| SERVICE OR SUPPLY | IN-NETWORK PLAN PAYS | OUT-OF-NETWORK PLAN PAYS |
|---|---|---|
| First 365 days of care during each confinement (combined in-network and out-of-network)<br><br>(Including maternity. Note: Maternity benefits are not available to dependent children of any age.) | 100% of the allowed amount for semi-private room and board, intensive care units, general nursing services, and usual hospital ancillaries, subject to a $200 deductible per admission and a $25 per day copayment beginning with the 2nd through the 5th day<br>Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury | 80% of the allowed amount for semi-private room and board, intensive care units, general nursing services, and usual hospital ancillaries, subject to a $200 deductible per admission and a $25 per day copayment beginning with the 2nd through the 5th day<br>Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury |
| Days of confinement extending beyond the 365-day benefit maximum | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |
| Inpatient rehabilitation<br>60 days of care during a lifetime (combined in-network and out-of-network) | 100% of the allowed amount, subject to a $200 deductible per admission and a $25 per day copayment beginning with the 2nd through the 5th day | 80% of the allowed amount, subject to a $200 deductible per admission and a $25 per day copayment beginning with the 2nd through the 5th day |

**Attention:** If you receive inpatient hospital services in an out-of-network hospital in the Alabama service area, no benefits are payable under the plan unless services are to treat an accidental injury or medical emergency.

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 by hospital employees 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, 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;
- Blood transfusions administered by a hospital employee.

If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward any applicable maximum number of inpatient days.

Blue Cross and Blue Shield of Alabama may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the setting in which they were rendered. This means that Blue Cross and Blue Shield of Alabama may, at times, reclassify an inpatient hospital admission as outpatient services. There may also be times in which Blue Cross and Blue Shield of Alabama denies benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

Group health plans and health insurance issuers offering group health insurance coverage generally 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 vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Inpatient Rehabilitation Benefits

(Limited to a lifetime of 60 days)

These inpatient hospital benefits consist of:

- General nursing care;
- Physical therapy and hydrotherapy;
- Speech and hearing therapy;
- Functional occupational therapy.

The patient's condition must require:

- A rehabilitation trained physician available 24 hours a day;
- A rehabilitation trained nurse present 24 hours a day;
- Four hours of therapy provided by a licensed therapist a day;
- Continued progress toward goals requiring you to remain in the hospital. Your record must show conferences with your physician, therapists, and nurses at least weekly about your progress, any problems and their solutions, and review of the goals set for you.

Inpatient care for rehabilitation is excluded:

- If it maintains or is mainly to keep you clean or fed, or to help you take care of yourself;
- If just to make sure you keep to a therapy schedule or take your prescribed medicine;
- If only repeating services that don't require a skilled therapist, e.g., walking, conditioning, or maintenance;
- If your condition warrants that your rehab services could be provided on an outpatient basis;
- If you can't improve further.

Occupational therapy services when the following conditions are met:

- The services must be medically necessary and performed by a licensed occupational therapist.
- The services must be related to the hand and/or treatment of lymphedema, and must be of a type that is covered under the occupational therapy program. Call Customer Service at 1-800-327-3994 to determine what specific diagnostic codes and procedures are covered.

If you see a Preferred Occupational Therapist, the therapist will bill Blue Cross and Blue Cross will pay him or her directly. By contrast, if you see an occupational therapist who is not a Preferred Occupational Therapist, you may have to file your claim, and Blue Cross will pay you directly.

Preferred Occupational Therapists may be required to pre-certify services during the course of your treatment. If so, the Preferred Occupational Therapist will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

Blue Cross's standards for inpatient stays for rehabilitation are based on physician referral, how weak you are, how many services you need, how often you need them, how skilled the providers must be, and whether these services will improve your condition.

## Outpatient Hospital Benefits

| SERVICE OR SUPPLY | IN-NETWORK PLAN PAYS | OUT-OF-NETWORK PLAN PAYS |
|---|---|---|
| Outpatient surgery (including ambulatory surgical centers) | 100% of the allowed amount, subject to a $150 facility copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Medical Emergency In-Area / Out-of-Area Emergency Room Facility Charge | 100% of the allowance subject to a $150 facility copayment if a true medical emergency. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowance subject to the calendar year deductible | 100% of the allowance subject to a $150 facility copayment if a true medical emergency. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowance subject to the calendar year deductible |
| Accidental Injury- Emergency Room Facility Charge | 100% of the allowance subject to a $150 facility copayment | 100% of the allowance subject to a $150 facility copayment when services are rendered within 72 hours of the accident; after 72 hours 80% of the allowed amount subject to the calendar year deductible |
| Outpatient diagnostic lab, and pathology | 100% of the allowed amount, no deductible; subject to a $5 copayment per test | 80% of the allowed amount, subject to the calendar year deductible |
| Outpatient diagnostic X-ray | 100% of the allowed amount, no deductible or copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Outpatient dialysis, IV therapy, chemotherapy, and radiation therapy (not administered in the emergency room) | 100% of the allowed amount, no deductible; subject to a $25 facility copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Services billed by the facility for an emergency room visit when the patient's condition does not meet the definition of a | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |
| Sleep studies on children ages 18 and under | 100% of the allowed amount, subject to a $10 facility copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Sleep studies on members ages 19 and above | 100% of the allowed amount, subject to a $150 facility copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Sleep studies performed in a free-standing sleep clinic | 100% of the allowed amount, subject to a $10 facility copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Outpatient hospital services or supplies not listed above | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |

**Attention:** If you receive outpatient hospital services in an out-of-network hospital in the Alabama service area, no benefits are payable under the plan unless services are to treat an accidental injury or medical emergency.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the setting in which they were rendered. This means that we may, at times, reclassify an outpatient hospital service as an inpatient admission. There may also be times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

**Attention:** The benefits listed below apply only to the physician's charges for the services indicated. Claims for outpatient facility charges associated with any of these services will be processed under your outpatient hospital benefits and subject to any applicable outpatient facility copayments. Examples may include 1) laboratory testing performed in the physician's office, but sent to an outpatient hospital facility for processing; 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

| SERVICE OR SUPPLY | IN-NETWORK PLAN PAYS | OUT-OF-NETWORK PLAN PAYS |
|---|---|---|
| Office visits and consultations | 100% of the allowed amount, subject to a $30 visit copayment by a primary physician and a $35 visit copayment by a specialist.<br>A primary physician includes Urgent Care, Internal Medicine, Family Practice, General Practice, Physician Assistant, Clinic, Gynecology, Obstetrics, Certified Nurse Practitioner, Midwives and Pediatrician. All other providers are considered specialists. | 80% of the allowed amount, subject to the calendar year deductible |
| Emergency room physician | 100% of the allowed amount, subject to a $35 visit copayment | 100% of the allowed amount, subject to a $35 visit copayment |
| Surgery, second surgical opinion, and anesthesia for a covered service | 100% of the allowed amount, no deductible or copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Maternity care | 100% of the allowed amount, no deductible or copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Inpatient visits | 100% of the allowed amount, no deductible or copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Inpatient consultations by a specialty provider (limited to one consult per specialist per stay) | 100% of the allowed amount, no deductible or copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Diagnostic lab and pathology | 100% of the allowed amount, no deductible; $5 copayment per test | 80% of the allowed amount, subject to the calendar year deductible |
| Diagnostic X-rays | 100% of the allowed amount, no deductible or copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Chemotherapy and radiation therapy | 100% of the allowed amount, no deductible or copayment | 80% of the allowed amount, subject to the calendar year deductible |
| Allergy testing and treatment | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |

**Attention:** If you receive other out-of-network physician services (such as out-of-network laboratory services) for a medical emergency in the emergency room of a hospital, those services will also be paid with the applicable in-network coinsurance and/or copayment amounts for such physician benefits described in the matrix above, but subject to the calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the applicable requirements of the Patient Protection and Affordable Care Act.

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, and heart catheterization.
- 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.

## Physician Preventive Benefits

**In accordance with the Affordable Care Act (ACA), PEEHIP will not impose any cost sharing requirements for:**

1. **Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;**
2. **Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and**
3. **With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.**
4. **With respect to women, such additional preventive care and screenings not described in paragraph 1 above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.**

**Attention:** In some cases, routine immunizations and routine preventive services may be billed separately from your office visit or other facility visit. In that case, and in all cases where the primary purpose for your visit is not routine preventive services and/or routine immunizations, the applicable office visit or outpatient facility copayments under your Physician Benefits or Outpatient Hospital Benefits may apply.

| SERVICE OR SUPPLY | IN-NETWORK PLAN PAYS | OUT-OF-NETWORK PLAN PAYS |
|---|---|---|
| Routine preventive services and immunizations:<br>(See www.AlabamaBlue.com/preventiveservices for a listing of specific preventive services and immunizations) | 100% of the allowed amount, no deductible or copayment | Not covered |

| SERVICE OR SUPPLY | IN-NETWORK PLAN PAYS | OUT-OF-NETWORK PLAN PAYS |
|---|---|---|
| Additional routine preventive services | 100% of the allowed amount, no deductible or copayment:<br>• Urinalysis (once by age 5 and once between age 12 through 17)<br>• CBC (once each calendar year)<br>In addition to the mandated coverage for HCR, the following codes are allowed with a routine diagnosis; no more than one of each per calendar year for members 18 and older with no copay:<br>80061<br>82465<br>83718<br>83719<br>83721<br>84478<br>82947<br>82948<br>82950<br>82951<br>82952<br>82953<br>82955<br>82960 | Not covered |
| Zostavax (Shingles) vaccine | 100% of the allowed amount, no deductible or copayment for members age 60 and over | Not covered |

## Mental Health and Substance Abuse Benefits

For services, supplies, or treatment for mental health disorders and substance abuse by a licensed clinical psychologist, psychiatrist, or medical doctor, the following benefits may be available subject to the benefit maximums, copayments, and deductibles shown below:

- Inpatient care for mental health disorders and substance abuse;
- Outpatient visits;
- Individual, group and family therapy or counseling;
- Psychological and laboratory testing.

| SERVICE OR SUPPLY | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Mental Health and Substance Abuse** | | |
| Inpatient Facility Services | 100% of the allowed amount, subject to the following copays: $15 per day for days 10-14; $20 per day for days 15-19; $25 per day for days 20-24; $30 per day for days 25-30.<br>Covers up to 30 days per person each plan year (10/1-9/30)<br>Inpatient Substance Abuse limited to one admission per plan year and a maximum of two admissions per lifetime<br>Mental Health and Substance Abuse days are aggregate<br>No rollover to Major Medical | 100% of the allowance subject to a **$200 per admission deductible and a $25 copay for days 2-5**<br>Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital<br>Precertification is required |
| Inpatient Physician Services | 80% of the allowed amount, subject to the calendar year deductible<br>Coverage is only available during a covered admission up to 30 days each plan year (10/01-9/30) | 80% of the allowed amount, subject to the calendar year deductible |
| Outpatient Physician Services | 100% of the allowed amount, subject to a $10 copayment per day for up to 20 outpatient visits per plan year (10/1-9/30) at approved mental health facilities | 50% of the allowed amount, subject to the calendar year deductible<br>Limited to 10 visits each plan year (10/1-9/30) |
| **Outpatient PPO Benefits** | | |
| Intake and Evaluation | Included in the combined 20-visit maximum per member each plan year | $10 copayment per day |
| Individual and Family Therapy | Limited to 2 units per procedure per member each day (billed in 30 minute units) | $10 per procedure |
| Crisis Intervention | Limited to 4 units per member each day (billed in 15 minute units) | $10 per day |
| Psychometric Testing and Diagnostic Testing by Psychologist | Limited to 5 hours per member each plan year (billed in one hour units) | $20 per day |
| Psychometric Testing and Diagnostic Testing by Technician | Limited to 5 hours per member each plan year (billed in one hour units) | $20 per day |
| Psychometric Testing and Diagnostic Testing by Computer | Limited to 1 hour per member each plan year (billed in one hour units) | $20 per day |
| Group Therapy | Limited to 2 hours per member each day (billed in 30 minute units) | $5 per hour |
| Physician Assessment | Limited to 4 units per member each day (billed in 15 minute units) | $10 per day |
| Substance Abuse Intensive Outpatient Program | Limited to 40 visits per member each plan year | No copayment |
| Partial Hospitalization | Limited to 90 visits per member each plan year | $20 per day |
| Adult and Child Mental Illness Intensive Day Treatment | Limited to 50 visits per member each plan year | $10 per day |
| Adult Rehabilitation Day Program | Limited to 35 visits per member each plan year | $5 per day |
| Hospital Screening/After Hours | Limited to $150 per day | No copayment |
| Medication Monitoring | Limited to 2 units per member per day (billed in 15 minute units) | No copayment |

| SERVICE OR SUPPLY | IN-NETWORK PLAN PAYS | OUT-OF-NETWORK PLAN PAYS |
|---|---|---|
| Medication Administration | Limited to $14 per day | No copayment |
| Outpatient Non-PPO | 10 visits per plan year, subject to the calendar year deductible | 50% copayment |

**Attention:** Inpatient hospital benefits for treatment of mental health disorders and substance abuse are available in the Alabama service area only if the hospital is an in-network provider.

The following services and supplies are not covered:

- Diagnosis or treatment of mental retardation;
- Rehabilitation of a temporary or permanent disability or for hearing or vision impairment;
- Treatment for chronic pain or solely for obesity;
- Services related to nicotine addiction;
- Sex therapy programs or treatment for sex offenders;
- Services or supplies furnished by a substance abuse facility (including a substance abuse residential facility), except for Alabama PPO facilities;
- Services or supplies furnished by a Residential Treatment Facility, except through Behavioral Health Case Management;
- Services provided by psychiatric specialty hospitals that do not participate with nor are considered members of any Blue Cross and/or Blue Shield plan, except for Alabama PPO facilities.

| EXHIBIT I: ALABAMA CERTIFIED MENTAL HEALTH CENTERS | | |
|---|---|---|
| AltaPointe Health Systems<br>5750 A Southland Drive<br>Mobile, AL 36693<br>251.450.5901 | Eastside MHC<br>129 East Park Circle<br>Birmingham, AL 35235<br>205.836.7283 | Northwest Alabama MHC ***<br>1100 7th Avenue<br>Jasper, AL 35501<br>205.387.0541 |
| Alta Point Health Systems ***<br>372 South Greeno Road<br>Fairhope, AL 36532-1905<br>251.990.4190 | Gateway Family Counseling Center<br>1401 20th Street South<br>Birmingham, AL 35205<br>205.510.2761 | Riverbend Center for MH ***<br>635 West College Street<br>Florence, AL 35630<br>256.764.3431 |
| Brewer-Porch Children's Center<br>2501 Woodland Road<br>Tuscaloosa, AL 35404<br>205.348.7236 | Glenwood, Inc.<br>150 Glenwood Lane<br>Birmingham, AL 35242<br>205.969.2880 | South Central AL MHC **<br>19815 Bay Branch Road<br>Andalusia, AL 36420<br>334.222.2525<br>877.530.0002 Access Number |
| Cahaba Center for MH/MR ** Reynolds Building<br>1017 Medical Center Parkway<br>Selma, AL 36701<br>334.875.6068 | Indian Rivers MHC **<br>2209 9th Street<br>Tuscaloosa, AL 35401<br>205.391-3131 | Southwest Al. Behavioral **<br>328 West Claiborne Street<br>Monroeville, Al. 36461 |
| Calhoun-Cleburne MH Center **<br>331 East 8th Street<br>Anniston, AL 36207<br>256.236.3403 | Jefferson-Blount-St. Clair MH/MR Authority<br>940 Montclair Road Suite 200<br>Birmingham, AL 35213<br>205.595.4555 | Spectracare Health System **<br>134 Prevatt Road<br>Dothan, AL 36301<br>334.794-0731 |
| Cheaha Regional MH Center **<br>351 West 3rd Street<br>Sylacauga, AL 35150<br>256.245.1340 | Mental Health Care of Cullman<br>1909 Commerce Avenue NW<br>Cullman, Al. 35056<br>256.734.4688 | UAB Community Psychiatry **<br>4th Floor<br>908 20th Street South<br>Birmingham, AL 35294<br>205.934.4108 |
| Cherokee-Etowah-DeKalb MHC **<br>425 5th Ave NW<br>Attalla, AL 35954<br>256.492.7800 | Mental Health Center of North Central Alabama<br>1316 Somerville Road SE Suite 1<br>Decatur, AL 35601<br>256.260.7324<br>800.365.6008 Access Number | West Alabama MH Center **<br>1215 South Walnut Ave.<br>Demopolis, AL 36732<br>334.289.2410 |
| Chilton-Shelby MHC **<br>151 Hamilton Ln<br>Calera, AL 35040<br>205.668.4308 | Montgomery Area MH Authority<br>2140 Upper Wetumpka Rd<br>Montgomery, AL 36107<br>334.279.7830 | Mountain Lakes Behavioral Healthcare**<br>2409 Homer Clayton Dr.<br>Guntersville, AL 35976<br>256.582.3203 |
| East Alabama MHC * **<br>2506 Lambert Drive<br>Opelika, Alabama 36801<br>(334) 742-2700<br>800.815.0630 | East Central MH/MR Board**<br>200 Cherry Street<br>Troy, AL 36081<br>334.566.6022 | |

*** Partial or Day Hospitalization**

**** Intensive Outpatient Program**

| EXHIBIT II: ALABAMA CERTIFIED MENTAL HEALTH CENTERS | | |
|---|---|---|
| Alcohol and Drug Abuse<br>Treatment Center**<br>2701 Jefferson Avenue SW<br>(205) 923-6552 | Chemical Addictions Program (CAP)<br>1155 Air Base Blvd.<br>P.O. Box 9269<br>Montgomery, AL 36108-0269<br>(334) 323-3204 | Center for Psychiatric Medicine***<br>1713 6th Avenue South<br>Birmingham, AL 35294<br>(205) 934-6054 |
| Children's Outpatient Psychiatric<br>Clinic***<br>1600 7th Avenue South<br>Birmingham, AL 35233<br>(205) 638-6245 | Children's Lakeshore Outpatient Clinic***<br>2204 Lakeshore Drive<br>Suite 410<br>Birmingham, AL 35209<br>(205) 638-6245 | Spain Rehab/Civitan MRI***<br>1717 6th Avenue South<br>Birmingham, AL 35233<br>(205) 934-4011 |
| Family Medicine***<br>930 20th Street South<br>Birmingham, AL 35233<br>(205) 934-7055 | Lighthouse Counseling Center***<br>1415 East South Boulevard<br>Montgomery, AL 36116<br>(334) 286-5980 | The Bridge, Inc. ***<br>3232 Lay Springs Road<br>Gadsden, AL 35901<br>(256) 546-6324 |
| Center for Psychiatric Medicine***<br>Eye Foundation Hospital<br>Psychiatric Clinic 3rd Floor<br>1720 University Blvd<br>Birmingham, AL 35233<br>(205) 934-5151 | Smolian Psychiatric Clinic***<br>1700 7th Ave. South<br>Birmingham, AL 35233<br>(205) 934-5151 | 1917 Clinic/Community Care***<br>908 20th Street South<br>Birmingham, AL 35233<br>(205) 934-1917 |
| Sparks Center***<br>1720 7th Avenue South<br>Birmingham, AL 35233<br>(205) 934-1089 | UAB Community Psychiatry***<br>4th Floor<br>908 20th Street South<br>Birmingham, AL 36732<br>(205) 934-4108 | |

** Also approved for intensive outpatient program treatment
*** Locations may change without notice

| COMMUNITY MENTAL HEALTH CENTER & SUBSTANCE ABUSE AGENCIES<br>ADOLESCENT INTENSIVE OUTPATIENT PROGRAMS | |
|---|---|
| **CENTER** | **COUNTY** |
| Baldwin County Mental Health Center | Baldwin |
| The Bridge, Inc. | Cullman/Dekalb/Mobile/Morgan/St. Clair/Tuscaloosa |
| The Cahaba Mental Health Center | Dallas/Perry/Wilcox |
| Calhoun/Cleburne Mental Health Center | Calhoun/Cleburne |
| Cheaha Mental Health Center | Clay/Coosa/Randolph/Talladega |
| Chemical Addictions Program | Montgomery |
| Chilton-Shelby Mental Health Center | Chilton/Shelby |
| Lighthouse Counseling Center | Autauga/Montgomery |
| Mental Health Center of Madison County | Madison |
| Mental Health Center of North Central AL | Morgan |
| Riverbend Center for Mental Health | Lauderdale |
| Spectracare Health Systems | Barbour/Dale/Geneva/Henry/Houston |
| West Alabama Mental Health Center | Choctaw/Greene/Hale/Marengo/Sumter |

## Other Covered Services

| SERVICE OR SUPPLY | IN-NETWORK PLAN PAYS | OUT-OF-NETWORK PLAN PAYS |
|---|---|---|
| Accident-related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |
| Ambulance services | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |
| Medically necessary infertility services which include artificial insemination and related services, including physician services, laboratory services, X-Ray services, ultrasound services and medications administered in the physician's office.<br>Limited to a lifetime maximum of eight artificial insemination attempts (whether successful or not).<br>Benefits are not provided for ART, IVF and GIFT. | 100% of the allowed amount, no deductible<br><br>Office visit copayments, laboratory services, x-ray services, ultrasound services and medications administered in the physician's office will be subject to the applicable copayments outlined in each respective section of this Summary Plan Description. | 80% of the allowed amount, subject to the calendar year deductible<br><br>Office visit copayments, laboratory services, x-ray services, ultrasound services and medications administered in the physician's office will be subject to the applicable copayments outlined in each respective section of this Summary Plan Description. |

| SERVICE OR SUPPLY | IN-NETWORK PLAN PAYS | OUT-OF-NETWORK PLAN PAYS |
|---|---|---|
| Chiropractic: Professional services of a licensed chiropractor practicing within the scope of his license | 80% of the allowed amount, no deductible<br>Note: In Alabama, more than 18 visits in a calendar year rendered by a participating chiropractor require precertification | 80% of the allowed amount, subject to the calendar year deductible<br>Member responsible for any difference between the charge and the allowed amount<br>Limited to 12 visits in a calendar year |
| Dialysis services at a renal dialysis facility | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |
| DME: Durable medical equipment and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints | 80% of the allowed amount, subject to the calendar year deductible (for DME the allowed amount will generally be the smaller of the rental or purchase price) | 80% of the allowed amount, subject to the calendar year deductible (for DME the allowed amount will generally be the smaller of the rental or purchase price)<br>Member responsible for any difference between the charge and the allowed amount |
| Eyeglasses or contact lenses: One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |
| Home health and hospice care within the state of Alabama | 100% of the allowed amount, no deductible | Not covered |
| Home health and hospice care outside the state of Alabama | 100% of the allowed amount, no deductible; **precertification is required – call 1-800-821-7231** | 80% of the allowed amount, subject to the calendar year deductible; **precertification is required – call 1-800-821-7231** |
| Occupational therapy services for the hand and/or treatment of lymphedema | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |
| Physical therapy | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible<br>Member responsible for any difference between the charge and the allowed amount |
| Speech therapy<br>Limited to 30 visits per calendar year | 80% of the allowed amount, subject to the calendar year deductible | 80% of the allowed amount, subject to the calendar year deductible |
| TMJ | 80% of the allowed amount, subject to the calendar year deductible<br>Surgical care must be precertified at least three weeks prior to surgery | 80% of the allowed amount, subject to the calendar year deductible<br>Surgical care must be precertified at least three weeks prior to surgery |

** When using a Preferred or Participating Provider, the provider will bill Blue Cross and Blue Cross will pay him or her directly. If you see a Non-Preferred or Non-Participating Provider, you may have to file your claim and you will be responsible for charges in excess of the allowed amount.*

# ADDITIONAL BENEFIT INFORMATION

## Individual Case Management Benefits

Unfortunately, some people suffer from catastrophic, long-term or chronic illness or injury. If you suffer due to one of these conditions, a Blue Cross Registered Nurse may work with you, your physician, and other healthcare professionals to design a benefit plan to best meet your healthcare needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The

program is voluntary to Blue Cross, you, and your physician and the PEEHIP plan encourages you to participate in these programs to learn more and improve your health. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through individual case management are subject to your plan benefit maximums. If you think you may benefit from individual case management, please call our Health Management Department at 205-733-7067 or 1-800-821-7231 (toll-free).

## Disease Management

You may also qualify to participate in the disease management program, which effective January 1, 2015 is provided by ActiveHealth for the following PEEHIP members enrolled in the PEEHIP Blue Cross Blue Shield hospital medical (group #14000) plan:

- Active employees and their covered spouses
- Non-Medicare eligible retirees
- Non-Medicare eligible spouses covered on retiree contracts

Children and adult child dependents continue to have access to disease management through Blue Cross Blue Shield of Alabama. Disease management provided by ActiveHealth is available for those members listed above with congestive heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD) and asthma. This program offers personalized care designed to meet your lifestyle and health concerns. ActiveHealth will connect you with a licensed nurse to work with you one-on-one on managing one of these long-term health conditions.

For both disease management provided by ActiveHealth to the members listed above, and disease management provided by Blue Cross to PEEHIP covered children, personalized care will be offered that is designed to meet your lifestyle and health concerns. Healthcare professionals will help you cope with your illness and serve as a source of information and education. Children's participation is completely voluntary, and enrollment or more information can be obtained by calling 1-888-841-5741 (Monday – Friday, 8:00 a.m. to 4:45 p.m. CST), or by emailing membermanagement@bcbsal.org.

Participation in disease management provided by ActiveHealth to those members listed above may be required by August 31, 2016 in order to earn a waiver of a $50 monthly wellness premium. This is dependent on you having received an invitation to disease management letter from ActiveHealth dated October 2015. Additionally, some members may be required to participate in an enhanced disease management program requiring at least four phone calls with an ActiveHealth nurse. These members were sent a letter in October 2015 indicating their specific requirement. To confirm your disease management or other wellness program requirements, visit www.MyActiveHealth.com/PEEHIP. For more information, see the PEEHIP Wellness Program section, or visit http://www.rsa-al.gov/index.php/members/peehip/health-wellness/. The disease management program at ActiveHealth can be reached at 1-855-294-6580 (Monday – Friday, 8:00 a.m. to 8:00 p.m. and Saturday 8:00 a.m. to 1:00 p.m. CST)

## Baby Yourself Program

Blue Cross and Blue Shield of Alabama and PEEHIP offer Baby Yourself, a prenatal wellness program for expectant mothers. This program is part of your PEEHIP hospital medical coverage and is available at no cost to you. PEEHIP strongly encourages all expectant mothers covered under the PEEHIP Hospital Medical Plan to sign up for Baby Yourself today. It is never too late to sign up during your pregnancy, but the sooner you sign up the better. If you are a soon-to-be expectant mother, please sign up as soon as you confirm your pregnancy. PEEHIP encourage you to sign up for the program with each pregnancy even if you have already participated. When you sign up, you will receive:

- Support from an experienced Blue Cross registered nurse;
- Educational information by telephone and email during your pregnancy;

- Useful gifts that encourage healthy habits, proper prenatal care, and help you understand the changes and challenges of pregnancy;

The vast majority of mothers who delivered premature babies did not participate in the PEEHIP Baby Yourself program. The goal of Baby Yourself is to have healthy mothers and babies at delivery. If you are pregnant, please enroll today in Baby Yourself by calling 800.222.4379 or register online at www.behealthy.com.

**PEEHIP will waive the $200 deductible for the delivery of a baby for those PEEHIP members or PEEHIP spouses who enroll in the Baby Yourself Program within the first trimester. The $25 copay for days 2-5 still applies.**

## Prescription Drug Benefits

| PRESCRIPTION DRUG BENEFITS ARE ADMINISTERED BY MEDIMPACT, NOT BLUE CROSS AND BLUE SHIELD OF ALABAMA | | |
|---|---|---|
| **Prescription Drug Plan:**<br>A copay will be charged for each 30-day supply at retail<br>Approved maintenance drugs may be purchased up to a 90-day supply **for a copayment of $12 for generic drugs, $80 for preferred brand name drugs and $120 for non-preferred brand name drugs**. The drug must be on the approved maintenance list of drugs and must be prescribed for a 90 day supply.<br>First fill for a new maintenance drug will be a 30-day supply<br>Refills on retail and specialty medications (30-day supply) are allowed only after 75% of the previous prescription has been used (for example, 23 days into a 30-day supply). For maintenance medications (90-day supply), refills are allowed only after 75% of the previous prescription has been used (for example, 77 days into a 90-day supply).<br>Certain medications are subject to Step Therapy, prior authorization, and quantity level limits<br>Certain medications are subject to Step Therapy<br>Pharmacists must dispense generic drugs unless physician indicates in longhand, "Do not substitute"(Section 16-25-18, Act #2002-266) | **Participating Pharmacy:**<br>Each prescription drug purchased from a Participating Pharmacy will be covered at 100%, subject to the following copays:<br>**Generic Drugs:**<br>**$6 copay** per prescription<br>**Preferred Brand Name Drugs:**<br>**$40 copay** per prescription (30-day supply)<br>**Non-Preferred Brand Name Drugs:**<br>**$60 copay** per prescription (30-day supply)<br>MedImpact is the administrator for the core pharmacy program, specialty and EGWP programs | **In-State and Out-of-State Non-Participating Pharmacy:**<br>Same as participating pharmacy with applicable copayments. Member will be responsible for the difference between the allowance and drug charge. You will be required to pay the full amount of the prescription, then file a claim form to MedImpact for reimbursement at the participating pharmacy rates. All PEEHIP clinical utilization management programs will apply. Your out of pocket expenses will be higher if you use a non-participating pharmacy. |
| Diabetic supplies (copays apply)<br>The following diabetic supplies are covered under the maintenance drug benefit: blood glucose test strips; injection devices; insulin syringe/needle U-100; insulin pen needles; lancets.<br>NOTE: Retirees who are Medicare eligible members must receive their blood glucose test strips and lancets under Medicare Part B. These products are not covered under the PEEHIP prescription drug benefit for members who have Medicare as primary coverage. | | |
| Drug benefits for medically necessary fertility drugs are covered at 50% copay for any fertility drug up to a lifetime maximum of $2,500 cost to the PEEHIP plan | | |
| Contraceptives for Women: All Food and Drug Administration (FDA) approved contraceptive methods.<br>Generic contraceptives are covered at zero copayment. | | |
| NOTE: To view current Preferred Drug Lists, visit www.rsa-al.gov/index.php/members/peehip/pharmacy/. | | |

For questions concerning prescription drugs, call MedImpact at 877.606.0727.
www.medimpact.com or https://mp.medimpact.com/ala

## PEEHIP Prescription Drug Changes Effective February 1, 2016

Effective February 1, 2016, PEEHIP made the following benefit changes for members enrolled in PEEHIP's non-Medicare (commercial) plan.

**DAW (Dispense as Written) Cost Differential:**
For brand drugs with a generic chemical equivalent, multi-source (MSB) drugs, the total amount covered by PEEHIP will not exceed the amount that would have been covered if the generic equivalent were dispensed. Therefore, members will be subject to the difference between the cost of the brand drug and its generic equivalent, regardless of whether the physician indicates the brand must be taken. This does not apply to the Narrow Therapeutic Index (NTI) drugs such as seizure medications.

**PEEHIP Maintenance Drug List – Copay Change for Preferred and Non-Preferred Brands Only:**

Effective 2/1/2016, 3 copayments are charged for a 3-month supply of all brand drugs on the PEEHIP Maintenance Drug List. Two copayments are charged for a 3-month supply of all generic drugs on the list. The DAW cost differential applies for multi-source brand drugs with a generic chemical equivalent.

**Copay Structure for PEEHIP's Maintenance Drug List Effective 2/1/2016:**

| Tier Number/Drug Type | Copay: 1 – 30 Day Supply | Copay: 31 – 60 Day Supply | Copay: 61 – 90 Day Supply |
|---|---|---|---|
| **Tier 1: Generic Drugs** | **$6** | **$12** | **$12** |
| **Tier 2: Preferred Brand Drugs** | **$40** | **$80** | **$120** |
| **Tier 3: Non-Preferred Brand Drugs** | **$60** | **$120** | **$180** |

**Specialty Drugs – New 4th Tier:**

A 4th tier copay was implemented for specialty drugs: 20% coinsurance with a minimum copay of $100 and a maximum copay of $150. The DAW cost differential applies for multi-source brand drugs with a generic chemical equivalent.

**Specialty Drugs – Copay Assistance Programs:**

Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs. PEEHIP and MedImpact will offer copay assistance programs for certain specialty drugs so that the member copayment will normally be less than the otherwise applicable copayment.

**Additional PEEHIP Changes - Compounds**

Effective 2/1/2016, PEEHIP no longer covers ingredients in a compound that are currently excluded from coverage in non-compound prescriptions, such as over-the-counter (OTC) medications. This exclusion applies to PEEHIP's non-Medicare (commercial) plan and the Medicare Part D plan.

**Drug Utilization Management –**

PEEHIP works with the Pharmacy Benefit Manager to review and update the drug utilization management policies such as the drug formulary status, step-therapy programs, quantity level limits, prior authorizations and other utilization management programs to reduce unnecessary spending by both the plan and members and to ensure the most effective drugs are used in the most appropriate ways. These programs are implemented throughout the plan year to keep your PEEHIP plan as beneficial and affordable as possible.

**Excluded Drugs:**

Certain prescription drugs and medications are excluded from PEEHIP coverage as explained in the Prescription Drug Exclusion Section of the handbook. Also, many of the excluded drugs can be found in the PEEHIP newsletters located at http://www.rsa-al.gov/index.php/members/peehip/pubs-forms/peehip-newsletters. To verify the formulary and coverage status of a medication, please visit the MedImpact website at https://mp.medimpact.com/ala

## Prescription Drug Benefits

Prescription Drug Benefits are administered by MedImpact. All benefits are subject to copays, conditions, limitations and exclusions of the plan.

1. To be eligible for benefits, drugs must be medically necessary, legend drugs prescribed by a physician and dispensed by a pharmacy. Legend drugs are medicines which must by law be labeled, "Caution: Federal Law prohibits dispensing without a prescription." Compound drugs are covered if at least one of the drugs in the compound is a legend drug. Oral contraceptives qualify for benefits when prescribed for a medical condition but not when prescribed for birth control. In some cases, drugs may also require prior authorization. Your participating Pharmacist will advise if this is a requirement.
2. The first fill of a maintenance drug can be dispensed for up to a 30-day supply. Refilled maintenance drugs can be dispensed in a 90-day supply when the prescription is written for a 90-day supply and the drug is on the approved PEEHIP maintenance list. Refills are allowed on maintenance medication only after 75% of the prescription has been used. Also, there cannot be more than a 130-day lapse from the time that the maintenance drug prescription has been purchased and filed through the PEEHIP prescription plan. Approved maintenance list drugs may be purchased up to a 90-day supply with two copays when the drug is prescribed by the physician as a maintenance drug. You can determine if a drug is on the maintenance list by going to http://www.rsa-al.gov/index.php/members/peehip/pharmacy/ or calling your Participating Pharmacy. In order for a drug to be considered for the Maintenance List, it must meet all the following criteria as determined by an expert panel of physicians and pharmacists:
   - 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;
   - Drug's most common use is to treat a chronic disease state;
   - 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;
   - New drugs that are classified as non-formulary are not eligible to be added to the PEEHIP maintenance list.
3. All claims must be received within 365 days after medications are filled in order for the claim to be considered for payment.
4. Manual claim forms can be obtained from the website: http://www.rsa-al.gov/index.php/members/peehip/pubs-forms/
5. A Participating Pharmacy must dispense a generic medication when one is available. Please read Section 16-25A-18 (Act#2002-266) in the Code of Alabama 1975 for additional information.

6. **Non-Medicare eligible retirees** and **Active** members requiring insulin and/or diabetic supplies:
   - Diabetic supplies such as insulin, test strips, lancets, and syringes are covered under PEEHIP prescription plan. The pharmacist must file insulin first and after filing insulin file syringes. Syringes are covered with no copay. Insulin and syringes must be filed by the pharmacist on the same day, otherwise each has a separate copay. The pharmacist must file test strips first and then the lancets, Lancets are covered with no copay. Test strips and lancets must be filed by the pharmacist on the same day, otherwise each has a separate copay.
   - Glucose monitors always have a separate copay. Glucose monitors are limited to one per person each contract year.
   - Insulin pump and supplies are covered under Blue Cross Major Medical benefits and not under the pharmacy program.
   - The copay that applies depends on whether the monitor or supplies are generic, Preferred Brand or Non-Preferred Brand.
   - Blood glucose test strips, lancets and glucose monitors are the only diabetic supplies available through the Prescription Drug program.
   - Benefits for insulin, needles and syringes, blood glucose test strips, lancets and glucose monitors are only provided under the Prescription Drug benefits.
7. **Medicare eligible retirees** requiring insulin and/or diabetic supplies:
   - Insulin, needles and syringes purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay.
   - Blood glucose test strips, lancets and glucose monitors are not covered under the Prescription Drug program for Medicare eligible retirees. These diabetic supplies are covered under Medicare Part B. In most cases, if you choose to use a Medicare participating pharmacy or supplier, the provider will bill Medicare and Medicare will pass your claim to Blue Cross and Blue Shield (not MedImpact) for the secondary processing. You will not pay anything at the point-of-sale after you have met your annual Medicare Part B deductible when you purchase from a Medicare participating provider.
   - Medicare Part B covered medications are excluded from coverage under the PEEHIP prescription drug benefit but will be covered under the Medicare Part B benefit.
   - Medicare Part B covers certain drugs and supplies that include but are not limited to those within the following categories: diabetes supplies (such as blood glucose test strips, lancets and blood glucose monitors); oral anti-cancer medications; respiratory medications; and immunosuppressants. Retirees who are Medicare-eligible must receive Medicare Part B drugs and diabetic supplies under Medicare Part B. These products are not covered under the PEEHIP prescription drug benefit for members who have Medicare as primary coverage.

### What is a Preferred Drug?

With so many prescription drugs available today, how can you be sure that you are receiving therapeutically safe and effective medication?

- An expert panel of physicians and pharmacists have developed and endorsed the Preferred Drug List.
- These drugs represent safe and cost-effective drug therapy.
- The Preferred Drug List is used primarily by physicians in selecting clinically appropriate and cost effective drugs for their patients.

- You can access the Preferred Drug List at the website: http://www.rsa-al.gov/index.php/members/peehip/pharmacy/

### Making a Choice

1. When you purchase a covered prescription from a Participating Pharmacy, you will only be responsible for the copay.
2. The amount of the copay is determined by whether the drug you purchase is a brand-name prescription on the Preferred Drug List, another brand name drug not on the preferred drug list, or a generic.
3. Required copays: Generic-**lowest copay**; Preferred Brand Products-**standard copay**; all other brand products (not included on the Preferred Drug List)-**highest copay**.
4. Copay amounts for prescription drugs are determined according to your benefit plan design. Please check your group benefit materials for specific copay amounts and coverage information.
5. You will always receive the lowest copay when purchasing generics.
6. Some drugs do not have a generic equivalent, but many do. Simply ask your physician or pharmacist if a generic is available for your prescription.

### Step Therapy Program

The PEEHIP prescription drug program includes Step Therapy for certain medications. The Step Therapy program was implemented to keep PEEHIP sound and to keep premiums and copayments at a reasonable and affordable level. The Step Therapy program applies to "new" prescriptions that have not been purchased in over 130 days. A prescription is considered "new" if the member or covered dependent has not filed and processed the prescription claim with MedImpact in over 130 days.

Step Therapy is a program especially for people who take prescription drugs regularly to treat ongoing medical conditions such as arthritis/pain, heartburn, or high blood pressure. It is designed to:

- provide safe and effective treatments for your good health
- make prescriptions more affordable
- enable PEEHIP to continue to provide affordable prescription coverage while controlling rising costs

Step Therapy is organized in a series of "steps" with your doctor approving your medication every step of the way. It is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts. Together with MedImpact, they review the most current research on thousands of drugs tested and approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness.

***How does Step Therapy work?***

**First Step:** Generic drugs are usually in the first step. These drugs are commonly prescribed, less expensive treatments that are safe and effective in treating many medical conditions. Your copayment is usually the lowest with a first-step drug. It will be necessary for you to use the first-step drugs before the plan will pay for second-step drugs.

**Second Step:** If your treatment path requires more medications, then the program moves you along to this step, which generally includes brand-name drugs. Brand-name drugs are usually more expensive than generics, so most have a higher copayment.

When a prescription for a second-step drug is processed at your pharmacy for the first time, your pharmacist will receive a message indicating the PEEHIP plan uses Step Therapy. If you would rather not pay full price for your prescription drug, your doctor needs to give you a prescription for a first-step drug. Only your doctor can change your current prescription to a first-step drug covered by your program. To receive a first-step drug: **Ask your pharmacist to call your doctor** and request a new prescription or **contact your doctor** to get a new prescription.

With Step Therapy, more expensive, brand-name drugs are usually covered in a later step in the program if you have already tried the first-step drug. If your doctor decides you need a different drug for medical reasons before you have tried a first-step drug, then your doctor can call MedImpact to request a "prior authorization." If the second-step drug is approved, you will pay a higher copayment than for a first-step drug. If the drug is not approved, you will need to pay the full price for the drug. You can appeal the decision through the appeals process outlined in this handbook.

If you have medical reasons that prevent you from trying a first-step drug, your physician can contact MedImpact to request a prior authorization by calling 800.347.5841. For other questions about the Step Therapy program, contact MedImpact Customer Service toll free at 877.606.0727.

Members who are new to PEEHIP or if a husband and wife switch from one PEEHIP contract to another, they may not be subject to the Step Therapy clinical programs. For these members to be grandfathered into the Step Therapy Program, they will need to provide documentation that they have been on the medication(s) 130 days prior to their enrollment date with PEEHIP.

### Prescription Drug Exclusions and Limitations

The following items are not eligible for coverage:

- Appetite Suppressants
- Desoxyn/Dexedrine-for Weight Control Purposes
- Agents used to suppress appetite and control fat absorption (e.g. Xenical, Meridia)
- Experimental Drugs
- Over-the-Counter Drugs (OTC is not covered even if prescribed by a physician unless mandated by the Affordable Care Act)
- Rx version of an OTC medication
- OTC equivalents (Items available over the counter without a prescription even when prescribed by a physician (vitamins and food supplements)
- Medical Foods
- Progesterone Suppositories-for PMS
- Replacement for Lost or Destroyed Drugs
- Topical Minoxidil
- Yocon
- Photo-aged skin products
- Hair growth agents
- Injectable cosmetics (e.g. Botox) and other drugs for cosmetic purposes
- Depigmentation products used for skin conditions requiring a bleaching agent
- Serums, toxoids and some vaccines
- Legend homeopathic drugs
- Nicotine Gum and lozenge and some smoking cessation agents, unless mandated by the Affordable Care Act
- Transcutaneous nicotine patches which are now OTC drugs

- Medications used to treat erectile dysfunction. Examples include, but are not limited to Viagra, Cialis, Levitra, and Yohimbine
- Prescription drugs and medicines are considered under "Prescription Drug Benefits" and are not eligible for coverage under Major Medical.
- Arestin
- Prescription drugs and medications excluded by the PEEHIP plan. Many of these drug exclusions can be found in the PEEHIP newsletters located at http://www.rsa-al.gov/index.php/members/peehip/pubs-forms/peehip-newsletters. Also, to verify the formulary and coverage status of a drug, please visit the MedImpact website at https://mp.medimpact.com/ala .
- Compound medications that contain bulk chemicals powders.

The following items have limited coverage:

- Certain drugs have quantity level limits for a 30-day supply. Your pharmacist will advise if this is a requirement.
- Certain drugs have step therapy requirements to try a first line agent before a second line agent will be covered.
- Certain drugs require prior authorization. Your pharmacist will advise if this is a requirement.
- Drug benefits for medically necessary fertility drugs are covered at a 50% copay for any infertility drug up to a lifetime maximum of $2,500 cost to the PEEHIP plan.

### Act 2002-266 Generic Equivalent Drug

As a condition of participation in PEEHIP, a pharmacist shall dispense a generic equivalent medication to fill a prescription for a patient covered by PEEHIP 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.

## Health Management Benefits

| HEALTH MANAGEMENT BENEFITS | |
|---|---|
| Individual Case Management | Coordinates care in event of catastrophic or lengthy illness or injury |
| Disease Management: Effective 1/1/2015, provided by ActiveHealth for subscribers and covered spouses; also provided by BCBSAL for covered children and members not required to participate in the PEEHIP Wellness Program | Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease |

Unfortunately, some people suffer from catastrophic, long-term or chronic illness or injury. If you suffer due to one of these conditions, a Blue Cross Registered Nurse may work with you, your physician, and other health care professionals to design a benefit plan to best meet your health care needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to Blue Cross, you, and your physician and the PEEHIP plan encourages you to participate in these programs to learn more and improve your health. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through individual case management are subject to your plan benefit maximums. If you think you may benefit from individual case management, please call the Health Management division at 205-733-7067 or 1-800-821-7231 (toll-free).

You may also qualify to participate in the disease management program. Effective January 1, 2015, ActiveHealth provides disease management to PEEHIP subscribers and covered spouses if enrolled in the PEEHIP Blue Cross Blue Shield hospital medical (group #14000) plan and not Medicare-eligible and covered on a PEEHIP retiree contract. Disease management provided by ActiveHealth offers personalized care designed to meet your lifestyle and health concerns. ActiveHealth will connect you with a licensed nurse to work with you one-on-one on managing your long-term health condition. This applies to members with congestive heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD) and asthma.

Participation in disease management provided by ActiveHealth to those members listed above may be required by August 31, 2016 in order to earn a waiver of a $50 monthly wellness premium. This is dependent on you having received an invitation to disease management letter from ActiveHealth dated October 2015. Additionally, some members may be required to participate in an enhanced disease management program requiring at least four phone calls with an ActiveHealth nurse. These members were sent a letter in October 2015 indicating their specific requirement. To confirm your disease management or other wellness program requirements, visit www.MyActiveHealth.com/PEEHIP.

PEEHIP covered children and adult child dependents may also qualify to participate in disease management provided by Blue Cross Blue Shield of Alabama. For both disease management provided by ActiveHealth to PEEHIP subscribers and covered spouses and disease management provided by Blue Cross to PEEHIP covered children, personalized care will be offered that is designed to meet your lifestyle and health concerns. Healthcare professionals will help you cope with your illness and serve as a source of information and education. Children's participation is completely voluntary, and the PEEHIP plan encourages you to participate in these programs to learn more and improve your health. If you would like to obtain more information about the program, call our customer service department, or call ActiveHealth at 1-855-294-6580.

# ADDITIONAL BENEFIT INFORMATION

### Infertility Services

Benefits for Medically Necessary infertility services are provided as follows:

- Artificial insemination and related services, including physician services, laboratory services, X-Ray services, and ultrasound services.
- Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum cost of $2,500 for PEEHIP per member contract. Members will pay 100% of the medications after the $2,500 lifetime maximum is reached.

Benefits are limited to a lifetime maximum of eight (8) artificial insemination attempts (whether successful **or not**).

Exclusions:

- Benefits are NOT provided for Assisted Reproductive Technology (ART) which is any process taking human eggs or sperm or both and putting them into a medium or a body to try to cause reproduction.
- Benefits are not provided for In-Vitro Fertilization (IVF), ART, or GIFT.

## Colorectal Cancer Screening

Benefits for colorectal cancer screening vary depending upon the reason the procedure is performed, the outcome of the procedure (i.e., discovery of a medical condition as a result of the procedure) and the way in which the provider files the claim.

- If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition (even if the medical condition was unsuspected or unknown prior to the procedure), and if the provider properly files the claim with this information, Blue Cross will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.
- If you are at high risk of developing colon cancer or you have a family history of colon cancer – within the meaning of Blue Cross's medical guidelines – and if the provider properly files the claim with this information, Blue Cross will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.

In all other cases the claim will be subject to the provisions and limitations described elsewhere in this booklet, including the section called Physician Preventive Benefits, and at www.AlabamaBlue.com/preventiveservices.

## Mastectomy and Mammograms

Women's Health and Cancer Rights Act Information:

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.

Benefits for this treatment will be subject to the same calendar year deductible and coinsurance provisions that apply for other medical and surgical benefits.

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

- If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic X-rays.
- If you are at high risk of developing breast cancer or you have a family history of breast cancer – within the meaning of our medical guidelines – and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic X-rays.
- In all other cases the claim will be subject to the provisions and limitations described elsewhere in this booklet, including the section called Physician Preventive 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 our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve 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 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 marrow registry
- 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 limited to up to 90 days of follow-up care after 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 our approved list for that type or for which we have 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, tendon, ligaments, meniscus, cornea, cartilage, skin, bone, veins, etc.

# COORDINATION OF BENEFITS (COB)

COB is a provision designed to help manage the cost of healthcare 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 healthcare coverage must be determined first without taking the existence of any other plan into consideration. A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

## Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies (Note, however, that if the other plan is Medicare, the order of benefit determination is determined by the applicable Medicare secondary payer laws.):

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

**Employee/Dependent:** The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the group, Medicare secondary payer rules may require Blue Cross 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 a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary. If the court-ordered parent has no health care 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 health care expenses or health care coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.

2. 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.

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

**Active Employee or Retired or Laid-Off Employee**:

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. For example, if a PEEHIP member has a retired PEEHIP contract and the spouse of that PEEHIP member is actively employed as has an active non-PEEHIP plan, the non-PEEHIP active contract is primary and the PEEHIP retiree contract is secondary.
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. In some cases, depending upon the size of the plan, Medicare secondary payer rules may require us

to reverse this order of payment. This can occur when the member 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 member as a dependent; second, Medicare; and third, the plan covering the member as an inactive or retired employee.

**COBRA or State Continuation Coverage:**

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

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

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

## Determination of Amount of Payment

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

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

## COB Terms

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

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

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

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

**Custodial Parent:** The term "custodial parent" means:

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

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

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

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

**Plan:** The term "plan" includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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

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

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

**Secondary Plan:** The term "secondary plan" means a plan that is not a primary plan.

### Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Blue Cross may get the facts they need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Blue Cross is not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give Blue Cross any facts they need 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, Blue Cross 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. Blue Cross 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 Blue Cross is more than they should have paid under this COB provision, Blue Cross 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.

## SUBROGATION

### Right of Subrogation

If PEEHIP pays or provide any benefits for you under this plan, PEEHIP is subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for

the amount of benefits PEEHIP has paid or provided. That means that PEEHIP may use your right to recover money from that other person or organization.

### Right of Reimbursement

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

PEEHIP 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 PEEHIP 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 PEEHIP first even if another person or company has paid for part of your loss. And it means that you promise to repay PEEHIP first even if the person who recovers the money is a minor. In these and all other cases, PEEHIP still has the right to first reimbursement or repayment out of any recovery you receive from any source.

### Right to Recovery

You agree to furnish Blue Cross promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us Blue Cross protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

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

You further agree not to allow our reimbursement and subrogation rights under this plan 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, we may suspend or terminate payment or provision of any further benefits for you under the plan.

# HEALTH BENEFIT EXCLUSIONS

In addition to other exclusions set forth in this booklet, we **will not** provide benefits under any portion of this booklet for the following:

# A

Services or expenses for elective **abortions**.

Services or expenses for **acupuncture**, biofeedback, and other forms of self-care or self-help training.

**Anesthesia** services or supplies or both by local infiltration.

Services or expenses for or related to **Assisted Reproductive Technology (ART)**. ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

# C

Services or expenses of a hospital stay, except one for an emergency, unless we **certify** it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 48 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.

Services or expenses for which a **claim** is not properly submitted to Blue Cross.

Services or expenses for a **claim we have not received within 12 months** after services were rendered or expenses incurred.

Services or expenses for personal hygiene, **comfort or convenience** items such as: air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.

Services or expenses for sanitarium care, **convalescent care**, or rest care, including care in a nursing home.

Services or expenses for cosmetic surgery. **Cosmetic surgery** is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. (See the section, Mastectomy and Mammograms, 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 us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.
- Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example,

a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.

Services or expenses for treatment of injury sustained in the commission of a **crime** (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.

Services or expenses for **custodial care**. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

# D

**Dental** implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.

Services for or related to a **dependent pregnancy**, including the six-week period after delivery. A dependent pregnancy means the pregnancy of any dependent other than the contract holder's wife.

**Drugs** – certain prescription drugs and medications are excluded from PEEHIP coverage as explained in the Prescription Drug Exclusion Section of the handbook. Also, many of the excluded drugs can be found in the PEEHIP newsletters located at http://www.rsa-al.gov/index.php/members/peehip/pubs-forms/peehip-newsletters. To verify the formulary and coverage status of a drug, please visit the MedImpact website at https://mp.medimpact.com/ala .

# 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 the limited circumstances set forth in the section of this booklet called Other Covered Services.

Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.

# F

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

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

## G

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

## H

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

## I

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

Benefits are not provided for **In-vitro Fertilization (IVF)**.

## L

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

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

## M

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

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

## N

Services or expenses of any kind for **nicotine addiction** such as smoking cessation treatment.

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

## O

Services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines of Blue Cross. Benefits will only be provided for one surgical procedure for obesity (morbid) per member under this plan in a lifetime. Benefits will be provided for a subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) only if medically necessary and in compliance with the guidelines of Blue Cross. However, no benefits will be provided for subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) (including revisions or adjustments to a covered surgical procedure or conversion to another covered bariatric procedure and weight gain or failure to lose weight) if the

complications arise from non-compliance with medical recommendations regarding patient activity and lifestyle following the procedure. This exclusion for subsequent surgery for complications that arise from non-compliance with medical recommendations applies even if the subsequent surgery would otherwise be medically necessary and would otherwise be in compliance with the guidelines of Blue Cross.

Services or expenses provided by an **out-of-network provider** for any benefits under this plan, unless otherwise specifically stated in the plan.

# P

Private duty nursing.

**Providers** on the Office of the Inspector General (OIG) Exclusion List.

# R

Services or expenses for **recreational** or educational therapy (excluding approved diabetic self-management programs, pulmonary rehabilitation programs, or Phase 1 or 2 cardiac rehabilitation.

Hospital admissions in whole or when the patient primarily receives services to **rehabilitate** such as physical therapy, speech therapy, or occupational therapy.

Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical therapist.

**Room and board** for hospital admissions in whole or in part when the patient primarily receives services that could have been provided on an outpatient basis based upon the patient's condition and the services provided.

**Routine physical examinations** except for the services described in Physician Preventive Benefits.

**Routine well child care** and routine immunizations except for the services described in Physician Preventive Benefits.

# S

Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition) or which are related to surgical sex transformations.

Services or supplies furnished by a **skilled nursing facility.**

**Sleep studies** performed outside of a healthcare facility, such as home sleep studies, whether or not supervised or attended.

Services or expenses of any kind for or related to reverse **sterilizations**.

# T

Services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or “dead” teeth, irregularities in the position of the teeth, artificial dental structures such as crowns,

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

Services provided through **teleconsultation**.

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

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

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

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

## W

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

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

# CLAIMS AND APPEALS

Remember that you may always call the Blue Cross Customer Service Department for help if you have a question or problem that you would like them to handle without an appeal. The phone number to reach the Customer Service Department is on the back of your ID card.

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of your booklet explains how Blue Cross processes these different types of claims and how you can appeal a partial or complete denial of a claim.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you

designate in writing to act on your behalf. Blue Cross has developed a form that you must use if you wish to designate an authorized representative. You can obtain the form by calling the customer service department. You can also go to www.AlabamaBlue.com and ask Blue Cross to mail you a copy of the form. If a person is not properly designated as your authorized representative, Blue Cross will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, Blue Cross will presume that your provider is your authorized representative unless you tell Blue Cross otherwise in writing.

## Post-Service Claims

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

In order for Blue Cross 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 Blue Cross with the data elements that Blue Cross specifies in advance. Most providers are aware of Blue Cross's claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the customer service department and ask for a claim form. Tell Blue Cross the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and Blue Cross will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to Blue Cross at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by Blue Cross within 12 months after the service takes place to be eligible for benefits.

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

**Processing of Claims:** Even if Blue Cross has received all of the information that Blue Cross needs in order to treat a submission as a claim, from time to time Blue Cross might need additional information in order to determine whether the claim is payable. If Blue Cross needs additional information, Blue Cross will ask you to furnish it to Blue Cross, and Blue Cross will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to Blue Cross. In order to expedite their receipt of the information, Blue Cross may request it directly from your provider. If Blue Cross does this, Blue Cross will send you a copy of their request. However, you will remain responsible for seeing that Blue Cross gets the information on time.

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

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

## Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from Blue Cross before

services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If Blue Cross grants a pre-service claim, Blue Cross is not telling you that the service or supply is, or will be, covered; Blue Cross is only telling you that the service or supply meets their medical necessity guidelines.

In order to file a pre-service claim you or your provider must call the Health Management Department at 205-988-2245 or 1-800-248-2342 (toll-free). You must tell Blue Cross your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person Blue Cross 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 Blue Cross 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 Blue Cross during their 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 Blue Cross within 48 hours of the admission and Blue Cross certify the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD). 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. For home healthcare and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

If you attempt to file a pre-service claim but fail to follow their procedures for doing so, Blue Cross will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Blue Cross's notification may be oral, unless you ask for it in writing. Blue Cross 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 Blue Cross's company 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:** Blue Cross 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 tells Blue Cross that your claim is urgent, Blue Cross will treat it as such.

If your claim is urgent, Blue Cross will notify you of their decision within 72 hours. If Blue Cross needs more information, Blue Cross will let you know within 24 hours of your claim. Blue Cross will tell you what further information Blue Cross needs. You will then have 48 hours to provide this information to Blue Cross. Blue Cross will notify you of their decision within 48 hours after Blue Cross receives the requested information. The response may be oral; if it is, Blue Cross will follow it up in writing. If Blue Cross does not receive the information, your claim will be considered denied at the expiration of the 48-hour period Blue Cross gave you for furnishing information to Blue Cross.

**Non-Urgent Pre-Service Claims:** If your claim is not urgent, Blue Cross will notify you of their decision within 15 days. If Blue Cross needs more information, Blue Cross will let you know before the 15-day period expires. Blue Cross will tell you what further information they need. You will then have 90 days to provide this information to Blue Cross. In order to expedite their receipt of the information, Blue Cross may request it directly from your provider. If Blue Cross

does this, Blue Cross will send you a copy of their request. However, you will remain responsible for seeing that Blue Cross gets the information on time. We will notify you of their decision within 15 days after we receive the requested information. If Blue Cross does not receive the information, your claim will be considered denied at the expiration of the 90-day period they gave you for furnishing the information to Blue Cross.

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

## Concurrent Care Determinations

**Determinations by Us to Limit or Reduce Previously Approved Care:** If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and Blue Cross later decides to limit or reduce the previously approved stay or course of treatment, we 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 Blue Cross establishes for the filing of your appeal, such as time limits within which the appeal must be filed.

**Requests by You to Extend Previously Approved Care:** If a previously approved hospital stay or 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 Blue Cross or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network physical therapy or occupational therapy (if covered by your plan) call 205-220-7202.
- For care from an in-network chiropractor (if covered by your plan) 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, Blue Cross will give you their 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, Blue Cross will give you their determination within 72 hours. If your request is not urgent, Blue Cross 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.

## Your Right To Information

You have the right, upon request, to receive copies of any documents that Blue Cross relied on in reaching their decision and any documents that were submitted, considered, or generated by Blue Cross in the course of reaching their decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that Blue Cross may have relied upon in reaching their

decision. If their decision was based on a medical or scientific determination (such as medical necessity), you may also request that Blue Cross provide you with a statement explaining their application of those medical and scientific principles to you. If Blue Cross obtained advice from a healthcare professional (regardless of whether Blue Cross relied on that advice), you may request that Blue Cross give you the name of that person. Any request that you make for information under this paragraph must be in writing. Blue Cross will not charge you for any information that you request under this paragraph.

## Appeals

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

- Any determination Blue Cross makes with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- Blue Cross's denial of a pre-service claim;
- An adverse concurrent care determination (for example, Blue Cross denies your request to extend previously approved care); or,
- Your group's denial of your or your dependents' initial eligibility for coverage under the plan or your group's retroactive rescission of your or your dependents' coverage for fraud or intentional misrepresentation of a material fact.

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

**How to Appeal Your Group's Adverse Eligibility and Rescission Determinations:** If you wish to file an appeal of your group's adverse determination relating to initial eligibility for coverage or retroactive rescission of coverage, you should check with your group regarding your group's appeal procedures.

**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 Blue Cross recommends that you use a form that Blue Cross has developed for this purpose. The form will help you provide Blue Cross with the information that Blue Cross needs to consider your appeal. To get the form, you may call the customer service department. You may also go to www.AlabamaBlue.com. Once there, you may request a copy of the form.

If you choose not to use their appeal form, you may send Blue Cross 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 and Blue Shield of Alabama
  Attention: Customer Service Department – Appeals
  P.O. Box 12185
  Birmingham, Alabama 35202-2185

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

**How to Appeal Pre-Service Adverse Benefit Determinations:** You may appeal an adverse benefit determination 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 or 1-800-248-2342 (toll-free).
- For in-network physical therapy or occupational therapy (if covered by your plan) call 205-220-7202.
- For care from an in-network chiropractor (if covered by your plan) call 205-220-7202.

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

- For inpatient hospital care and admissions:

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

or

- For in-network physical therapy, occupational therapy, or care from an in-network chiropractor (when covered by your plan):

  Blue Cross and Blue Shield of Alabama
  Attention: Health Management – Appeals
  P.O. Box 362025
  Birmingham, Alabama 35236

Your written appeal should provide Blue Cross 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 Blue Cross without following the rules just described for filing an appeal, Blue Cross will not treat your inquiry as an appeal. Blue Cross will, of course, do everything they can to resolve your questions or concerns.

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

If Blue Cross needs more information, Blue Cross will ask you to provide it to Blue Cross. In

some cases Blue Cross may ask your provider to furnish that information directly to them. If Blue Cross does this, Blue Cross will send you a copy of their request. However, you will remain responsible for seeing that Blue Cross gets the information. If Blue Cross does not get the information, it may be necessary for Blue Cross to deny your appeal.

**Time Limits for Our Consideration of Your Appeal:** If your appeal arises from Blue Cross's denial of a post-service claim, Blue Cross will notify you of their decision within 60 days of the date on which you filed your appeal.

If your appeal arises from their denial of a pre-service claim, and if your claim is urgent, Blue Cross will consider your appeal and notify you of their decision within 72 hours. If your pre-service claim is not urgent, Blue Cross will give you a response within 30 days.

If your appeal arises out of a determination by Blue Cross to limit or reduce a hospital stay or course of treatment that Blue Cross previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), Blue Cross will make a decision on your appeal as soon as possible, but in any event before they impose the limit or reduction.

If your appeal relates to their decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), Blue Cross will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

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

**If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies:** If you filed an appeal and are dissatisfied with Blue Cross's response, you may do one or more of the following:

- You may ask the Customer Service Department for further help;
- You may file a voluntary appeal (discussed below);
- You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below); or
- You may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

**Voluntary Appeals:** If Blue Cross has given you their 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), Blue Cross will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. Blue Cross 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, Blue Cross will not impose any fees or costs on you as part of your voluntary appeal.

You may ask Blue Cross 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 Blue Cross for an independent, external review of their decision. You must request this external review within 4 months of the date of your receipt of their 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 Department Appeals, P.O. Box 10744, Birmingham, AL 35202-0744.

If you request an external review, an independent organization will review Blue Cross'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 Blue Cross copies of this additional information to give Blue Cross an opportunity to reconsider the denial. Both of us will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both of us.

### 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 Blue Cross at 1-800-248-2342 (toll-free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll-free).

**Claim Hold Provision**: PEEHIP may place your account on hold (i.e., suspend your account, thus suspending payment of medical and prescription drug claims under your account) for either of the following reasons:

- Non-payment of an amount owed PEEHIP (including failure to pay premiums or refunds due PEEHIP and payment by check drawn on an account which had insufficient funds or chargebacks for credit cards);
- Failure to provide required documentation to PEEHIP (including documentation relating to the eligibility of you or any of your dependents, as well as subrogation documentation).

If your account is placed on claims hold, your claims will not be processed by Blue Cross until PEEHIP notifies Blue Cross that the account has been returned to active status. In the event your account is placed on claims hold, please contact PEEHIP at 877.517.0020 immediately so that PEEHIP may work with you to return your account to active status.

# RESPECTING YOUR PRIVACY

The confidentiality of your personal health information is important to us. Under a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and healthcare operations and to put in place appropriate safeguards to protect your protected health information. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the plan's notice of privacy practices.

**Disclosures of Protected Health Information to the Plan Sponsor:**

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

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

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

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you or the plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the 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 protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

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

- HIPAA Privacy Office/Administrator
- HR Director
- HR Manager
- HR Benefits Personnel

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

**Security of Your Personal Health Information:**

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

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

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

**Our Use and Disclosure of Your Personal Health Information:**

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

# GENERAL INFORMATION

## Delegation of Discretionary Authority to Blue Cross

The group has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of benefits and/or administrative services under the plan.

Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan (including, when applicable, arbitration) and thereafter to judicial review to determine whether our determination was arbitrary or capricious.

## Notice

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so.

Unless otherwise specified in this booklet, if you are required to provide notice to us, you should do so in writing, including your full name and contract number, and mail the notice to us at 450 Riverchase Parkway East, P.O. Box 995, Birmingham, Alabama 35298-0001.

## Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will be reflected in your claims report.

## Responsibility for Providers

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we are not responsible. We need not do anything to enable them to treat you.

## Misrepresentation

If you commit fraud or make any intentional material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.

## Governing Law

The law governing the plan and all rights and obligations related to the plan shall be ERISA, to the extent applicable. To the extent ERISA is not applicable, the plan and all rights and obligations related to the plan shall be governed by, and construed in accordance with, the laws of the state of Alabama, without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the plan.

## Termination of Benefits and Termination of the Plan

Our obligation to provide or administer benefits under the plan may be terminated at any time by either the group or us by giving written notice to the other as provided for in the contract. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If the group fails to pay us the amounts due under the contract within the time period specified therein, our obligation to provide or administer benefits under the plan will terminate automatically and without notice to you or the group as of the date due for payment. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

Subject to any conditions or restrictions in our contract with the group, the group may terminate the plan at any time through action by its authorized officers. In the event of termination of the plan, all benefit payments by us will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by the group or us. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If for any reason our services are terminated under the contract, you will cease to receive any benefits by us for any and all claims incurred after the effective date of termination. In some cases, this may mean retroactive cancellation by us of your plan benefits. This is true for active contract holders, retirees, COBRA beneficiaries and dependents of either. Any fiduciary obligation to notify you of our termination belongs to the group, not to us.

## Changes in the Plan

Subject to any conditions or restrictions in our contract with the group, any and all of the provisions of the plan may be amended by the group at any time by an instrument in writing. In many cases, this instrument will consist of a new booklet (including any riders or supplements to the booklet) that we have prepared and sent to the group in draft format. This means that from time to time the benefit booklet you have in your possession may not be the most current. If you have any question whether your booklet is up to date, you should contact your group. Any fiduciary obligation to notify you of changes in the plan belongs to the group, not to us.

The new benefit booklet (including any riders or supplements to the booklet) will state the effective date applicable to it. In some cases, this effective date may be retroactive to the first day of the plan year to which the changes relate. The changes will apply to all benefits for services you receive on or after the stated effective date.

Except as otherwise provided in the contract, no representative, employee, or agent of Blue Cross is authorized to amend or vary the terms and conditions of the plan or to make any agreement or promise not specifically contained in the plan documents or to waive any provision of the plan documents.

## No Assignment

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

# DEFINITIONS

**Accidental Injury:** A traumatic injury to you caused solely by an accident.

**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 booklet, for a description of the contracting arrangements that exist outside the state of Alabama.

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

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

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

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

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

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

**Blue Cross:** Blue Cross and Blue Shield of Alabama, except where the context designates otherwise.

**BlueCard 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. The BlueCard program is explained in more detail in other sections of this booklet, such as In-Network Benefits and Out-of-Area Services.

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

**Contract:** Unless the context requires otherwise, the terms "contract" and "plan" are used interchangeably. The contract includes our financial agreement or administrative services agreement with the group.

**Cosmetic Surgery:** Any surgery done primarily to improve or change the way one appears, cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma, or birth defect. For important information on cosmetic surgery, see the exclusion under Health Benefit Exclusions for cosmetic surgery.

**Custodial Care:** Care primarily to provide room and board for a person who is mentally or physically disabled.

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

**Durable Medical Equipment (DME):** Equipment we approve 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 made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

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

**Employer:** Unless the context otherwise requires, the terms “employer” and “group” have the same meaning.

**General Hospital:** Any institution that is classified by Blue Cross as a "general" hospital using, as Blue Cross deems applicable, generally available sources of information.

**Group:** The employer or other organization that has contracted with us to provide or administer group health benefits pursuant to the plan.

**Health Agency:** An organization that provides care at home for homebound patients who need skilled nursing or skilled therapy. In order to be considered a home healthcare agency under the terms of the plan, the organization must meet the conditions for participation in Medicare.

**Hospice:** An organization whose primary purpose is the provision of palliative care. Palliative care means the care of patients whose disease is not responsive to curative treatments or interventions. Palliative care consists of relief of pain and nausea and psychological, social, and spiritual support services. In order for an organization to be considered a hospice under this plan,

it must meet the conditions for participation in Medicare.

**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:** See the In-Network Benefits subsection of the Overview of the Plan section of the booklet.

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

**Investigational:** Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we 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 we make determinations about the investigational nature of a service or supply we are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

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

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

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

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

**Member:** You or your eligible dependent who has coverage under the plan.

**Mental Health Disorders:** These are mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. These disorders, illnesses, and conditions are considered mental health disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders regardless of how they are caused, based, or brought on. Mental health disorders 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.

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

**Outpatient:** A patient who is not a registered bed patient of a hospital. For example, a patient receiving services in the outpatient department of a hospital or in a physician's office is an outpatient; provided that we reserve the right in appropriate cases to reclassify outpatient services as inpatient stays, as explained above in Inpatient Hospital Benefits and Outpatient Hospital Benefits.

**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:** The plan is the group health benefit plan of the group, as amended from time to time. The plan documents consist of the following:

- This benefit booklet, as amended;
- The Blue Cross contract with PEEHIP, as amended;
- Any benefit matrices upon which Blue Cross has relied with respect to the administration of the plan; and,

If there is any conflict between any of the foregoing documents, Blue Cross will resolve that conflict in a manner that best reflects the intent of the group and Blue Cross as of the date on which claims were incurred. Unless the context requires otherwise, the terms "plan" and "contract" have the same meaning.

**Plan Administrator:** The group that sponsors the plan and is responsible for its overall administration. If the plan is covered under ERISA, the group referred to in this definition is the “administrator” and "sponsor" of the plan within the meaning of section 3(16) of ERISA.

**Preadmission Certification:** The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, based upon medically recognized criteria.

**Pregnancy:** The 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 – and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

**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 we or any Blue Cross and/or Blue Shield plan (or its affiliates) determines. A psychiatric specialty hospital does not include a substance abuse facility.

**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 we or any Blue Cross and/or Blue Shield plan (or its affiliates) determine and that solely provides residential and/or outpatient substance abuse rehabilitation services.

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

**We, Us, Our:** Blue Cross and Blue Shield of Alabama.

**You, Your:** The contract holder or member as shown by the context.

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