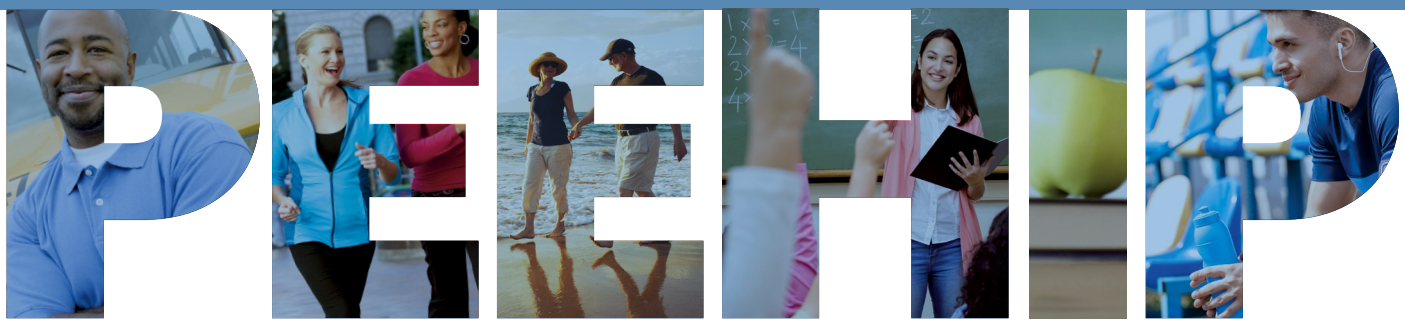
PEEHIP

Member Handbook 2025–2026

with Open Enrollment Information



Public Education Employees' Health Insurance Plan

How to reach us.

Phone **877.517.0020** or **334.517.7000**

Fax **877.517.0021** or **334.517.7001**

Email **peehipinfo@rsa-al.gov**
Because email submissions are unsecured, do not include confidential information like your Social Security number. Please include your full name, employer, home mailing address, and daytime phone number.

Mail **Public Education Employees' Health Insurance Plan**
P.O. Box 302150
Montgomery, AL 36130-2150

Website www.**rsa-al.gov**

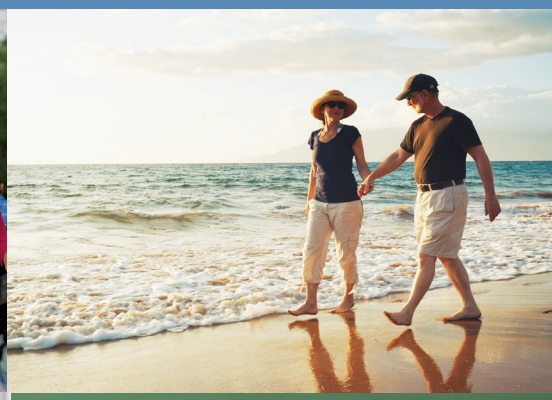
Member Online Services (MOS Login)
Enroll in PEEHIP coverage online
https://**mso.rsa-al.gov**

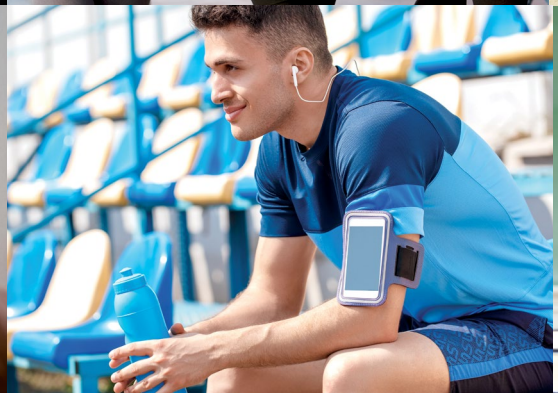
Building Location
201 South Union Street
Montgomery, Alabama

Flexible Spending Accounts
877.517.0020 or **334.517.7000**
www.**rsa-al.gov/peehip/flex-account**

Business Hours
8:00 a.m.-5:00 p.m.
Monday-Friday








Plan Administrator Contact Information

Hospital Medical Plans

Blue Cross Blue Shield of Alabama (PPO) #14000
www.alabamablue.com/peehip/
450 Riverchase Parkway East
P.O. Box 995
Birmingham, AL 35298
Customer Service 800.327.3994
Preadmission Certification 800.248.2342
Subrogation 205.220.2744
Fraud Hot Line 800.824.4391
Rapid Response® 800.248.5123
(to order ID cards, claim forms, & directories)
Baby Yourself® 800.222.4379 - Maternity Program
Teladoc® 855.477.4549
www.teladoc.com/alabama

VIVA Health Plan (HMO)
www.vivahealth.com/peehip
417 20th Street North, Suite 1100
Birmingham, AL 35203
Customer Service 205.558.7474 or 800.294.7780
Delta Dental Customer Service 800.521.2651
(dental provider for VIVA Health Plan)
Teladoc® 800.TELADOC (835.2362)
www.teladoc.com

Supplemental Medical Plan #61000

See Blue Cross Blue Shield of Alabama Information Above

Group Medicare Advantage (PPO) Plan

Until December 31, 2025
UnitedHealthcare®
www.retiree.uhc.com/peehip
9900 Bren Road East
Minnetonka, MN 55343
Customer Service 877.298.2341
Renew Active 855.604.1588
Renew Rewards 888.219.4602

Effective January 1, 2026
Humana
your.humana.com/PEEHIP
P.O. Box 14601
Lexington, KY 40512-4601
Customer Service 800.747.0008, 7 a.m. - 8 p.m., CT
Go365® 866.677.0999
SilverSneakers® 888.523.4632

Wellness Programs

Alabama Department of Public Health (ADPH)
Vendor for Wellness Screenings and Flu Shots
www.alabamapublichealth.gov/worksitewellness/
Flu Shots 844.842.2954
Tobacco Cessation Quitline 800.QUIT.NOW
or 800.784.8669
quitnowalabama.com

BCBS Health Coaching
888.841.5741

Pack Health
www.packhealth.com/peehip
Customer Service 855.255.2362

Wondr Health
www.wondrhealth.com/peehip

Optional Coverage Plans (Cancer, Dental, Indemnity, & Vision)

Southland Benefit Solutions
http://southlandpeehip.com
2200 Jack Warner Pkwy, Suite 150
P.O. Box 1250
Tuscaloosa, AL 35401
Customer Service 800.476.0677

Flexible Spending Accounts

HealthEquity
www.healthequity.com/peehip
Customer Service 877.288.0719 - 24 hours/day

Non-Medicare Pharmacy Plan

Express Scripts (ESI)
www.express-scripts.com
One Express Way
St. Louis, MO 63121
Customer Service 800.363.9389
Pharmacy Help Desk 800.922.1557
Prior Authorization 800.211.1456 (for physicians)
PA Fax 800.845.6190
EasyRx Fax 888.EASYRX1 (888.327.9791) - submit prescriptions

PEEHIP Member Handbook with Open Enrollment Information

The Public Education Employees' Health Insurance Plan, or PEEHIP for short, was established in 1983 to provide quality healthcare insurance benefits for the health and well-being of its members.

Members can access their PEEHIP coverage information on the Member Online Services website https://mso.rsa-al.gov.

Use Member Online Services to:

- View current coverage
- Enroll or change PEEHIP coverage
- Upload required documents
- Make PEEHIP payments

Summary of Benefits and Coverage Availability of Summary Health Information

The Patient Protection and Affordable Care Act (PPACA) of 2010 created a new federal requirement for group health plans to provide the Summary of Benefits and Coverage (SBC) document to health plan members. Health benefits represent a significant component of a member's compensation package. The benefits also provide important protection for members and their families in the case of illness or injury.

PEEHIP offers a series of health coverage options. Choosing a health coverage option is an important decision. To help members make an informed choice, PEEHIP makes a Summary of Benefits and Coverage (SBC) available, which summarizes important information about health coverage options in a standard format, to help members compare across coverage options available to them in both the individual and group health insurance coverage markets. The SBC is available at www.rsa-al.gov/peehip/publications/. A paper copy is also available, free of charge, by calling Member Services toll-free at 877.517.0020.

The SBC is meant as a summary only and the coverage examples in the SBC on page 7 are for illustration purposes only and may not be representative of the actual charges for copayments or out-of-pocket expenses for the PEEHIP plan. For more detailed benefit information, see the PEEHIP Summary Plan Description (SPD) at www.rsa-al.gov/peehip/publications/.

The information in this handbook is based on the Code of Alabama, 1975, Title 16, Chapter 25A. This handbook is not intended as a substitute for the laws of Alabama governing PEEHIP nor will its interpretation prevail should a conflict arise between its contents and Chapter 25A. Furthermore, the laws summarized here are subject to change by the Alabama Legislature. Members should not rely solely upon the information provided in this handbook to make any decision regarding their healthcare benefits, but should contact PEEHIP with any questions they may have about their healthcare benefits.

Table of Contents

Benefit Policy & Premium Changes

Hospital Medical Plan Changes

Administered by Blue Cross Blue Shield of Alabama (Group #14000)

The combined medical and prescription drug in-network maximum annual out-of-pocket amounts will increase from $9,200 to **$10,150** for individual coverage and from $18,400 to **$20,300** for family coverage for calendar year 2026. This is an enhanced benefit for our members enrolled in PEEHIP's Hospital Medical Plan Group #14000 coverage, as they will pay no more than these annual out-of-pocket amounts.

Flexible Spending Account (FSA) Plan Changes

- The annual maximum Health FSA contribution amount will increase from $3,200 to **$3,300** for the fiscal year beginning October 1, 2025.
- The Dependent Care Reimbursement Account (DCRA) annual maximum contribution remains unchanged at $5,000 ($2,500 each if married filing separately).
- The carryover limit will increase from $640 to **$660.** See **Flexible Spending Accounts** section for more information.

Supplemental Medical Plan Changes

- The annual maximum amount of claims paid under Group #61000 will increase from $9,200 to **$10,150** per individual and from $18,400 to **$20,300** per family for calendar year 2026.
- Members enrolled in High Deductible Health Plans (HDHP) are not eligible for the PEEHIP Supplemental Medical Plan. The IRS-defined minimum deductibles for HDHPs for calendar year 2026 will increase from $1,650 to **$1,700** for individual and from $3,300 to **$3,400** for family. *Members must provide a copy of their primary plan document to PEEHIP for verification of the deductibles.*

Medicare Advantage Plan Changes

- Effective January 1, 2026, Humana will administer the PEEHIP Medicare Advantage Plan.
- The plan will have two separate ID Cards: one for hospital medical and one for pharmacy.
- Hospitals, medical offices, and pharmacies will know which card to use if both are presented.
- The Humana customer service number dedicated to PEEHIP will be the same on both cards.
- Members do not need to take any action. ID Cards will be mailed December 2025.

Premium Rate Changes for Fiscal Year 2026

COBRA and Leave of Absence Hospital Medical or VIVA Health Plan Rates

Individual	$ 644
Family	$1,617
Supplemental Medical Plan (Individual or Family)	$ 198

Surviving Spouse/Dependent Hospital Medical or VIVA Health Plan Rates

Individual/Non-Medicare-eligible (NME) Survivor	$1,014
Family/NME Survivor & More Than 1 Dependent or Only Dependent NME	$1,715
Family/NME Survivor & Only Dependent Medicare-eligible (ME)	$1,380
Individual/ME Survivor	$ 260* subject to change 1/1/26
Family/ME Survivor & More Than 1 Dependent or Only Dependent NME	$1,207
Family/Medicare-eligible Survivor & Only Dependent ME	$ 520* subject to change 1/1/26
Supplemental Medical Plan (Individual or Family)	$ 198

For purpose of the charts below, NME designates "non-Medicare-eligible" and ME designates "Medicare-eligible."

Coverage Type	Premium if Retiree Subscriber is NME	Premium if Retiree Subscriber is ME
Individual Coverage:	$210	$ 25
Family Coverage:		
NME dependent(s) but no spouse	$465	$280
NME dependent(s) and NME spouse	$565	$380
NME dependent(s) and ME spouse	$465	$280
NME spouse only	$540	$355
ME spouse only	$275	$ 90
Non-spousal ME dependent only	$275	$ 90
Non-spousal ME dependent and ME spouse	$340	$155

These rates apply to the PEEHIP Hospital Medical Plan, the VIVA Health Plan, and the Medicare Advantage PPO Plan for Medicare-eligible retired members and Medicare-eligible dependents and are the monthly amount that will be deducted from a retiree's benefit. The VIVA Health Plan is not available to retired members who are Medicare-eligible or retired members with dependents who are Medicare-eligible.

See the **Retiree Sliding Scale Legislation** section for more information about how the sliding scale may affect a member's premium.

Updating Personal Contact Information

(Active and Retired Members)

Name and Social Security Number Changes

The name on all insurance and Teachers' Retirement System (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 (SSN) can be changed. Active members must provide a copy of their current Social Security card to their employer for the employer to correct their PEEHIP and TRS accounts. **The disclosure of a member's SSN is mandatory for PEEHIP coverage so that PEEHIP may ensure compliance with the federal Medicare Secondary Payer rules created by 42 USC 1395y(b)**. A member's SSN will be used by PEEHIP for the purpose of coordination of benefits.

Address Changes

Members can change an address through Member Online Services (MOS) on the RSA website at www.rsa-al.gov. Members should select Member Log In at the top left of the home page and follow the instructions. This address change will automatically transmit to the insurance carriers and will update their address with the TRS and RSA-1 if they are a participant in those accounts. The address change made through MOS will not change the address with an employer. **Active members must contact their employer to have their address changed in their system. For those who do not have access to the internet, a signed, written request can be submitted to PEEHIP.**

PEEHIP policies do not allow changes to be made over the phone.

Preferred Method for Receiving Communication from PEEHIP and the RSA

MOS provides members **the ability to set their preferred method of receiving communication to email instead of paper mail.** In addition to preserving paper and helping PEEHIP and the RSA save on postage cost, this allows members to receive notifications immediately in their email rather than waiting for paper mail. This can be particularly helpful with PEEHIP documents that involve deadlines for response or application. After signing up for email notifications, members will receive a confirmation email at the email address indicated in MOS. If they do not receive this email within 24 hours or if they signed up to receive emails but are not getting them from PEEHIP or the RSA, they should check their junk mail or spam settings and make sure their email settings allow messages from noreply@rsa-al.gov.

When additional action/information is needed by PEEHIP, members will be sent an email notification stating that **important correspondence from PEEHIP or the RSA requires their immediate attention.** This additional action/information will be in their MOS Secure Message Center. Members can view the document by logging into MOS and selecting Secure Message Center. It is important that members respond to the request in a timely manner. Even if a member chooses to receive communication by paper mail, they will be able to access secure communications in their Secure Message Center anywhere that they have internet access.

Insurance Eligibility

(Active and Retired Members)

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 TRS 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 TRS 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 eligible for PEEHIP if they agree 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 worker is employed. An eligible permanent part-time employee is not a substitute or a transient employee.

Ineligible Employees

These 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.

Retired Employees

Retired employees are defined as follows:

- Any person receiving a monthly benefit from the TRS who at the time of their retirement was employed by a public institution of education within the state of Alabama which provided instruction at any combination of grades K through 14, exclusively, under the auspices of the State Board of Education or pursuant to Section 16-25A-11.
- Any person receiving a monthly benefit from the TRS who at the time of their retirement was employed by a state-supported postsecondary institution and any person receiving a monthly benefit from the Employees' Retirement System (ERS) whose retirement under the ERS was from a local board of education or a state-supported postsecondary institution who participated pursuant to Section 36-27-6.

Family Coverage Eligibility

Eligible Dependents

Eligible active and retired employees can enroll their eligible dependents in PEEHIP coverage. An eligible dependent is defined as the following:

- **Spouse** - A spouse is defined as the active or retired employee's spouse, as defined by Alabama law, to whom you are currently and legally married, excludes a divorced spouse. Appropriate documentation is required by PEEHIP before a spouse can be enrolled. Refer to the **Dependent Eligibility Verification Required Documentation** section for details.
- **Children** - PEEHIP offers dependent coverage to children up to age 26. Appropriate documentation is required by PEEHIP before dependents can be enrolled. Coverage cancels the first of the month following the date they turn 26. Refer to the **Dependent Eligibility Verification Required Documentation** section for details. **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.**

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 the member's biological child, legally adopted child, stepchild, or foster child without conditions of residency, student status, or dependency. A foster child is any child who is placed with the member 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 the member by decree or other order of any court of competent jurisdiction, for example, legal custody or legal guardianship.
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.
   - An existing member requests hospital medical coverage of the incapacitated child over the age of 26 within 45 days of the qualifying life event of loss of other hospital medical group coverage.

The member must contact PEEHIP and request an Incapacitated Dependent Certification 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 they reach the limiting age of 26 as an incapacitated child. For example, approved permanently incapacitated children can remain covered 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 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 the VIVA Health Plan or the Optional Coverage Plans if they have already reached the limiting age of 26.

Ineligible Dependents

- An ex-spouse, regardless of what the divorce decree states
- Ex-stepchildren, regardless of what the divorce decree states
- Children aged 26 and older
- Disabled children over age 26 who were never enrolled or whose coverage was previously canceled
- A child of a dependent child cannot both be covered on the same policy
- A spouse of a dependent
- Grandchildren or other children related to the member by blood or marriage for which the member does 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(e) or non-married significant other

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 for other eligible dependents and regardless of what the divorce decree states. The ex-spouse and ex-stepchildren must be removed 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. An ex-spouse and ex-stepchildren are eligible for COBRA if the request to enroll in COBRA is made within 60 days of the cancellation of coverage. Refer to the **COBRA** section for details.

To remove the ex-spouse from coverage effective the first day of the month following the divorce, the member can:

- Click the Enroll or Change PEEHIP Coverages link from the PEEHIP Services tab after logging in to MOS. Select the QLE option, select Divorce from the drop-down box and provide the date the divorce was final. This is generally the date the judge signed the Final Order of the Divorce Decree. A confirmation page will be generated to ensure this change was saved and submitted to PEEHIP. This will remove the ex-spouse from the member's coverage once PEEHIP has been provided a signed copy of the Divorce Decree.
- Members without internet access must timely notify PEEHIP of their divorce by completing and submitting to PEEHIP a New Enrollment and Status Change form and a copy of their divorce decree.

Open Enrollment

(Active and Retired Members)

Open Enrollment is a member's opportunity to enroll in or change plans and add or remove eligible dependents from coverage. All eligible active and retired members are mailed an Open Enrollment Notice in June of each year, which provides information about Open Enrollment deadlines, how to enroll or make changes online through MOS, identifies the coverage in which they are currently enrolled, and the current tobacco status on file with PEEHIP.

The Open Enrollment web page www.rsa-al.gov/peehip/open-enrollment/ is available July 1 and contains information about Open Enrollment deadlines, the PEEHIP Member Handbook, and other important information.

Open Enrollment begins July 1 and ends by the following deadlines:

- Paper forms must be postmarked by **August 31** to be accepted.
- The deadline for submitting online changes is midnight on **September 10**. After September 10, the Open Enrollment link will be closed.
- The deadline for enrolling or re-enrolling in a **Flexible Spending Account (FSA)** online or using a paper form is **September 30.**

Open Enrollment changes will not be accepted after these deadlines.

Other Open Enrollment information:

- Members do not need to re-enroll in coverage if they want to continue their current coverage. Their current coverage will remain in effect, and premium deductions will continue if they do not add/change/cancel coverage during Open Enrollment.
- New coverage elections are not effective until the initial premium payment is made. The initial premium can be paid via MOS at the same time of enrollment.
- Members enrolling in new insurance plans should receive their new ID cards from the insurance carrier(s) before October 1.
- Payroll deductions for the changes made during Open Enrollment effective October 1 will be reflected in the September paycheck. All members covered by PEEHIP insurance should review their monthly payroll deductions each month to ensure the proper amount has been deducted for their PEEHIP premiums.
- Members who choose to participate in the FSA are required to submit a new enrollment each year. Members who enroll in the FSA effective October 1 will have their first contribution withheld from their October paycheck. **The preferred method to enroll is online through MOS.**
- Members who choose to apply for the Premium Assistance discount program are required to submit a Premium Assistance Application each plan year. The paper application can be uploaded in MOS.
- New PEEHIP members can refer to the **Wellness Programs** section for details on the wellness benefits and the required wellness screening that earns the wellness premium waiver.

All Open Enrollment changes will have an effective date of October 1.

Transfers

Employees who transfer from one system to another system and who do not have a break in coverage are considered current employees and are not considered new employees for insurance enrollment purposes. Transfers are required to continue existing PEEHIP coverage and cannot make insurance changes until the Open Enrollment period for an October 1 effective date.

Rehired Employee and 3-1 Rule

If an employee is terminated at the end of the school year and transfers to another system or is rehired by the same system for the next school year, or a retiree suspends their retirement and comes back to work, the employee is not considered a "new employee" for insurance purposes, and the employee cannot make insurance changes until the Open Enrollment period. If an employee transfers to another system, is rehired by the same system, or if a retiree suspends their retirement and returns to work and is **not** enrolled in PEEHIP coverage, they would be permitted to enroll within 30 days from the date they return to work. Refer to the **Employer Contribution** section for more information about the 3-1 Rule.

PEEHIP-Eligible Spouses Who Enroll in Their Own Plans

PEEHIP requires a physical or electronic signature to enroll in or change coverage. Therefore, a member will not be automatically canceled from their existing plan in the event they enroll in a new plan as a subscriber or a dependent.

Example: John and Jane are both PEEHIP-eligible. John is the subscriber and covers Jane as a dependent. Jane decides to enroll as a subscriber in an individual plan. Jane will remain on John's plan as a dependent unless John submits a New Enrollment and Status Change form or uses MOS to cancel Jane as a dependent.

Part-Time to Full-Time Employment

Employees who are employed less than full-time and are enrolled in only Optional Coverage Plans cannot enroll in a PEEHIP hospital medical plan outside of the Open Enrollment period if they become full-time. Members may add the other Optional Coverage Plans when they become full-time.

Full-Time to Part-Time (Non-Temporary) Employment

A member is not eligible to cancel their PEEHIP hospital medical plan outside of the Open Enrollment period when they change from full-time to part-time status.

Pre-Existing Conditions

Pursuant to the federal healthcare reform laws, all members and dependents added to coverage have no waiting periods applied on pre-existing conditions.

New Employee Enrollment

(Active Members)

Member Online Services (MOS)

New employees who choose to enroll in PEEHIP coverage must do so online through MOS at https://mso.rsa-al.gov **within 30 days of their hire date.** Using MOS is the only way to receive instant confirmation of coverage requests.

New employees can choose one of the following effective dates of coverage:

- Date of hire
- First of the month following the date of hire
- October 1 (if hired during Open Enrollment)

Members are responsible for ensuring PEEHIP has received their enrollment request and any other documents required for enrollment (i.e., dependent eligibility documents such as marriage certificate, other proof of marriage, birth certificate, etc.).

Premium payments

- PEEHIP premiums for hospital medical and Optional Coverage Plans are deducted in the month prior to the month of coverage. New employees who have enrolled in PEEHIP coverage effective their date of hire or the first of the month following their date of hire must make payment directly to PEEHIP for their initial premiums. Payment can be made through MOS (e-check, debit card, or credit card), or a check can be mailed to PEEHIP.

  Example 1: An employee who is hired August 4 and elects coverage effective August 4 whose first paycheck is August 31 will have premiums deducted to pay for September coverage but not for August coverage. The August premium must be paid directly to PEEHIP.

  Example 2: An employee who is hired August 4 and elects coverage effective August 4 whose first paycheck is September 30 will have premiums deducted to pay for October coverage but not for August or September coverage. The August and September premiums must be paid directly to PEEHIP.

- **Failure to timely pay your initial premiums will result in a claim hold being placed on your account. A claim hold will prevent you and your dependents from using your coverage. Once payment is received, the hold will be removed.**
- Unlike other PEEHIP premiums, which are deducted in the month prior to the month of coverage, FSA contributions are deducted in the current month.

  Example: Contributions for October are deducted in October.

If MOS enrollment is not completed within 30 days:

- The New Employee enrollment link in MOS will be removed.

Family Coverage Options

New employees who wish to enroll in family hospital medical and/or optional coverage must do so within 30 days from their date of hire. The family coverage can be effective on their date of hire or the first of the month following their date of hire. Since premiums are deducted one month in advance and to accommodate new hires who may not have received their full monthly pay, family coverage can be deferred until the first of the second month following their date of hire. To request family coverage to begin the first of the second month following the new employee's date of hire, a New Enrollment and Status Change form must be submitted to PEEHIP within 30 days of the new employee's date of hire. Otherwise, family coverage can be added during annual Open Enrollment.

Hospital Medical Coverage

New employees can enroll in individual, family (without spouse), or family (with spouse) coverage with the PEEHIP Hospital Medical Plan or the VIVA Health Plan. Refer to the **Comparison of In-Network Benefits Chart** for more information.

Optional Plan Coverage

New employees employed during the Open Enrollment period cannot enroll in the Optional Coverage Plans effective the date of hire or the first month following the date of hire and cancel the plans October 1 of that same year. The coverage must be retained for at least one year or until the next Open Enrollment period. Refer to the **Optional Coverage Plans** section for more information.

Supplemental Medical Coverage

New employees can enroll in the Supplemental Medical Plan if they are enrolled in a primary health plan not affiliated with PEEHIP and which includes prescription coverage. There is no premium charge for the Supplemental Medical Plan if the member is not enrolled in any other PEEHIP coverage. Refer to the **PEEHIP Supplemental Medical Plan** section for more information and qualifications.

Members Not Enrolled in a PEEHIP Hospital Medical Plan

Members who choose not to enroll in a PEEHIP hospital medical plan can enroll in the PEEHIP Supplemental Medical Plan **or** up to four Optional Coverage Plans at no premium cost for individual or family coverage. Spouses who are independently eligible for PEEHIP coverage cannot be covered by a PEEHIP hospital medical plan and enroll in the PEEHIP Supplemental Medical Plan or the Optional Coverage Plans at no cost.

Adult Children under Age 26 Independently Eligible for PEEHIP

Covered children under age 26 who become employed and eligible for their own PEEHIP coverage can either enroll in their own coverage or remain on their parent's PEEHIP coverage until they reach age 26. Upon reaching age 26, the adult child will have 45 days to enroll in their own PEEHIP coverage. If the adult child chooses to enroll in their own coverage, they will be removed from their parent's identical coverage due to non-duplication of benefits.

Members on COBRA Who Return to Work

When a member who is enrolled in PEEHIP under COBRA returns to work for a PEEHIP participating employer and wishes to enroll in new coverage, the member must complete a New Enrollment and Status Change form within 30 days of their hire date. The member cannot cancel existing coverage until the Open Enrollment period.

*Refer to the **Member Online Services (MOS)** section for more information.*

Member Online Services (MOS)

Information Needed to Enroll Online

1. Your Personal Identification (PID) Number. If you do not know your PID number, you can request a PID letter online. You will need your PID to create a User ID and Password.
2. Last five digits of your SSN
3. Email address
4. SSN and dates of birth for each dependent being enrolled in coverage
5. Additional health insurance information under which you and your dependents are covered
6. Credit card, debit card, or e-check to make first premium payment at the time of enrollment

Registering as a First Time User

From the RSA Home Page at www.rsa-al.gov, members can click Member Log In located at the top left of the web page.

- Members can click **Need to Register** or login with your User ID and Password.
  - If you do not remember your User ID and/or Password, you can re-register by clicking **Forgot User ID or Password**.
  - The RSA mails new members their Personal Identification Number (PID).
  - If you do not have your PID, you can request a PID letter through MOS, and one will be mailed to you.
  - Click **Need a PID?**
  - Your PID will also be located on all personal correspondence sent to you by PEEHIP.
- Multi-factor Authentication (MFA)
  - Select your MFA delivery method and click Send Authorization Code

Important: Your coverage request was not successful unless you received a confirmation page. Your coverage will not be effective until you submit your initial premium payment.

Enroll or Change PEEHIP Coverages

From the **PEEHIP Services** tab, select one of the following:

- Click **Enroll or Change PEEHIP Coverages** to enroll in a hospital medical plan, Optional Coverage Plans (dental, vision, cancer, indemnity), or FSA as:
  - Click **New Enrollment** *(available for 30 days from date of hire)* if wanting to enroll as a new hire or newly eligible member.
  - Click **Open Enrollment** *(available July 1 – September 10)* to:
    - Enroll, Change, or Cancel Hospital Medical Plan
    - Enroll, Change, or Cancel PEEHIP Optional Coverage Plan(s) (Cancer, Dental, Indemnity, Vision)
    - Add, Update, or Cancel My Additional Insurance Coverage Information
    - Enroll or Re-enroll in Flexible Spending Accounts
    - Add or Update Medicare Information
  - Click **Qualifying Life Event (QLE)** to add a newly acquired dependent within 45 days of QLE.
    - Adoption of a Child
    - Birth of a Child
    - Legal Custody of a Child
    - Marriage of a Subscriber

To make changes outside of Open Enrollment for QLE's not listed, members must complete a New Enrollment and Status Change form and send it to PEEHIP within 45 days of the QLE.

- Select **Other** *(available year-round)* to add or update:
  - Tobacco user status
  - Other medical insurance coverage information
- Retiree Employment Information

From the **PEEHIP Services** tab at the top of the screen, you can:

- View Current Coverages
- Wellness Completion Status

Update Contact Information

It is important that PEEHIP has your current mailing address, physical address, phone number(s), and email in order to receive important correspondence regarding your coverage and critical deadlines. From the **My Account**, you can:

- Update **Contact Information**
  - View or change your phone or email information
  - View your address information
  - Change User ID, Password, or Secret Question

Securely upload required documentation to PEEHIP through MOS. Do not send personal documents via email to PEEHIP.

Correspond with PEEHIP

From the **Secure Message Center**, you can:

- Send or upload a document to the RSA
- View secure messages sent to you from PEEHIP and the RSA
- Submit a question to PEEHIP and the RSA
- View **Member Correspondence** including:
  - Enrollment Confirmation Pages
  - Account statements
  - Upload a document to PEEHIP and RSA
  - Outgoing correspondence sent to you from PEEHIP and the RSA
  - Retirement benefit and PEEHIP premium estimates
- From the **Question Center**, you can
  - Select a Category from the drop-down menu
  - **Question not answered?** Type your questions and click **Submit**.
    - By using this method of communication, your personal and private health information is protected and encrypted to safeguard your security. PEEHIP staff members monitor and respond to your questions to give you a timely response.

Acceptable Methods of Sending Documents to PEEHIP

In order to ensure greater protection for our member's protected health information (PHI), PEEHIP can only accept documents containing PHI through the following secure formats:

- **Online** via MOS Secure Message Center:

Visit https://mso.rsa-al.gov to log into the secure MOS account portal

  - Click on the Secure Message Center tab at the top of the screen and click the Send a Document link
  - Follow the on-screen instructions to upload document(s) to PEEHIP
- **Paper mail** sent to: PEEHIP, P.O. Box 302150, Montgomery, AL 36130
- **In-person** delivery to: Member Services in the RSA Headquarters building at 201 S. Union Street, Montgomery, AL 36104

PEEHIP will not accept any documents containing PHI sent by any method other than those listed above.

Members without Computer Access

If a member does not have access to a computer or the internet, enrollments and/or changes can be made by submitting a New Enrollment and Status Change form to PEEHIP by the appropriate deadlines. Members can request a New Enrollment and Status Change form to be mailed to them by calling Member Services at 877.517.0020.

Dependent Eligibility Verification Required Documentation

(Active and Retired Members)

Every member who enrolls dependent(s) in their PEEHIP coverage(s) is required to certify dependent eligibility to PEEHIP. Certification requires submission of appropriate documents to verify dependent eligibility. All dependents must have a valid SSN to be eligible and must provide a copy of their Social Security card to PEEHIP. Any dependent without an SSN must provide valid, unexpired immigration documents. An Individual Tax Identification Number can be provided for tax reporting purposes, but it must be accompanied by unexpired immigration documents.

Documents must be mailed or emailed (encrypted) to PEEHIP or uploaded in MOS. Enrollments cannot be processed without the appropriate documentation. Black out account numbers, income, or statement balances prior to sending documents to PEEHIP. Under no circumstances does PEEHIP solicit this type of information from members. **PEEHIP is not bound by court order to insure dependents who do not meet PEEHIP guidelines.**

Spouse - A person to whom the member is currently and legally married. Required documents:

- Copy of Social Security card **and**
- Copy of Marriage Certificate filed with probate court **and, if married six months or more,**
  - Copy of one additional proof of marriage dated within the last six months listing the member and the spouse. Acceptable proof documents are:
    - Current mortgage statement, home equity loan, or lease agreement
    - Current utility bill (water, electric, gas, cellular, cable, satellite service bill, etc.)
    - Current credit card or account statement
    - Property Tax documents
    - Current automobile registration

If the above documents are unavailable, you may provide the transcript of the member's most current Federal 1040 Income Tax Return listing both member and spouse. If filed separately, spouse's transcript also required.

Separated Spouse - A legally separated spouse. Required document: Notice of Legal Separation (court documents signed by a judge)
Not eligible for coverage: Ex-Spouse, Common-Law Spouse, and Ex-Stepchildren

Biological Child - Member's biological child who is under age 26. Required documents:

- Copy of Social Security card **and** Birth Certificate (issued by a state, county, or vital records office)

Foster Child - 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:

- Copy of Social Security card **and** Placement Authorization signed by a judge **or**
- Final Court Order with presiding judge's signature and seal

Adopted Child - Member's legally adopted child under age 26. Required documents:

- Copy of Social Security card **and one** of the following documents:
- Certificate of Adoption
- Papers from the adoption agency showing adoption record or placement for adoption
- Court documents signed by a judge showing the member has adopted the child
- International adoption papers from country of adoption
- Birth Certificate (issued by a state, county, or vital records office naming the adopted parents)

Stepchild - A child under age 26 who is the natural offspring or adopted child of the covered member's spouse. Required documents:

- Copy of Social Security card **and**
- Birth certificate of stepchild showing member's spouse's name **and**
- Marriage certificate showing the stepchild's biological parent is married to member **and**

If the spouse is not covered under the PEEHIP plan, members must submit proof that their marriage is still current. Refer to the Spouse category for a list of acceptable documentation. **If stepchild is added at different time than spouse, one additional proof of marriage is required.**

Incapacitated Child - 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:

- New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment; **or**
- Existing member requests hospital medical coverage of the 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 they reach the limiting age of 26 as an incapacitated child. Once reaching the limiting age of 26, if the child cancels coverage, they cannot re-enroll. The following documents are required:

- Copy of Social Security card; **and**
- Incapacitated Dependent Certification Form including the Authorization for Disclosure of Protected Health Information. 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; **and**
- Proof of the required document(s) for one of the dependent categories as noted above to show the child is the member's biological child, adopted, or stepchild; **and** Medicare Card, if applicable

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

- Copy of Social Security card **and** Placement Authorization signed by a judge **or**
- Final Court Order with presiding judge's signature and seal

Pursuant to the federal healthcare reform mandates, a child under the age of 26 can be married or unmarried without conditions of residency, student status, or dependency. **PEEHIP is not required and will not provide coverage for a child of a child receiving dependent coverage.**

To ensure enrollment deadlines are met, you should submit your enrollment even if all documents are not available to you at the time of enrollment.

Resources to Obtain Documents

- **Birth certificates and marriage licenses:** www.cdc.gov/nchs/w2w.htm **(click on your state for details)**
- **Children born outside the United States:** www.travel.state.gov/passport/faq/faq_1741.html
- **Social Security cards:** www.ssa.gov
- **Immigration documents:** https://www.uscis.gov/forms/explore-my-options

HIPAA Special Enrollment Outside of Open Enrollment

(Active and Retired Members)

The Health Insurance Portability and Accountability Act (HIPAA) offers protections for workers and their families. The law provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events. HIPAA also prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information.

Special Enrollment Opportunities

What is Special Enrollment?

Special enrollment allows members who previously declined health coverage to enroll in coverage. Special enrollment rights arise regardless of a plan's Open Enrollment period.

There are two types of special enrollment – upon loss of eligibility for other health coverage and upon certain qualifying life events (QLE). For both types, the member must request enrollment within 45 days of the life event triggering the special enrollment.

1. Under the first, members and dependents who decline coverage due to having other health coverage have special enrollment rights when they experience a **loss of eligibility for other health coverage**. For instance, a member turns down enrollment in PEEHIP health coverage for themselves and their dependents because they have coverage through their spouse's plan. Coverage under their spouse's plan ceases. The member can then request enrollment in PEEHIP's health plan for themselves and their dependents. Proof of loss of eligibility must be provided for each person for which enrollment in PEEHIP coverage is requested. This special enrollment opportunity pertains to enrolling in a PEEHIP hospital medical plan. It does not create a special enrollment opportunity to enroll in the Optional Coverage Plans even if these were part of the coverage that was lost.
2. Under the second, members are permitted to special enroll a **newly acquired dependent** because of marriage, birth, adoption, placement for adoption, or legal custody. This special enrollment pertains to adding the newly acquired dependent(s) to any PEEHIP coverage in which the member is enrolled at the time they acquired the new dependent. **Tag-Along Rule:** When a newly acquired dependent becomes eligible for special enrollment, all eligible dependents can be added to the PEEHIP coverages at that time.

A special enrollment right also arises for members and their dependents who lose coverage under Medicaid, ALL Kids, or the state Children's Health Insurance Program (CHIP). The employee must request enrollment within 60 days of the loss of coverage. A member may also be able to add a child during the plan year due to a Qualified Child Medical Support Order.

How long does a member have to request special enrollment?

The request for enrollment must be made within 45 days after losing eligibility for coverage or after a marriage, birth, adoption, placement for adoption, or legal custody. The request for enrollment must be made within 60 days of the loss of coverage under the state Medicaid or CHIP program.

After a member requests special enrollment, how long will they wait until coverage begins?

Those taking advantage of special enrollment because of a loss of eligibility for other coverage begin coverage the day of the loss of other coverage. Those taking advantage of special enrollment because of marriage, birth, adoption, placement for adoption, or legal custody begin coverage the day of the event or the first day of the month following the event based on their selected effective date.

How does a member request special enrollment?

To request special enrollment, members must either enroll through MOS for applicable QLEs or complete and mail a New Enrollment and Status Change form to PEEHIP.

- When requesting special enrollment due to the **loss of eligibility for other health coverage**, in addition to submitting a New Enrollment and Status Change form, PEEHIP requires documentation demonstrating the loss of eligibility for other coverage, such as: a letter on company letterhead from the employer through which coverage was lost indicating the date coverage ended and reason for the loss of eligibility for coverage such as termination of employment, resignation, retirement with no insurance benefits, relocation outside the HMO's service area, or total exhaustion of COBRA coverage. Proof of loss of coverage must be submitted for each person who has lost coverage. If the loss of eligibility for other coverage is due to divorce or legal separation, in addition to the proof of loss of coverage, a copy of the divorce decree signed by a judge of competent jurisdiction must be submitted to PEEHIP. A member is eligible to cancel any of the Optional Coverage Plans when enrolling in a PEEHIP hospital medical plan due to a loss of eligibility for other coverage if they have been enrolled in the Optional Coverage Plans for at least one year. Refer to the **Dependent Eligibility Verification Required Documentation** section for more information.

- When requesting special enrollment of **a newly acquired dependent** due to marriage, birth, adoption, placement for adoption, or legal custody of a child, PEEHIP requires documentation of proof of the new dependent. The enrollment can be submitted online through MOS or by mailing a completed New Enrollment and Status Change form to PEEHIP.

To avoid missing enrollment deadlines, you should submit enrollment requests to PEEHIP even if you do not yet have all required documentation at the time of enrollment. Refer to the **Dependent Eligibility Verification Required Documentation** section for more information.

When Special Enrollment Rights Do NOT Apply

Several common scenarios are a frequent cause of confusion. An individual does NOT have a special enrollment right if the individual loses the other coverage for the following reasons:

- As a result of the individual's failure to pay premiums
- For cause, such as making a fraudulent claim
- If the individual was removed during another employer's Open Enrollment period
- If the individual stops paying for COBRA under a prior employer's plan before the maximum period of coverage is exhausted
- Voluntarily removing a dependent from another plan

Special Enrollments or QLE change requests must be submitted to PEEHIP within 45 days after the date of the QLE. If a newborn is not added within 45 days of the date of birth for coverage to be effective the date of birth, claims incurred at the time of birth will not be paid.

Qualifying Life Events (QLEs)	Add	Remove	Use MOS
Adoption of a child	✓		✓
Birth of a child *(not QLE to cancel coverage)*	✓		✓
Commencement of spouse/dependent employment		✓	
Death of spouse leaving member without coverage under their spouse's plan	✓		
Death of spouse or dependent		✓	
Divorce or annulment (Divorce Decree required)		✓	✓
Exhaustion of COBRA coverage	✓		
Leave of absence (LOA)		✓	
Legal custody of a child	✓		✓
Legal separation *(if results in member losing coverage under their spouse's health plan)*	✓	✓	
Loss of eligibility for other health coverage	✓		
Marriage of dependent child		✓	
Marriage of subscriber *(QLE to cancel when enrolling in new spouse's qualified health plan)* ** New spouse and/or stepchildren can be added online*	✓	✓	✓
Medicaid and/or Medicare entitlement		✓	
Member relocates outside the HMO's service area	✓		
Pregnancy of covered dependent child *(with physician documentation)*		✓	
Spouse's employer has different Open Enrollment period than PEEHIP		✓	
Spouse's employer discontinues insurance coverage completely or changes insurance carriers and no longer offers previous carrier (not just a change in benefits and premiums) **Does not apply to self-insured plans that only change insurance carriers*	✓		
Spouse's employment ends, as does eligibility under their employer's coverage *(e.g., due to layoff, employment strike, involuntary termination, voluntary resignation or voluntary change in employment)*	✓		
Total cessation of employer contributions	✓		

Canceling PEEHIP Hospital Medical Coverage Outside of Open Enrollment

Active Employees

PEEHIP participates in a cafeteria plan which allows active employees to pay their PEEHIP premiums with pre-tax dollars in accordance with the regulations of Section 125 of the Internal Revenue Code. When premiums are paid with pre-tax dollars, an employee cannot cancel PEEHIP hospital medical coverage or cancel a covered dependent's coverage outside of the annual Open Enrollment period unless the employee or their dependent experiences a QLE or change in personal status. The IRS defines what is considered a QLE. The following are examples of life events that would allow an active employee to cancel their PEEHIP hospital medical coverage outside of Open Enrollment. The cancellation request must be sent to PEEHIP within 45 days of the life event. Appropriate documentation must also be provided to PEEHIP to verify the event.

- Going on Family Medical Leave Act (FMLA) or Leave of Absence (LOA)
- Commencement of spouse or dependent employment
- Marriage (if enrolling in the new spouse's qualified health plan)
- Divorce
  - Ex-spouses and ex-stepchildren are not eligible dependents even if a member continues to pay for family coverage for other eligible dependents and regardless of what the divorce decree states. The ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of divorce and PEEHIP must receive a signed copy of the Divorce Decree. The member will be responsible for an ex-spouse's and ex-stepchildren's claims when they are not removed from coverage. An ex-spouse and ex-stepchildren are eligible for COBRA if the request to enroll in COBRA is made within 60 days of the cancellation of coverage. Refer to the **COBRA** section for details.
- Medicare/Medicaid entitlement
- Spouse's employer has a different Open Enrollment period than PEEHIP
  - Members can remove their spouse from their PEEHIP hospital medical coverage during their spouse's Open Enrollment if the plan year for the other employer group coverage does not coincide with the PEEHIP plan year. This option is available as long as the other employer health plan is a cafeteria plan or qualified benefits plan. This does NOT apply to Medicare's Open Enrollment.
  - Members can use this QLE prospectively at any time during the year at such point that their spouse elects coverage under their employer group health plan with a different plan year than the PEEHIP plan year. This new QLE not only creates a path to remove a spouse as a dependent, but also allows members the option to remove all family coverage and change to individual coverage or drop hospital medical coverage altogether outside of the PEEHIP Open Enrollment. Timely notification and documentation demonstrating the spouse's or dependent's eligibility for their employer group health plan must be provided to PEEHIP within 45 days from the effective date of the new plan year of their employer group health plan.
  - 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. Policies are only canceled effective on the first day of the month.

Retired Members

Retired members **do not** pay PEEHIP premiums with pre-tax dollars. A retiree can cancel their PEEHIP hospital medical coverage anytime during the plan year on a prospective basis. A signed New Enrollment and Status Change form must be sent to PEEHIP to cancel coverage. The coverage will be canceled the first day of the month following receipt of the New Enrollment and Status Change form. Optional Coverage Plans can only be canceled during Open Enrollment.

Spouse Becomes Independently Eligible for PEEHIP

A subscriber whose covered spouse becomes employed with a PEEHIP-participating employer and becomes independently eligible for PEEHIP can submit a request to PEEHIP to remove the spouse from their hospital medical plan effective the first of the month following the spouse's date of hire. For the newly eligible spouse to continue PEEHIP coverage in their own name, they will need to enroll through MOS within 30 days of their date of hire.

Dually eligible married members enrolled in separate PEEHIP hospital medical plans can cancel one of the individual plans and change the other to family while adding all eligible dependents due to acquiring a new dependent (for example, marriage, birth of a child, etc.). PEEHIP must receive both change requests within 45 days of the life event. Refer to the **Dependent Eligibility Verification Required Documentation** section for more information.

Dually eligible spouses enrolled in family hospital medical coverage will receive the lower premium calculation regardless of whether the active member or the retired member is the subscriber.

Example 1: A retired member is enrolled in family coverage. Their spouse is hired by a PEEHIP-participating employer and becomes eligible for PEEHIP. When the employer enters the active member into the Employer Self-Service portal, the retiree's family hospital medical premium will automatically be changed to the active member rate since it is the lower of the two calculations.

Example 2: Both spouses are actively employed. The spouse carrying the family hospital medical coverage retires. The retiree's family premium will remain the active member rate since it is the lower of the two calculations.

Employer Contributions

(Active Members)

An employer will pay an employer contribution to PEEHIP each month an active member is in pay status at least one-half of the working days of that month. This enables an active member to be eligible to receive PEEHIP coverage at the active member premium rates during each month the member is in pay status at least one-half of the working days of that month. An employee may be eligible to extend their PEEHIP coverage through COBRA during a month in which the employee is in pay status less than one-half of the working days of that month. Refer to the COBRA section for more information.

Example: An employee who works October 1 through November 6 is eligible to receive PEEHIP coverage for October but not for November, assuming there were more than 12 working days in November. (As set forth below, the employee may still be eligible to extend their PEEHIP coverage through COBRA.)

An employee may get paid for a portion of a month but may not be eligible to receive PEEHIP coverage for the remainder of that month if they are not in pay status at least one-half of the working days of that month.

To be eligible for full coverage under PEEHIP, a teacher, counselor, librarian, administrative employee, or other professional employee, must be employed full-time. A support worker, such as a janitorial staff employee, custodian, maintenance worker, lunchroom worker, or teacher aide, must be employed at least 20 hours per week (excluding bus drivers, who are full-time by law at 10 or more routes per week) to earn the full coverage. Permanent part-time employees who meet the required qualifications will be entitled to coverage on a pro rata basis as follows:

	Entitlement if Enrolled in Hospital Medical or HMO Plan	**Entitlement if Enrolled in Optional Coverage Plans**
Professional/Administrative Employee Works		
Less than ¼ time	0	0
At least ¼ time but < ½ time	¼ insurance coverage	1 Plan
At least ½ time but < ¾ time	½ insurance coverage	2 Plans
At least ¾ time but < Full-time	¾ insurance coverage	3 Plans
Full-time	Full coverage	4 Plans
	(Each additional optional plan can be purchased for $38/month or $50/month for the family dental plan.)	
Permanent Support Worker Works		
0 to 4.9 hours/week	0	0
5.0 to 9.9 hours/week	¼ insurance coverage	1 Plan
10.0 to 14.9 hours/week	½ insurance coverage	2 Plans
15.0 to 19.9 hours/week	¾ insurance coverage	3 Plans
20 or more hours/week	Full coverage	4 Plans
	(Each additional optional plan can be purchased for $38/month or $50/month for the family dental plan.)	

3-1 Rule

A member earns one month of additional insurance coverage for every three months the employee is in pay status at least one-half of the working days in the month for that school year. The 3-1 Rule only applies when an employee has terminated employment, retires, is not in pay status at least one-half of the working days of the month, goes on an approved leave of absence without pay, or begins employment in the middle of the year.

The 3-1 Rule is applied from August through August of the following year.

- Extra months of coverage earned by a member must be applied to insurance premiums immediately after the member is separated from employment.
- The member cannot pick and choose the months to use the coverage.
- An employee must be in pay status at least one-half of the available workdays for three full months to earn an extra one month of insurance coverage.
- An employee can only use the coverage month for the current fiscal year (i.e., the coverage cannot be used after August 31).
- The 3-1 Rule is handled in the same manner for all employees regardless of whether they are paid on a 9, 10, 11, or 12-month basis.
- If a terminated employee is hired back before they have exhausted their extra coverage months, the employee will not have a lapse in coverage, and the same insurance plans will automatically be reinstated. These employees are treated as existing employees and not considered to be new employees for insurance purposes; they will not be allowed to enroll in or cancel coverage except during the Open Enrollment period.
- Employees who terminate employment and have a break in coverage can enroll as new employees the day they return to work or during Open Enrollment for an October 1 effective date of coverage. PEEHIP must receive an online enrollment request.

Leave

A member can use their accrued or donated sick leave in order to be in pay status to remain eligible for PEEHIP coverage. However, sick leave, annual leave, or catastrophic leave cannot be manipulated in such a way that a member receives coverage inappropriately. **A member must use their accrued sick leave, annual leave, or catastrophic leave continuously and consecutively when not actively employed.**

Family Medical Leave Act (FMLA)

The 3-1 Rule applies even when a member is granted leave under the FMLA. If the employee earns additional months of coverage under the 3-1 Rule prior to going on leave under the FMLA, the extra months are applied following said leave.

Military Leave

If an employee is on military leave status, the employee earns credit for the insurance coverage which is paid by the PEEHIP plan. The employer will not be charged for the employer contribution when a member is on military leave status in the Employer Self-Service (ESS) Portal.

Terminated Employee

The school system is not required to pay the August employer contribution for an employee terminating the beginning of May when the employee has worked August through April. These employees are eligible to receive insurance coverage through July only.

Additional Information about Employer Contributions

- A contribution for the month will be due if a member is hired on the first day of the month.
- If an employee earned three employer contributions while working a contract that began before August 16 and ended after May 15, they will be eligible for coverage and contributions will be due for June, July, and August.
- A full August contribution is due if the member has had continuous coverage through the summer. A member who has paid a LOA rate or COBRA for July and returns to work a new contract effective after August 1 and works more than ½ days of August is eligible for coverage for the entire month of August.

Members Enrolled in a PEEHIP Hospital Medical Plan

Members who enroll in a PEEHIP hospital medical plan and any number of the Optional Coverage Plans must pay their respective premiums.

Members Not Enrolled in a PEEHIP Hospital Medical Plan

Members who do not enroll in a PEEHIP hospital medical plan can enroll in either the PEEHIP Supplemental Medical Plan or the Optional Coverage Plans at **no premium cost**. Refer to the appropriate section of this handbook for detailed information and limitations on these plans.

Transferring School Systems

When an employee transfers from one participating system to another without a break in coverage, the **new** system will be responsible for paying the contribution for the **first full month**, including when hired on the first of August, of the employee's contract and all additional months of coverage, thereafter.

Death

In the event of an employee's death, health insurance will cancel the first of the month following the employee's death. Extra employer contributions earned under the 3-1 Rule cannot be used by the employee's family in the event of the employee's death. The employee's covered dependents are eligible to enroll in coverage as surviving dependents.

Active Employees Not Enrolled in Coverage

Section 16-25A-5, *Code of Alabama, 1975*, requires the employer contribution to be paid for all employees eligible for insurance even if no coverage is elected.

Employers are not required to pay the pro rata employer contribution for a new employee if the employee does not enroll in insurance coverage effective as of their date of employment. However, Section 16-25A-9, *Code of Alabama, 1975*, requires the employer contribution to be paid for a full month of coverage even if the employee does not enroll in any coverage.

Example: A new employee begins work August 23 and does not enroll in coverage until October 1. PEEHIP would not require the system to pay the pro rata contribution for August if the employee does not elect coverage on his date of employment; however, PEEHIP would require the employer contribution amount for the full month of September.

Members who are not enrolled in any insurance coverage with PEEHIP can enroll in individual hospital medical coverage effective on the date of notification.

Retiring Members

Retiring members are eligible to receive the extra coverage months earned under the 3-1 Rule, and the employer is required to pay the appropriate employer contribution earned under the 3-1 Rule. Examples:

- A May 1 retiree who works 9 months during the school year may receive coverage through July 31. July is the last contribution the employer is required to pay.
- A June 1 retiree who works 9 months during the school year may receive coverage through August 31. August is the last contribution the employer is required to pay.
- A July 1 retiree who works the entire school year may receive coverage through August 31. August is the last contribution the employer is required to pay.

The 3-1 Rule is handled in the same manner for retirees as for active employees regardless of whether they are paid on a 9, 10, 11, or 12-month basis.

If a member and/or spouse is Medicare-eligible at the time of retirement, **the date of retirement is the date when Medicare becomes primary**, regardless of the 3-1 Rule. Medicare-eligible members and/or dependents must have both Medicare Parts A and B on their retirement date to have coverage with PEEHIP.

Medicare

If a member or dependent is already Medicare-eligible due to age or disability on their retirement date, Medicare will become the primary payer and PEEHIP the secondary payer **effective on the date of the member's retirement**.

It is important to know that Medicare-eligible retired members and Medicare-eligible dependents must be enrolled in Part A **and** Part B of Medicare to have coverage with PEEHIP's Group Medicare Advantage (PPO) Plan. If the Medicare-eligible member does not have both Part A and Part B, they will not be eligible for PEEHIP's Group Medicare Advantage (PPO) Plan, and they will not have hospital medical or prescription drug coverage with PEEHIP.

Medicare rules require a Medicare-eligible, active PEEHIP member covered as a dependent on their spouse's PEEHIP **retired** contract to have Medicare as the primary payer. In this scenario, the active, Medicare-eligible dependent must have both Medicare Part A and Part B coverage.

If the active member referenced above does not want Medicare as their primary payer and does not want to enroll in Medicare Part B until retirement, they will have to enroll in a PEEHIP active contract as the subscriber and will not be able to remain on the contract as a dependent with the retired PEEHIP eligible spouse. When the active Medicare-eligible member retires, they must enroll in both Medicare Part A and Part B to have coverage with PEEHIP. The effective date of both Medicare Part A and Part B must be effective no later than the date of retirement to avoid a lapse in coverage.

Refer to the **Health Insurance Policies for Retired Members** or the **Provision for Medicare-Eligible Active Members** sections of this handbook for more information regarding PEEHIP's Group Medicare Advantage (PPO) Plan.

PEEHIP Supplemental Medical Plan Group 61000

(Only for Active Members and Non-Medicare-Eligible Retired Members)

The PEEHIP Supplemental Medical Plan is administered by BCBS of Alabama and is designed to supplement other eligible primary medical and prescription coverage by paying for the out-of-pocket amounts charged by the other plan. To allow even greater flexibility to members who are enrolled in a non-Medicare PEEHIP hospital medical plan, those members can switch to the Supplemental Medical Plan prospectively at any point during the plan year.

General Information

- No monthly premium charge for an individual or family plan if the member is not enrolled in any other PEEHIP coverage
- Provides secondary coverage when eligible primary coverage is provided by another employer
- Supplements a primary insurance plan by covering the copayment, deductible, and/or coinsurance of a primary insurance plan or the preferred or participating allowance, whichever is less
- Spouses who are independently eligible for PEEHIP who are covered by the PEEHIP Supplemental Medical Plan and Optional Coverage Plan will not be charged a premium.
- Members are responsible for providing PEEHIP a copy of the current plan summary for the primary plan when enrolling in the PEEHIP Supplemental Medical Plan.
- **All PEEHIP Group #14000 exclusions and limitations such as precertification requirements, visit maximums, procedure limitations, age limits, etc., will apply in addition to the exclusions and limitations of the primary insurance coverage.**
- The PEEHIP Supplemental Medical Plan will not pay for amounts exceeding the allowed amount for services rendered by a non-preferred provider, amounts exceeding the maximums provided under the primary insurance plan, any services denied by the primary insurance plan, or any penalties or sanctions imposed by the primary insurance plan.
- **Members enrolled in High Deductible Health Plans (HDHP) are not eligible for the PEEHIP Supplemental Medical Plan.** The IRS defined the minimum deductibles for HDHPs as **$1,700** or more for individual and **$3,400** or more for family. *Members must provide a copy of their primary plan document for verification of the deductibles.*
- To be eligible for reimbursement under the PEEHIP Supplemental Medical Plan, the primary insurance plan must have either 1) applied the eligible charges to the deductible, or 2) made primary payment for the services rendered.
- The annual maximum amount paid from the PEEHIP Supplemental Medical Plan will be limited to **$9,200** for individual coverage and **$18,400** for family coverage for calendar year 2025 and **$10,150** for individual coverage and **$20,300** for family coverage for calendar year **2026**.
- Only active and non-Medicare-eligible retired members and covered dependents are eligible to enroll in the PEEHIP Supplemental Medical Plan.
- Members who are enrolled in the PEEHIP Hospital Medical Plan (Group 14000), VIVA Health Plan (offered through PEEHIP), Marketplace (Exchange) Plans, State Employees Insurance Board (SEIB), Local Government Health Insurance Board (LGHIB), Medicare, Medicaid, ALL Kids, Tricare, or Champus as their primary coverage, or are enrolled in a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA), **are not eligible to enroll** in the PEEHIP Supplemental Medical Plan.
- The PEEHIP Supplemental Medical Plan cannot be used as a supplement to Medicare (i.e., members cannot be enrolled in Medicare only). Upon becoming Medicare-eligible, members and their covered dependents will be canceled from this plan. Retired members who become eligible for Medicare will be eligible to enroll in the PEEHIP Group Medicare Advantage (PPO) Plan or the Optional Coverage Plans.

Optional Coverage Plans

(Administered by Southland Benefit Solutions)

Important Information

- Optional Coverage Plan enrollment must be retained for the entire plan year (October 1 – September 30). New members employed during the Open Enrollment period cannot enroll in the Optional Coverage Plans on their date of hire or first of the month following their date of hire and cancel the plans effective October 1 of that same year.
- Members enrolled in family Optional Coverage Plans cannot change to individual Optional Coverage Plans outside of the Open Enrollment period unless all dependents become ineligible due to age, death, or divorce.
- **If not enrolled in a PEEHIP hospital medical plan**, a full-time active member can enroll in four of the Optional Coverage Plans with no premium cost. A retired member can enroll in two Optional Coverage Plans with no premium cost and enroll in the other two at the applicable premium cost. If the active member or retired member enrolls in a PEEHIP hospital medical plan and any Optional Coverage Plan(s), they will **pay the applicable premium cost for all coverages**. (See **Premium Rates** for details).
- Members who have been enrolled in the Optional Coverage Plans for at least one year are eligible to cancel any of the Optional Coverage Plans when enrolling in a PEEHIP hospital medical plan due to the loss of eligibility for other coverage.
- Members cannot enroll in Optional Coverage Plans as a result of the loss of eligibility for other hospital medical coverage even if these plans were included in the coverage they lost.

Cancer Plan

- This plan covers cancer disease only.
- Benefits are provided regardless of other insurance.
- Benefits are paid directly to the insured unless assigned.
- Coverage provides $250 per day for the first 90 consecutive days of hospital confinement, $500 per day thereafter.
- Actual surgical charges are paid up to the amounts in the surgical schedule.
- The lifetime maximum benefit for radiation and chemotherapy coverage is $10,000. This benefit covers actual charges for cobalt therapy, x-ray therapy, or chemotherapy injections (excluding diagnostic tests).
- Benefits are also provided for Hospice care, anesthesia, blood and plasma, nursing services, attending physician, prosthetic devices, and ambulance trips.
- Limit of $5,000 per year for blood and plasma for leukemia.
- Added new surgical procedures to the care schedule.
- Plan will allow any physician-recommended observation period that is greater than 24 hours to qualify as an inpatient stay.

Hospital Indemnity Plan

- This plan provides a per-day benefit when the insured is confined to the hospital.
- The in-hospital benefit is $150 per day for individual coverage; $75 per day for family coverage.
- In-hospital benefits are limited to 365 days per covered accident or illness.
- Intensive care benefit is $300 per day for individual coverage; $150 per day for family coverage.
- Convalescent care benefit is $150 per day for individual coverage; $75 per day for family coverage.
- Convalescent care benefits are limited to a lifetime benefit of 90 days. This plan does not cover assisted living facilities.
- There is a supplemental accident coverage for $1,000. The reimbursement for an accident(s) is limited to a maximum of $1,000 per contract for each covered individual. There is no limit on the number of accident claims that can be filed per contract year.
- The plan will allow a physician-recommended observation period that is greater than 24 hours to qualify as an inpatient stay.

Dental Plan

- This plan covers diagnostic and preventative services, as well as basic and major dental services.
- Diagnostic and preventative services are not subject to a deductible and are covered at 100% (based on Alabama reasonable and customary charges). These services include oral examinations, teeth cleaning, fluoride applications for insured children up to age 19, space maintainers, x-rays, and emergency office visits.
- Routine cleaning visits are limited to two times per plan year.
- Basic and major services are covered at 80% for individual coverage and 60% for family coverage, with a $25 deductible for family coverage (based on the Usual Customary Rates (UCR) for Alabama). These services include fillings, general anesthetics, oral surgery not covered under a Group Medical Program, periodontics, endodontics, dentures, bridgework, and crowns. The family coverage deductible for basic and major services is applied per person, per plan year, with a maximum of three per family.
- All dental services are subject to a maximum of $1,250 per year for individual coverage and $1,000 per person per year for family coverage. Dental coverage does not cover pre-existing dentures or bridgework, nor does it provide orthodontia benefits.
- The dental coverage does not cover the replacement of natural teeth removed before a member's coverage is effective.
- This plan does not cover temporary partials, implants, or temporary crowns.
- The dental plan administered by Southland Benefit Solutions also offers a money-saving network program known as DentaNet. Under the DentaNet program, members can use network dentists but still have the freedom to use any dentist.
- Dental benefits under this plan will always be paid secondary to other dental plans.

Vision Care Plan

This plan provides coverage for:

- One examination in any 12-month period (actual charges up to $40)
- One new prescription or replacement prescription for lenses per plan year (up to $50 for individual vision, $75 for bifocals, $100 for trifocals, and $125 for Lenticular)
- One new prescription or replacement of contacts per plan year (up to $100 for contact lenses)
- Disposable contact lenses
- One new or replacement set of frames per plan year (up to $60)
- Either glasses or contacts, but not both, in any plan year
- Vision benefits under this plan will always be paid secondary to other vision plans.

Additional Savings Programs

All members who are enrolled in at least one of the four Optional Coverage Plans are eligible for the following savings programs at **no premium cost** to the member for individual or family coverage.

- Amplifon Hearing Health Care – Southland Benefit Solutions has teamed up with Amplifon Hearing Health Care to ensure healthy hearing for a lifetime. The Amplifon Benefit Program covers members and their extended family. On top of the 40% members save on hearing test and diagnostic services, Amplifon also guarantees the lowest price on over 2,300 hearing aids. They have partnered with the nation's leading brands, including Miracle-Ear and Phonak.
- There are 40+ clinic locations in Alabama to provide members and their family best-in-class hearing solutions. Members can get started with this completely **free program** and find a provider near them by calling Amplifon at 888.669.2177. An Amplifon Care Advocate will explain the process and help schedule an appointment. Amplifon will handle dealing with the provider to ensure that they will get their discount. For more information, visit www.amplifonusa.com/sbs.

Comparison of In-Network Benefits

(Active Members and Non-Medicare-Eligible Retired Members)

Effective October 1, 2025 – September 30, 2026

Refer to the *Summary of Benefits and Coverage* document on the PEEHIP website for a more comprehensive list of benefits, limitations, and exclusions.

(Changes are in bold)

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	**VIVA Health Plan (HMO) (Service area includes all 67 AL counties)**
Calendar Year Deductibles for Major Medical Services	$300 individual; $900 family maximum	$300 individual; $900 family maximum
Calendar Year Out-of-pocket Maximums	Covered members will pay no more than: **$10,150** individual and **$20,300** family for calendar year **2026**. Out-of-pocket maximums apply to in-network combined medical and prescription drugs during the calendar year.	Covered members will pay no more than: **$9,100** member and **$18,200** family for calendar year **2026**. Out-of-pocket maximums apply to in-network combined medical and prescription drugs during the calendar year.
Major Medical Services and Coinsurance	Once deductible is met, benefits are payable at 80% of the allowed amount. The member is responsible for the remaining 20% when using an in-network provider. There is a $400 per member out-of-pocket maximum for each calendar year. Other covered services are the only expenses applicable to the annual out-of-pocket maximum. Members are responsible for expenses above the allowed amount when using out-of-network.	The plan pays 80% of the allowed amount of covered expenses after member pays the $300 deductible.
Inpatient Facility Benefits		
Inpatient Hospital Services* (including maternity) Maternity benefits are not available to dependent children of any age.	Covered at 100% of the allowed amount for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries after $200 per admission deductible and $25 per day copay for days 2-5 (maximum copay of $300). Members are responsible for the difference in cost of a private and semi-private room and other non-medical items such as TV, phone, etc. *Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers® which can be found at www.alabamablue.com. All hospital admissions require preadmission certification (PAC). To obtain PAC, call 800.248.2342.	Covered in full after **$300** copay per admission and $50 per day for days 2-5 for semi-private room. Members are responsible for the difference between private and semi-private accommodations and other non-medical items such as TV, phone, etc. All inpatient admissions require authorization from VIVA Health prior to receiving services.

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	VIVA Health Plan (HMO) (Service area includes all 67 AL counties)
Inpatient Physical Rehabilitation	Covered at 100% of the allowed amount after a $200 per admission deductible and a $25 per day copay for days 2-5 (maximum copay of $300). Precertification is required. For precertification, call 800.248.2342.	Covered at 80% Limited to 60 inpatient days and 30 outpatient days per calendar year. Requires a referral from a Participating Physician and prior approval of the Medical Director.
Outpatient Facility Benefits		
Outpatient Surgery* (including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount after $150 facility copay *Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®	$150 copay per services performed at ambulatory surgical center; 90% coverage for services performed at other facilities
Outpatient Surgery and Anesthesia Physician Visits	Covered at 100% of the allowed amount; no copay or deductible	90% coverage after deductible is satisfied
Emergency Room Facility (Medical Emergency) In-Area/Out-of-Area	Covered at 100% of the allowed amount after $150 facility copay for true medical emergencies Covered at 80% of the allowed amount subject to the calendar year deductible if diagnosis does not meet medical emergency criteria	**$300** emergency room visit for facility; waived if admitted through ER
Emergency Room Facility (Accidental Injury) In-Area/Out-of-Area	Covered at 100% of the allowed amount after $150 facility copay	**$300** emergency room visit for facility; waived if admitted through ER
Outpatient Diagnostic Lab and Pathology	Covered at 100% of the allowed amount after $5 per test copay Certain testing requires precertification. For precertification, call 800.248.2342.	$7.50 per lab test at independent labs 90% coverage per test at hospital-based labs 80% coverage for x-rays and other diagnostics
Chemotherapy, Dialysis, IV Therapy and Radiation Therapy	Covered at 100% of the allowed amount after $25 facility copay Radiation therapy management services requires precertification. For precertification, call 866.803.8002.	80% coverage after deductible is satisfied
Outpatient Diagnostic X-ray	Covered at 100% of the allowed amount; no copay or deductible	90% coverage
Advanced Imaging (i.e., MRA, MRI, PET, CT and CTA)	Covered at 100% of the allowed amount; no copay or deductible Precertification required. If precertification is not obtained, no benefits will be payable under the plan. For precertification, call 866.803.8002.	90% coverage

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	VIVA Health Plan (HMO) (Service area includes all 67 AL counties)
Physician Benefits		
Inpatient Physician Visits and Consultations*	Covered in full *Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®	Covered in full
Surgeon	Covered in full	Covered in full
Anesthesiologist	Covered in full	Covered in full
Primary Care Physician Office Visit and Consultations	$30 copay per visit	$25 copay per visit
Specialist Office Visit and In-Person Consultations	$35 copay per visit	**$50** copay per visit; no referral required (medical physician and OB/GYN Services)
Teladoc®	$0 copay per consultation	$25 copay for primary/urgent care consultation $40 copayment for behavioral health consultation
Emergency Room Physician	Covered at 100% of the allowed amount after $35 copay per visit	Covered in full
Outpatient Surgery and Anesthesia	Covered at 100% of the allowed amount; no copay or deductible	Covered in full
Second Surgical Opinions	Covered at 100% of the allowed amount; no copay or deductible	Covered in full
Diagnostic Lab and Pathology	Covered at 100% of the allowed amount after $5 copay per test	$7.50 per lab test at independent labs 90% coverage per test at hospital-based labs 80% coverage for x-rays and other diagnostics
Advanced Imaging (i.e., MRA, MRI, PET, CT and CTA)	Covered at 100% of the allowed amount; no copay or deductible	90% coverage
Maternity Care	Covered at 100% of the allowed amount; no copay or deductible	**$50** copay per delivery
Preventative Services		
Preventive Medical	$0 copayment then covered in full	$0 copay then covered in full
Well Baby Care	Covered at 100% of the allowed amount; no copay or deductible, see www.alabamablue.com/preventiveservices.	$0 copay then covered in full
Routine Immunizations	$0 copay then covered in full	$0 copay then covered in full
Mental Health and Substance Abuse		
Inpatient Facility Services	Covered at 100% of the allowed amount subject to a $200 per admission deductible and a $25 per day copay for days 2-5 **(copays and inpatient hospital deductible can be less than but not greater than medical).** Precertification required.	Covered in full after **$300** copay per admission and $50 copay for days 2-5 Treatment at a residential facility is not a covered service. See the Certificate of Coverage for details.
Inpatient Physician Services	Covered at 100% of the allowed amount; no copay, **no visit limits**. Precertification required.	100% coverage

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	VIVA Health Plan (HMO) (Service area includes all 67 AL counties)
Outpatient Facility Services	Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) - $150 copay per treatment episode. Precertification required.	Covered in full after **$50** copay per visit
Outpatient Physician Services	Certified Community Mental Health Centers Covered at 100% of the allowed amount after $10 copay per visit. Blue Choice Behavioral Network Providers Covered at 100% of the allowed amount after $15 copay per visit, **no visit limits** For a list of in-network Blue Choice Behavioral Health Network providers, see www.alabamablue.com.	Covered in full after **$50** copay per visit
Residential Treatment Facilities	Covered at 100% of the allowed amount after **$200 per admission deductible and a $25 copay for days 2-5**. Precertification and approval through case management (NDBH) required.	Not covered
Other Covered Services		
Allergy Testing & Treatment	Covered at 80% of the allowed amount subject to calendar year deductible	**$50** copay per visit (physician) 80% coverage (testing and treatment)
Ambulance Service	Covered at 80% of the allowed amount subject to calendar year deductible	80% coverage; must be medically necessary
Participating Chiropractic Services	Covered at 80% of the allowed amount; no deductible Limited to 18 visits per calendar year. Additional services subject to precertification.	**$50** copay per visit Limited to 25 visits per calendar year
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount subject to calendar year deductible	80% coverage
Physical Therapy	Covered at 80% of the allowed amount subject to calendar year deductible; Maximum of 15 visits per person per calendar year. Precertification required to determine medical necessity for continued therapy. Autism not included in maximum.	80% coverage; limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay
Occupational Therapy	Covered at 80% of the allowed amount subject to calendar year deductible; Maximum of 15 visits per person per calendar year. Precertification required to determine medical necessity for continued therapy. Autism not included in maximum.	80% coverage; limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay
Speech Therapy	Covered at 80% of the allowed amount subject to calendar year deductible; Maximum of 30 visits per person per calendar year combined in and out-of-network. Precertification not required. Autism not included in maximum.	80% coverage; limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	VIVA Health Plan (HMO) (Service area includes all 67 AL counties)
Sleep Studies	Covered when rendered by a BCBS-approved sleep facility. Free-standing sleep clinic: $10 facility copay Hospital outpatient facility: $150 facility copay for adults and $10 copay for children 18 and under	**$50** copay per visit $150 copay per sleep study
Applied Behavioral Analysis (ABA) Therapy for Autism Spectrum Disorders	Covered at 100% of the allowed amount subject to $15 copay per visit, **no dollar limits** Preauthorization is required prior to rendering ABA therapy to determine medical necessity. Preauthorization is required every six months thereafter to determine medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied.	80% of the allowed amount subject to calendar year deductible; limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay. Member coinsurance is 20%
Preferred Home Health and Hospice	Covered at 100% of the allowed amount; no copay or deductible	Covered at 100% coverage; limited to 60 visits per calendar year
Home Infusion Services	Covered at 100% of the allowed amount; no copay or deductible	100% coverage
Infertility Testing and Treatment	Covered at 100% of the allowed amount; no copay or deductible. Limited to a lifetime maximum of eight artificial insemination attempts (whether successful or not). Benefits are not provided for IVF (in-vitro fertilization), ART or GIFT (gamete intrafallopian transfer). Drug benefits for medically necessary fertility drugs are covered at 50% copay for any fertility drug up to a lifetime maximum payment of $2,500 for PEEHIP per member contract. Members will pay 100% of the cost of the medications after the $2,500 lifetime maximum is reached. Benefits are not provided for IVF, ART, or GIFT.	Infertility Services – limited to initial consultation and one counseling session only. Infertility Testing – limited to semen analysis, HSG and endometrial biopsy (covered once during the member's lifetime). Infertility Treatment – not a covered service

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	VIVA Health Plan (HMO) (Service area includes all 67 AL counties)
Out-of-state Coverage for Non-PPO Provider	Covered at 80% of the allowed amount after member pays the $300 yearly deductible Major Medical benefits apply. When choosing a hospital or outpatient facility located outside Alabama, members may want to consider checking with the facility first to determine if they are a BCBS participating provider. Members have the freedom to choose their healthcare provider. To maximize their coverage and minimize out-of-pocket expenses, members should always use network providers for services covered by their health plan. Out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When choosing a network provider, members do not have to worry about extra out-of-pocket expenses.	Only Emergency and Urgent Care Services and Prescription Benefits available When choosing a hospital, outpatient facility, or provider, members should first check to see if they are a participating provider/facility with VIVA Health. The VIVA Health Plan gives members the freedom to choose their healthcare provider among VIVA Health's contracted providers/facilities. To maximize their coverage and minimize their out-of-expenses, members should always use network providers for services covered by their health plan. Out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When choosing a network provider, members do not have to worry about extra out-of-pocket expenses.
Out-of-state Coverage for PPO Provider	$30 copay per visit. Members must use providers participating in the BCBS plan of that state. The Blue Card PPO program offers "PMD-like" benefits when members access out-of-state providers if the physician or hospital is a participant in the local BCBS PPO program in that state. This program allows members to receive PMD benefits such as well-baby care, routine physicals, and routine mammograms when accessing out-of-state PPO providers.	Only Emergency and Urgent Care Services and Prescription Benefits available
Out-of-country Coverage	If medical treatment is received outside of the United States and the services are medically necessary, PEEHIP will pay primary under the major medical benefits. All PEEHIP deductible and coinsurance amounts, and contract limitations will apply. The claims must be stated in U.S. dollars and filed with BCBS of Alabama.	Limited to Emergency Services and Urgently Needed Services subject to the plan limitations. Applicable deductible, coinsurance, and co-payments will apply. The claim must be stated in U.S. dollars and remitted to VIVA Health for processing.
Excluded Services	Excluded services in the group #14000 hospital medical plan include but are not limited to nursing home costs, vision, and dental care (except accidental injuries), cosmetic surgery, hearing aids, and experimental procedures/therapy.	A detailed listing of plan exclusions can be found in the current plan year certificate of coverage.
Vision	Not Covered in the group #14000 hospital medical plan	Covered in full after **$50 copay** per visit; no PCP referral required One routine vision exam per calendar year. Other eye care office visits covered when medically necessary.

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	VIVA Health Plan (HMO) (Service area includes all 67 AL counties)
Dental	Not Covered in the group #14000 hospital medical plan	Administered by Delta Dental PPO® Plan Plan allows member to seek treatment from any licensed dentist. If treatment is provided by a non-PPO provider, members may be required to pay the difference between the billed rate and the allowed rate. Type I – Diagnostic/Preventive Services (ex. routine oral exams, cleaning, x-rays, etc.) Covered at 100% of Maximum Plan Allowance; no deductible Type II – Basic Services (ex. fillings, extractions, general anesthesia, etc.) Covered at 50% of Maximum Plan Allowance; deductible applies Type III – Major Services+ (ex. crowns, bridges, root canals, etc.) Covered at 25% of Maximum Plan Allowance; deductible applies Deductible: $50 per person/$150 per family Calendar Year Maximum: $750 per person Major Services: +12-month waiting period applies Time served on a prior carrier's dental plan with current employer may be credited toward the Delta Dental plan's waiting periods, subject to Underwriting approval. Refer to dental schedule of benefits for full benefit descriptions. For questions, call Delta Dental at 800.521.2651.

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)			VIVA Health Plan (HMO) (Service area includes all 67 AL counties)		
Prescription Drug Benefits (Participating Pharmacy Copays)						
Drug Type	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**	**30 Day Supply**	**Mail Order 90 Day Supply**	**Retail 90 Day Supply**
Generic	$ 6	$ 12	$ 12			
Preferred Generic				$ 5	$ 12	$ 15
Non- Preferred Generic				$ 20	$ 43	$ 60
Preferred Brand	$ 40	$ 80	$120	$ 60*	$150	$180
Non-Preferred Brand	$ 60	$120	$180	$ 80*	$200	$240
Specialty Drug	20% coinsurance with a minimum copay of$100 and a maximum copay of $150.	More than 30 day supply not permitted for specialty drugs.		70% coverage		
The Dispense as Written (DAW) cost differential applies for multi-source brand drugs with a generic chemical equivalent. *Administered by Express Scripts for BCBS PPO Plan.*				*When generic is available and brand name is chosen, member pays difference between generic and brand price plus applicable copay.		
Medication received through manufacturer samples, bridge programs, or free drug programs cannot be used to satisfy continuation of therapy requirements. Therefore, these programs cannot be used to circumvent requirements in prior authorization, medical necessity reviews, or other drug evaluation processes.						

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	VIVA Health Plan (HMO) (Service area includes all 67 AL counties)
	Contraceptives - $0 copay for generic; applicable copay for brand name Flu shot - $0 copay when administered by a participating retail pharmacy Maintenance Drugs – must be on approved maintenance drug list and be prescribed for 90-days; can refill after 75% of previous prescription has been used. Retail and Specialty Drug Refills – 30-day supply allowed only after 75% of previous prescription has been used. Opioid and Benzodiazepine Refills – allowed after 90% of previous prescription has been used. Refer to www.rsa-al.gov/peehip/pharmacy-benefits for the Formulary Drug List. Certain medications are subject to Step Therapy, Prior Authorization, and Quantity Level Limitations. The Step Therapy program applies to "new" prescriptions that have not been purchased within a certain time period. Step Therapy is organized in a series of "steps" with the member's doctor approving their medication every step of the way. Reference the Summary Plan Description at www.rsa-al.gov/peehip/publications/ for detailed information. Pharmacists shall dispense a generic equivalent medication when one is available unless the physician indicates in longhand writing on the prescription, indicates by mark or signature in the appropriate place on the prescription, or indicates in an electronic prescription, the following: "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(s), and shall be of the same dosage, form, and strength.	Contraceptives - $0 copay for generic; applicable copay for other generic and all brand name drugs. Maximum out-of-pocket is combined with the major medical out-of-pocket for a total combined out-of-pocket of **$9,100** per member and **$18,200** for family for calendar year **2025**. Some medications require prior authorization from VIVA Health. Biological, Biotechnical and Specialty Pharmaceuticals and Non-Preferred Drugs may be administered in the home, physician's office or on an outpatient basis. When received from Express Scripts, they must be ordered by calling 800.803.2523. Refer to www.vivaemployer.com/members/default.aspx for more information. Participating pharmacies only. No pharmacy benefits provided when using a non-participating pharmacy in Alabama.
	Copay Assistance Programs are available for certain drugs so the member copay will be less than the applicable copayment or reduced to zero.	

	PEEHIP Hospital Medical Plan (PPO) (Administered by BCBS)	VIVA Health Plan (HMO) (Service area includes all 67 AL counties)
	Certain medications available under the pharmacy and medical benefits have copays that may vary and be set to the maximum of available manufacturer-funded copay assistance programs. DAW Cost Differential – For multi-source brand drugs with a generic equivalent, the total amount covered by PEEHIP will not exceed the amount that would have been covered if the generic equivalent were dispensed. Members will be subject to the difference between cost of brand drug and its generic equivalent, regardless of whether physician indicates the brand must be taken. This does not apply to the Narrow Therapeutic Index (NTI) drugs such as seizure medications. Certain prescription drugs, medications, and over-the-counter (OTC) medications, OTC equivalent drugs, prescription version of OTC drugs, vitamins, food supplements, and medical foods are not covered even if prescribed by a physician unless mandated by the Affordable Care Act. Ingredients in a compound that are currently excluded from coverage in non-compound prescriptions, such as OTC medications are not covered. This applies to the non-Medicare commercial plan and the Medicare Part D plan. Out-of-pocket expenses will be higher when using a non-participating pharmacy (in-state or out-of-state). Members must pay the full amount of the prescription and then can file the claim to be reimbursed at the participating pharmacy rate. Members will pay the difference in cost plus appropriate copays. All PEEHIP copayments and clinical utilization management programs will apply. Certain prescription drugs and medications are excluded. To verify the formulary and coverage status of a medication, see www.express-scripts.com. Weight loss drugs are not covered. Mail order for Retail Drugs is not covered.	

Teleconsultation Benefits

(Active and Retired Members)

All PEEHIP members enrolled in the PEEHIP Hospital Medical Plan, VIVA Health Plan, or the PEEHIP Group Medicare Advantage (PPO) Plan have access to teleconsultation benefits as described below. This service can be used when considering going to the ER or urgent care center for non-emergency issues, when on vacation, or in the middle of the night.

	Hospital Medical Plans (Active and non-Medicare-Eligible Retired Members)		Medicare Advantage Plan (Medicare-Eligible Retired Members)	
	BCBS (PPO)	**VIVA Health (HMO)**	**UHC (PPO)**	**Humana**
Benefit	Teladoc®		Virtual Visits (administered by Amwell®, Doctors on Demand®, and Teladoc®)	MDLIVE
Availability	Nationwide 24/7/365; phone, web, and mobile app			
Video/Telephonic	Video and telephonic consults available		Video consults available via computer/smartphone/tablet; telephonic consults available	
Needed for Sign Up	Member ID card along with basic identifying information			
Cost	Medical: $0 Behavioral Health: N/A	Medical: $25 Behavioral Health: $40	Medical: $0 Behavioral Health: $0	
Website	www.teladoc.com/alabama	www.teladoc.com	retiree.uhc.com/peehip	your.humana.com/PEEHIP
Phone	855.477.4549	800.TELADOC (800.835.2632)	877.298.2341 Customer Service gives step-by-step instructions to access Virtual Visits via web or mobile app	800.747.0008
Apps	Apps available on App Store or Google Play			
Doctor Types	PCP, pediatricians, family medicine		PCP, pediatricians, family medicine, behavioral health	
Common Conditions Treated	cold, flu, allergies, bronchitis, UTI, respiratory infection, sinus, and more		cold, flu, allergies, bronchitis, UTI, respiratory infection, sinus, behavioral health, and more	

Coordination of Benefits (COB)

(Other Insurance Coverage)

Members and dependents are legally required to notify PEEHIP of other insurance under which they may be covered to ensure accurate claims processing in the correct payment order of primary and secondary. Members must notify PEEHIP when changes to other insurance coverage occurs. Changes can be submitted online through MOS or by submitting a Coordination of Benefits (COB) form to PEEHIP in a timely manner.

In cases where the member needs to inform PEEHIP of other insurance that was in effect during any time frame in which PEEHIP was also in effect for the member and/or dependent and the other insurance has canceled, information about that other coverage will still be required. Members must either submit information about that other coverage via MOS or submit a Coordination of Benefits (COB) form regarding their other coverage. **It is the member's responsibility to submit legal proof of cancellation (e.g., Certificate of Creditable Coverage or Proof of Prior Coverage letter) to PEEHIP so the coordination of benefits can be updated.** Documentation must show a cancellation date.

How to Update Other Insurance Coverage

- Online through MOS: From www.rsa-al.gov click Member Log In at the top left of the home page. Click PEEHIP Services then click Other and follow the on-screen prompts.
- Coordination of Benefits (COB) Form: Go to www.rsa-al.gov/peehip/forms/ and Other PEEHIP Forms to print a form.

Dental and Vision Plans

If a member or covered dependent is enrolled in the dental and/or vision plans provided by PEEHIP and is also entitled to any other dental or vision coverage, the total amount that is payable under all plans will not be more than 100% of the allowable expenses. PEEHIP will coordinate benefits with other dental and vision coverages.

PEEHIP dental and vision benefits will be secondary to all other dental and vision coverages for the subscriber. Dental and vision claims incurred and filed on the Southland Benefit Solutions Plan are always paid secondary to other dental and vision plans. Refer to the **PEEHIP Summary Plan Description** at www.rsa-al.gov/peehip/publications for more information on the COB rules.

Non-Duplication of Benefits

All PEEHIP members and covered dependents who use their PEEHIP hospital medical plan as their secondary coverage will be required to pay deductibles and copayments imposed by PEEHIP. PEEHIP will cover the portion of the health plan deductibles and copayments that exceed the PEEHIP copayments.

Wellness Programs

(Active Members and Non-Medicare-Eligible Retired Members)

PEEHIP offers the wellness program to all members and their covered spouses enrolled in the PEEHIP Blue Cross Blue Shield (BCBS) Group #14000 Hospital Medical Plan. The program is designed to encourage members and their covered spouse to take an active role in their healthcare by requesting that each get a wellness screening each plan year. Members and covered spouses can get one free wellness screening each year. Health coaching from BCBS of Alabama and their partners, Pack Health and Wondr Health, is also available on a voluntary basis for members that may need additional help in improving or maintaining their health.

Wellness Premium Waiver

Members and their covered spouses enrolled in the PEEHIP Hospital Medical Plan (Group #14000) will earn a waiver of the $50 monthly wellness premium by completing a wellness screening by August 31 each year. The waiver becomes effective at the start of the new plan year, October 1. There are no additional requirements to earn the monthly wellness premium waiver. Members and covered spouses can get a wellness screening through:

- An ADPH work site wellness clinic or county health department
- A BCBS in-network participating pharmacy
- A primary care physician or healthcare provider – *must complete a PEEHIP Healthcare Provider Screening Form*

Members and covered spouses who do not complete a wellness screening by August 31 will be charged the $50 monthly wellness premium beginning October 1. The wellness premium applies separately to members and spouses for a potential combined wellness premium of $100 per month. Dependent children are not required to get a wellness screening.

If you are unable to obtain a wellness screening due to pregnancy, disability, or other infirmity, you may be entitled to a reasonable accommodation or an alternative standard to receive the wellness premium waiver. Contact PEEHIP at 877.517.0020 for additional details.

Newly Enrolled PEEHIP Members

Newly enrolled PEEHIP members and covered spouses have the same August 31 due date as the existing PEEHIP members unless their new effective date of coverage occurs between June 2 and September 30. If their effective date of coverage falls within this period, their due date to complete their required activities will be August 31 of the following year rather than the year in which they enroll. No PEEHIP member will ever have less than 3 months to complete the wellness screening.

Screenings Submitted After the Deadline

Members and covered spouses can still get a wellness screening after the deadline for a prospective waiver through the end of the plan year in which they have been charged the wellness premium. The wellness premium waiver will be applied beginning the first day of the second month after ADPH receives the signed and completed PEEHIP Healthcare Provider Screening Form or after BCBS receives a completion notification from a participating pharmacy. Refunds will not be issued for wellness premium charges resulting from incomplete or late submissions.

View Your Wellness Completion Status

Your status toward earning your $50 monthly wellness premium waiver will be available on your MOS log in at https://mso.rsa-al.gov under the Wellness Completion Status link.

Wellness Screenings

Wellness screenings will measure biometric values, including:

- Blood pressure
- Total cholesterol (HDL and LDL)
- Blood glucose
- Height, weight, and body mass index (BMI)
- Triglycerides

In accordance with healthcare reform law, there is no required health standard which must be met. Members and covered spouses who receive their screening may be given an Office Visit Referral form to take to a physician's office to follow up with abnormal results or risk factors identified during the screening process. No copay is required if the Office Visit Referral form is submitted within 60 days from the screening date. The member should ask the physician's office to use the modifier code shown on the Office Visit Referral form to avoid the copay charge. Office Visit Referral forms are not required to be completed but are a further health benefit for PEEHIP members.

Work Site Screenings offered by ADPH

All PEEHIP members and covered spouses are eligible to receive one free annual wellness screening performed by the ADPH nurses at various work sites during the year, with the yearly restart date of August 1 to coincide with the start of each school year. Members and covered spouses will earn a waiver of the monthly wellness premium by completing a wellness screening by August 31 of each year. The ADPH online screening calendar is available at https://dph1.adph.state.al.us/publiccal2 to show when and where screenings will be offered. Participants will be required to show their BCBS card at the screening.

Pharmacy Biometric Screenings

Members and covered spouses can get their wellness screening performed at an in-network participating pharmacy to earn the monthly wellness premium waiver. Participants will need to schedule an appointment and bring a printed copy of the Pharmacy Biometric Screening Form and their BCBS card with them to the screening. The screening form and a list of participating pharmacies can be found at www.rsa-al.gov/peehip/wellness.

Healthcare Provider Screenings

Members and covered spouses also have the option to have their wellness screening performed by a primary care physician. To earn the wellness premium waiver, participants will need to have the physician complete a PEEHIP Healthcare Provider Screening Form. The screening form is located on the PEEHIP website at www.rsa-al.gov/peehip/wellness. The physician's office must complete and mail or fax the form to ADPH. The form must be signed by the participant and physician. Unsigned forms will be considered incomplete and may delay getting the monthly premium waiver. It is the participant's responsibility to make sure the information is complete and sent to ADPH by the August 31 deadline. A refund will not be given for failure to timely submit appropriate information by the deadline. Participants should keep a copy of the completed form for their records and track the completion status through their MOS account at https://mso.rsa-al.gov.

Under the Affordable Care Act (ACA), as part of the federal healthcare reform laws, no copay is required for one preventive routine office visit per calendar year obtained through an in-network healthcare provider. Wellness screenings obtained at a primary care physician's office are normally classified as a routine office visit and the routine lab tests for total cholesterol, triglycerides, and blood glucose are covered once per calendar year at no copay through an in-network lab. You will be responsible for the cost of other elected routine lab tests that are not a covered benefit under PEEHIP that are not necessary to complete the PEEHIP screening form. You will also be responsible for office visit claims that are denied due to multiple routine office visits filed in one calendar year. Remember, to earn the wellness premium waiver, only one wellness screening is required by August 31 each year.

Health Coaching

PEEHIP's health coaching offerings include coaching provided by BCBS, Pack Health, and Wondr Health. The range of coaching provided includes content and education aimed to help create healthier lifestyles, prevent disease, or help manage existing conditions.

Members will be sent an invitation to enroll at the start of each program. Because health coaching is such an extensive benefit, space is limited in these programs. Members and covered spouses are encouraged to sign up quickly to secure their spot. Participation in health coaching is strictly voluntary and is not required to earn the monthly wellness premium waiver. Dependent children, including adult dependent children, are not eligible to participate in health coaching.

Blue Cross Blue Shield, Pack Health, and Wondr Health

BCBS Disease Management programs focus on chronic health conditions that are sometimes debilitating but can be managed through early intervention, awareness of appropriate treatment, and lifestyle changes. Disease management is a service for members diagnosed with chronic conditions including diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease, and heart failure. The program uses the latest clinical guidelines, educational materials, and self-management support strategies to educate, coach, and empower members and caregivers. Contact BCBS directly at 888.841.5741 any time to enroll and get connected with a personal clinician to work with members one-on-one to help manage these long-term conditions.

Pack Health is a digital health coaching company that helps people manage their weight and prediabetes. Pack Health is here to help members improve their health with weekly lessons, coaching calls, and personalized text and email follow-up, including reminders and encouragement, informational videos, resource recommendations, discounts, personalized action plans, and care coordination services. Members will work one-on-one with a Health Advisor, online and over the phone, to overcome barriers and achieve their personal health goals. For more information or to speak to someone at Pack Health, please call 855.255.2362.

Wondr Health is an online program that teaches clinically proven health habits that lead to less stress, better sleep, and weight loss with no restrictive diets, calorie-counting, or specialty foods required. With Wondr Health, members learn to change when and how to eat, not what to eat, so they can improve their physical and mental health while still eating the foods they love.

While health coaching is not a required activity to earn the monthly wellness premium waiver, PEEHIP and its partners highly encourage members to take advantage of these benefits proven to improve the health of members who participate.

REACH Kidney Care is a health coaching company dedicated to kidney health management whose goal is to help members delay or avoid the need for dialysis. Participation is free for eligible members who are in chronic kidney disease (CKD) stages 3a or 3b with albuminuria levels greater than 300mg/g, or CKD stages 4 or 5. REACH matches you with a personal nurse care manager to review your prescribed plan of care to help you achieve your health goals. REACH has registered dietitians to assist with diet plans and a pharmacy team to work with your doctor to monitor medications and make drug recommendations. They also manage other chronic conditions, such as diabetes and heart disease.

Gaps in Care

BCBS continuously analyzes healthcare information to look for opportunities to recommend certain tests, medications, or treatments based upon the established best practice medical guidelines. These are called gaps in care. BCBS will notify members as well as their providers of any gaps in care that need to be considered to encourage the best healthcare for that member. These messages encourage members to first speak with their healthcare provider about the recommendation. Members are not required to close any gaps in coverage to earn the wellness premium waiver.

Baby Yourself® Program

Baby Yourself® is a maternity program administered by BCBS of Alabama for expectant mothers. This program is part of the PEEHIP Hospital Medical Plan and is available at no cost to the member. PEEHIP strongly encourages all expectant mothers covered under the plan and eligible for maternity benefits to sign up for Baby Yourself® today. Expectant mothers should sign up as soon as their pregnancy is confirmed. PEEHIP encourages members to sign up for the program with each pregnancy, even if they have already participated. Members who sign up will receive:

- Support from an experienced BCBS registered nurse
- Educational information by telephone and email during their pregnancy
- A free mobile app to track pregnancy and baby's development
- Useful gifts that encourage healthy habits, proper prenatal care, and help to understand the changes and challenges of pregnancy

PEEHIP will waive the $200 copayment for the delivery of their baby for members who enroll during the first trimester and complete the program. The $25 per day copayment for days 2 through 5 will apply (maximum of $100 copayment). PEEHIP is committed to helping members achieve their best health. The goal of Baby Yourself® is to have healthy mothers and babies at delivery. Members who are pregnant, please enroll today in Baby Yourself® by calling 800.222.4379 or registering online at www.alabamablue.com/babyyourself.

Non-Tobacco User Discount

All PEEHIP members and covered spouses enrolled in the PEEHIP Hospital Medical Plan or VIVA Health Plan are each charged a $50 monthly tobacco premium. The tobacco premium does not apply to the Optional Coverage Plans or the PEEHIP Supplemental Medical Plan. Members who do not use tobacco or electronic smoking devices can have the tobacco premium waived with a non-tobacco user discount by certifying under penalty of perjury that they and/or their covered spouse have not used tobacco products or electronic smoking devices within the last 12 consecutive months. Members are required to re-certify tobacco usage status for themselves and/or their covered spouses if there is a tobacco status change during the year, when members make changes to their coverage, and at the time of the wellness screening. **Members can certify their non-tobacco use either online through MOS at** https://mso.rsa-al.gov **or by submitting a completed New Enrollment and Status Change form**.

Non-tobacco user discounts are part of PEEHIP's automated premium invoice generation. These discounts are prospectively applied to member accounts effective the first day of the second month after PEEHIP receives certification that a member and/or covered spouse has been a non-tobacco user for the previous consecutive 12 months.

Tobacco Cessation Programs

Quitting tobacco is not easy. The ADPH offers a tobacco cessation program with live and online counseling to PEEHIP members who are ready to quit tobacco or e-cigarette use. For more information on how members can get started on a free, personalized plan from an experienced quit coach who can give them tips and support that increase their chances of quitting, call 800.Quit.Now (800.784.8669) or visit quitnowalabama.com.

Commitment to Participate in Tobacco Cessation Program

For members and/or covered spouses who do not qualify for the non-tobacco user discount due to their tobacco use within the past 12 months, eligibility for the discount can be obtained via completion of one of PEEHIP's tobacco cessation programs. Removal of the tobacco premium is not automatic upon completion of the program. By completing all necessary steps according to PEEHIP's policy and procedure, they may become eligible to receive the discount for either the entire plan year or prospectively from the time they complete the program through the end of the plan year.

Members can seek the premium discount from the beginning of the plan year by completing PEEHIP's Commitment to Participate in Tobacco Cessation form and returning it to the PEEHIP office with a postmarked date between October 1 and October 31 of the new plan year. This form is available at www.rsa-al.gov/peehip/forms/. Upon receipt of this form, PEEHIP will notate that you are in pending status for a tobacco cessation program.

If the participant completes the cessation program before the end of the plan year, the member must send their completion certificate to PEEHIP along with a signed letter requesting to have their tobacco premium removed based on their completion of the tobacco cessation program. The completion certificate and written request must have a postmarked date prior to the end of the plan year. If PEEHIP receives the required documentation by the time periods previously specified, the member will be eligible to receive reimbursement of the tobacco premiums paid for the participant since the beginning of the plan year. They will also receive a prospective tobacco premium discount through the end of the plan year.

If the member does not send a Commitment to Participate in Tobacco Cessation form to PEEHIP by October 31, they will not be eligible to receive the tobacco premium discount for the entire plan year. If they proceed to complete the tobacco cessation program prior to the end of the plan year, they will only be eligible to receive the premium discount prospectively from the time PEEHIP receives their tobacco cessation completion certificate and signed written request to have their tobacco premium removed. Their discount will expire at the end of the plan year. Additionally, a physician may recommend an alternative method for members and/or covered spouses to qualify for the tobacco premium discount if they are medically unable to stop using tobacco products for 12 consecutive months and/or participate in the tobacco cessation program.

Members and/or covered spouses who receive the discount by means of completing the PEEHIP tobacco cessation program are required to complete the program again each plan year to continue receiving their discount if they continue to use tobacco products. For members who utilize the tobacco cessation program and then become non-tobacco users for 12 consecutive months, the premium discount will be applied, and no further cessation program participation will be required if their status remains tobacco free and is certified through MOS or by completing a New Enrollment and Status Change form. If they would like to receive more information about the tobacco cessation program, they can contact the PEEHIP Wellness Program Manager toll-free at 877.517.0020.

New members who enroll in the PEEHIP Hospital Medical Plan or VIVA Health Plan must certify their tobacco status (and their spouse's tobacco status, if covered as a dependent) by answering the tobacco questions through MOS at the time of enrollment.

Premium Rates

(Active, Leave of Absence, and COBRA Members)

October 1, 2025 – September 30, 2026

The following insurance premiums are the base rates set by the PEEHIP Board. **Base rates are before the wellness and tobacco premiums are applied, if applicable.** Insurance premiums are calculated by PEEHIP, not by the employer. If a payroll deduction is in question, members should contact PEEHIP rather than their employer. Premiums are paid with pre-tax dollars and are excludable from federal and state income taxes under Sections 105(b) or 106 of the Internal Revenue Code for active employees. PEEHIP premiums are deducted in the month prior to the month of coverage (e.g., the premium for October's insurance coverage is deducted in September). FSA contributions are deducted in the current month (e.g., the contribution for October is deducted in October).

- Premiums and/or FSA contributions not payroll deducted at the proper time can be deducted from the member's next available paycheck.
- Those who do not receive a check large enough to cover the amount of their total premium shall submit their monthly premium payment directly to PEEHIP (i.e., new employee who has not begun receiving a paycheck, members on Leave of Absence (LOA) or COBRA.)
- Failure to pay premiums timely will result in a cancellation of coverage if the member is **not actively employed** by a PEEHIP employer. Otherwise, their account will be placed on **claim hold** if they are actively employed with a PEEHIP employer.

PEEHIP Hospital Medical Plan & VIVA Health Plan (Base Rate*)

Active Member

Individual	$ 30
Individual plus non-spouse dependents (no spouse)	$ 207*
Individual plus spouse only (no other dependents)	$ 282
Individual plus spouse plus other dependents	$ 307

Member on LOA/COBRA

Individual	$ 644
Family	$1,617

Spouses dually eligible for PEEHIP enrolled in family coverage qualify for this premium tier.

Tobacco Premium and Wellness Premium

	Tobacco	Wellness
Member	$ 50	$ 50
Spouse	$ 50	$ 50

Refer to the **Wellness Programs** section to learn how a member and/or their spouse can receive the non-tobacco user discount and wellness premium waiver.

Optional Coverage Plan Premiums

Cancer, Indemnity, and Vision	Individual or Family (cost per plan)	$ 38 (each)
Dental	Individual	$ 38
Dental	Family	$ 50

PEEHIP Supplemental Medical Plan

Active Member

Individual or Family	$ 0

Member on LOA/COBRA

Individual or Family	$ 198

Premium Assistance Program

(Active and Retired Members)

PEEHIP can provide some assistance to its members by giving a discount on hospital medical premiums based on (1) family size and (2) total combined household income. **Members must be enrolled in a PEEHIP hospital medical plan before applying for the Premium Assistance Program.** To apply for this discount, PEEHIP members must submit the Premium Assistance Application and furnish acceptable proof of total annual household income based on their current year filed Federal Income Tax Return.

Active and retired members may apply. The discount will be effective the first day of the second month after PEEHIP's receipt and approval of the application. The discount only applies to hospital medical premiums and is for the current plan year only. Members must **reapply** each plan year.

The discount does not apply to the tobacco premium, wellness premium, or the PEEHIP Supplemental Medical Plan, even if the member is also enrolled in the Optional Coverage Plans. The discount does not apply to members on Leave of Absence, COBRA, or a surviving dependent contract.

How to Apply for Premium Assistance

1. Estimate eligibility for the discount using the household income table below and on the Premium Assistance Application located online at www.rsa-al.gov/peehip/forms/.
2. Complete the Premium Assistance Application and send it to PEEHIP.
3. Provide a copy of the current year Federal Tax Return Transcript. Obtain a transcript by calling 800.908.9946 or visit https://www.irs.gov/individuals/get-transcript. The transcript should be received within 7-10 business days.

Reminders:

- Only one application can be submitted per plan year regardless of income change.
- Members must reapply every year during Open Enrollment, or their discount will expire on the upcoming October 1.
- Unacceptable documents are Record of Account, Account Transcript, and Wage and Earnings Transcript.
- Any Premium Assistance Application postmarked after the Open Enrollment period (July 1 – August 31) will be effective for the first day of the second month after the receipt and approval of the application.

Any information provided to PEEHIP is kept strictly confidential and in compliance with HIPAA regulations. A member's income and tax information will not be shared with any third party.

Discounts for Family Size and Household Income

Family Size	50% Discount for Incomes	40% Discount for Incomes	30% Discount for Incomes	20% Discount for Incomes	10% Discount for Incomes
1 member	0 - $15,650	$15,651-$23,474	$23,475-$31,299	$31,300-$39,124	$39,125-$46,950
2 members	0 - $21,150	$21,151-$31,724	$31,725-$42,299	$42,300-$52,874	$52,875-$63,450
3 members	0 - $26,650	$26,651-$39,974	$39,975-$53,299	$53,300-$66,624	$66,625-$79,950
4 members	0 - $32,150	$32,151-$48,224	$48,225-$64,299	$64,300-$80,374	$80,375-$96,450
5 members	0 - $37,650	$37,651-$56,474	$56,475-$75,299	$75,300-$94,124	$94,125-$112,950
6 members	0 - $43,150	$43,151-$64,724	$64,725-$86,299	$86,300-$107,874	$107,875-$129,450
7 members	0 - $48,650	$48,651-$72,974	$72,975-$97,299	$97,300-$121,624	$121,625-$145,950
8 members	0 - $54,150	$54,151-$81,224	$81,225-$108,299	$108,300-$135,374	$135,375-$162,450

Free Tax Help

- Free tax preparation assistance is available at https://www.irs.gov/individuals/free-tax-return-preparation-for-you-by-volunteers.
- Free tax preparation software is available at https://www.irs.gov/uac/free-file-do-your-federal-taxes-for-free.

How to Reapply

Discounts granted from the Premium Assistance Program are only effective until September 30 of each year. The premium discount does not renew each year. To continue a premium discount past September 30, a new Premium Assistance Application must be submitted and approved by PEEHIP. Any premium discount granted will only apply to hospital medical premiums. No discounts are granted to Optional Coverage Plan premiums, nor to the wellness premium or tobacco premium. Premium Assistance is only available for active and retired members, and it is not available to members on a Leave of Absence, COBRA, or surviving dependent contract. See below for more about when to re-apply.

Applications submitted during Open Enrollment: To receive an October 1 effective date of discount, applications must be received and approved during PEEHIP's Open Enrollment (July 1 – August 31). If a discount is approved during Open Enrollment, the discount will be effective for the entire new plan year beginning October 1 through September 30.

Applications submitted outside of Open Enrollment: If a member is granted a discount from an application received and approved outside of Open Enrollment, their discount will not be made effective until the first day of the second month after receipt and approval of their application. Any discount granted from their application will then remain in effect until the following September 30.

Premium Assistance Law

Section 16-25A-17.1, *Code of Alabama, 1975*

The annual income of an employee or retiree shall be aggregated with the annual income of the spouse of such employee or retiree and shall include all sources of income including, but not limited to, wages, pension benefits, and Social Security benefits, that may be included in gross income for purposes of federal income taxation. Applicants must submit with their application a copy of their federal tax return and, if the applicant did not file a joint return with their spouse, a copy of the spouse's federal tax return. Any reduction in an employee's or retiree's contribution pursuant to this section shall not be considered income of the employee or retiree for purposes of determining Medicaid eligibility for such employee or retiree.

Flexible Spending Accounts (FSA)

(Active Members Only)

FSA are available to all actively employed members of PEEHIP. An FSA is a tax-advantage plan that allows members to set aside a portion of their earnings to pay for eligible medical and day care expenses through monthly payroll deduction on a pretax basis. HealthEquity, through partnership with BCBS of Alabama, will process the PEEHIP flex claims and reimbursements and handle all FSA customer service issues.

For a complete summary of the PEEHIP Flexible Spending Account Plan, please visit www.rsa-al.gov/peehip/flex-account/.

The PEEHIP Flexible Benefits Plan consists of the following three programs:

1. Premium Conversion Plan requires all active members to pay premiums for PEEHIP using pre-tax dollars. This plan is strictly a function of the payroll system in which the member does not have to pay federal and state of Alabama income taxes on their health insurance premium.
2. Dependent Care Reimbursement Account (DCRA) allows active members to set aside up to a maximum of $5,000 in pre-tax contributions each year to pay for dependent day care expenses so the member (and spouse, if married) can work outside of the home or attend school full time. If the member and spouse file separate tax returns, the maximum contribution amount for each is $2,500. The minimum annual election to participate in this plan is $120.
3. Healthcare Flexible Spending Account (Health FSA) allows active members to set aside up to a maximum of **$3,300** of pre-tax contributions each year to pay for eligible healthcare expenses incurred by them and their dependents. The minimum annual election to participate in this plan is $120.

Listed below are some of the eligible expenses that can be paid from members' FSAs as defined by IRS Section 125:

DCRA:

- Licensed nursery school and day care facilities for children
- Childcare in or outside the home
- Summer day camp
- Day care for elderly or disabled dependents

Health FSA:

- Physician office copayments
- Prescription drug copayments
- Lab fees
- Dental copayments
- Orthodontia
- Deductibles
- Hearing care
- Vision care including Lasik and cataract surgery
- Chiropractors
- Medical equipment, such as blood pressure/glucose monitors, and CPAP devices
- Select over-the-counter drugs and medicines without a doctor's prescription
- Menstrual care products (such as tampons, pads, and liners)

More information is available at www.rsa-al.gov/peehip/flex-account/ and www.healthequity.com/peehip.

Flex Enrollment and Cancellation

The Open Enrollment period for the FSA begins July 1 and extends through September 30. Accounts become effective at the start of the plan year on October 1. **Participation in the PEEHIP FSA program automatically cancels at the end of the plan year.** Members must re-enroll every year to continue participation. Members can enroll online at https://mso.rsa-al.gov or complete a Flexible Spending Account Enrollment Application. Enrollment in a PEEHIP hospital medical plan or an Optional Coverage Plan is not required to participate in the PEEHIP DCRA or Health FSA plan.

New employees can enroll in the FSA within 30 days of their date of hire. Members who are currently enrolled in another FSA through their employer can enroll in the PEEHIP FSA at the end of their employer's plan year. Members who enroll in the PEEHIP FSA while also enrolled in another FSA should be mindful not to exceed the IRS yearly allowable maximum amount per taxpayer.

All FSA's cancel at the end of the plan year on September 30. Early cancellation or change in the elected amount before the end of the plan year is only permitted when a member has experienced a QLE. A Flexible Spending Account Status Change form must be submitted within 45 days of the QLE. If the member terminates employment or retires before the end of the plan year, the FSA will cancel the first day of the following month or when the member has exhausted their employer-paid insurance contributions. Any unused funds will remain in the account and will be forfeited by the member.

Elected Amount and Reimbursement

The member can only be reimbursed for eligible expenses outlined in the plan. Refunds are not permitted. Funds assigned to one account cannot be transferred to the other account under any circumstances. Members should carefully plan the annual amount they elect to contribute to each FSA. A Tax Savings Calculator is available at www.healthequity.com/peehip to assist in determining the contribution amount. The annual contribution amount selected is divided equally based on the number of remaining months in the plan year to determine the monthly contribution amount. Active members enrolling during Open Enrollment will have their annual amount divided by 12. Funds for reimbursement from the DCRA become available only after contributions have been withheld from the member's paycheck. Health FSA funds are available for reimbursement, up to the annual amount elected, as of the first effective day of the plan.

Flex Debit Card: All Health FSA enrollees will be issued a Flex Debit Visa Card to pay for qualified medical, prescription drug, dental, vision copays, and eligible healthcare expenses not covered by insurance. Members must save a copy of all receipts, invoices, and other documentation received in connection with using this card to provide to HealthEquity for substantiation, if requested. Failure to provide substantiation documentation upon request will result in card privileges being suspended, and a Refund Request Notice will be sent to the member asking for them to repay the amount of the unsubstantiated charges. Use of this card for Health FSA expenses is encouraged but not required. Enrollees choosing not to use this card for Health FSA expenses may request a reimbursement using the Manual Reimbursement method. This card cannot be used for DCRA expenses.

Manual Reimbursement: This method is available for the DCRA and Health FSA. The member must submit a Health FSA or DCRA Reimbursement Form along with an itemized receipt indicating the charges that were incurred. The request may be submitted online through the HealthEquity member portal, mobile app, fax, or mail. Reimbursement form. Recurring orthodontics and DCRA claims can be scheduled for the duration of the plan year.

Members should be sure to keep a copy of all receipts in the event additional information is needed to substantiate a reimbursement regardless of the reimbursement method selected.

Timely Filing Period Deadline

The FSA plan year ends September 30. Members have until January 15 to submit a Reimbursement form along with receipts for eligible expenses that were incurred during the plan year (October through September). No reimbursement will be allowed for funds remaining in the Health FSA or DCRA after the deadline of January 15. Remaining funds cannot be refunded and will be forfeited.

Carryover Provision *(Applicable to Health FSA Only)*

In accordance with IRS Notice 2013-71, modified by IRS Notice 2020-33, PEEHIP allows members to carry over up to **$660** of unused funds remaining in a Health FSA after the timely filing period to be used for eligible Health FSA expenses in the following plan year. The carry over funds do not affect the annual maximum contribution amount. The Carryover Provision will apply to all plan participants that are still in active status at the beginning of the following plan year. Any funds remaining in the Health FSA after the timely filing period has ended in excess of the maximum carry over limit will be forfeited. Members will have until the end of the new plan year to use the carry over funds on qualifying medical expenses. If a member terminates employment or goes on an unpaid leave of absence before the end of the plan year, carryover funds will be lost. Carryover funds may not be available for use until 30 days after the timely filing period has ended.

Retired Members

Retired members are not eligible to participate in the FSA since their premiums are not pre-taxed.

Leave of Absence (LOA) & Family Medical Leave Act (FMLA)

Leave of Absence (LOA)

The beginning date of the leave of absence should be the date any accrued leave is exhausted (sick leave, donated leave, annual leave, or personal days). The employer must enter the leave of absence status and beginning date in the ESS Portal when an employee is granted an official leave of absence. Upon return to work, employees who paid for their insurance while on an authorized LOA cannot pick up new insurance coverage that they did not have while on leave. (See **Exception** below.)

Employees who do not pay for their insurance while on an official LOA or have a break in coverage can enroll as new employees within 30 days and choose the effective date of the day they return to work, the first day of the month after they return to work or can enroll during Open Enrollment for an October 1 effective date.

PEEHIP must receive an enrollment request before the member can be enrolled. Employees who continue insurance coverage while on leave must wait until the Open Enrollment period to make insurance changes for an October 1 effective date. **Exception:** Employees enrolled in one or more Optional Coverage Plans while on LOA can add the remaining Optional Coverage Plans when they return to work and become eligible for a full employer contribution. Employees enrolled in one or more Optional Coverage Plans while on leave cannot enroll in a hospital medical plan until Open Enrollment.

When the employee returns to work, the employer must update the ESS Portal and enter the hire status as the date the LOA terminated.

Authorized Leave of Absence

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 that is approved by their employer before they 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.

When PEEHIP is notified of a qualifying event, PEEHIP will send written notification to the eligible member that they have the right to choose continuation of coverage. **It is important to note that the eligible member has 60 days from the date they would lose coverage because of one of the qualifying events to inform PEEHIP that they want continuation of coverage.**

If the eligible member does not choose continuation of coverage, their PEEHIP group health insurance coverage will end the last day of the month in which the member becomes ineligible. A dependent's coverage ends on the last day of the month in which the dependent becomes ineligible by turning age 26, by divorce, or legal separation.

If a member and/or dependent becomes entitled to Medicare after electing COBRA coverage, they are 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.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 requires employers to continue health benefits to employees taking FMLA leave.

Eligibility

Employees are eligible for leave under FMLA if they have worked 1,250 hours over the prior 12 months and if they have worked for a covered employer for at least one year. (Although bus drivers are classified as full-time, normally they do not work 1,250 hours.)

Conditions

- Leave earned under FMLA is for a maximum of 12 weeks, not 3 months.
- Employees must provide a 30-day notice for foreseeable leave. Leave under FMLA cannot be granted retroactively.
- Leave granted under FMLA cannot and should not be applied to the summer months for 9-month employees or during any time that the employee is not required to be at work. FMLA should begin when an employee is required to be at work.
- Employees on FMLA do accrue extra months of coverage while on leave under FMLA; the 3-1 Rule does apply while an employee is on FMLA. If extra months of coverage are earned for the summer months, the months should be applied to the end of the 12 weeks that were granted under FMLA.
- An employee cannot earn extra months of coverage under FMLA if he or she is retiring or not returning to work unless the reason for not returning to work is a serious health condition or circumstance beyond the control of the employee.
- The school system will collect premiums while the employee is on leave under FMLA and should collect premiums for any extra months earned under the 3-1 Rule.
- Employers must enter the FMLA status and beginning date in the ESS Portal when an employee is granted FMLA.
- Employers must enter the new status and FMLA ending date in the ESS Portal when the FMLA benefit ends.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires PEEHIP and most other group health plans to offer employees and their families who lose their health plan benefits 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.

An individual may have other options available to them when they lose group health coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, they may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, they may qualify for a 30-day special enrollment period for another group health plan for which they are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. For more information on the plans offered through the Marketplace, go to www.healthcare.gov or call 800.318.2596.

An individual who elects COBRA coverage will be eligible for Marketplace coverage during the annual Marketplace Open Enrollment upon experiencing an event that creates another Marketplace special enrollment opportunity, such as marriage or the birth of a child, or upon exhausting COBRA coverage. **In the absence of another special enrollment event, an individual who terminates COBRA coverage before the end of the maximum COBRA period will have to wait until Open Enrollment to enroll in Marketplace coverage. An individual who enrolls in Marketplace coverage relinquishes his or her COBRA rights.**

COBRA Compliance and PEEHIP Notification

The sanctions imposed under the auspices of COBRA can be quite severe, making a determination of compliance is 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 ESS Portal before the next payroll cycle. Employers must key the termination date in the ESS Portal for each employee who loses insurance coverage due to termination, resignation of employment, reduction in hours, or for an employee who does not earn the employer contribution, 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.

Termination for Gross Misconduct

If an employer terminates an employee for gross misconduct, 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 ESS Portal.

COBRA 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. A COBRA Enrollment Application can be requested from PEEHIP by phone or in writing.

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 they had prior to the qualifying event. If they are entitled to Medicare before they become a qualified beneficiary, they may elect COBRA continuation coverage; their Medicare coverage will be primary, and their COBRA continuation coverage will be secondary. They must have both Medicare Part A and B effective on the date of COBRA to be eligible for COBRA coverage with PEEHIP, and they will be enrolled in the PEEHIP Group Medicare Advantage (PPO) Plan that includes prescription drug coverage.

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 eligible for COBRA 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:

1. PEEHIP no longer provides group health coverage to any of its employees.
2. The premium for continuation of coverage is not paid by the member when payment is due, or the premium payment is insufficient.
3. The member becomes covered under another group health plan.
4. The member or dependent becomes entitled to Medicare after COBRA benefits begin.
5. The member becomes divorced from a covered employee 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.

Under COBRA, members are required to pay the full COBRA monthly premium for continuation of coverage.

If a member who is on COBRA dies before the 18 months have 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, they have 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 an eligible child under the Plan

Members on COBRA Who Return to Work

Members who terminate and have a break in coverage and/or continue coverage through COBRA and return to work for a PEEHIP participating employer have 30 days from the date they return to work to enroll in new coverage effective their date of hire (date returned to work) or first of the month following the date they return to work. Otherwise, they can enroll during Open Enrollment for an October 1 effective date. To enroll, PEEHIP must receive an online enrollment request or a completed New Enrollment and Status Change form. Members can only change or cancel existing coverage during the Open Enrollment period.

COBRA Extension for Covered Members Who Have Become Disabled

In certain circumstances, COBRA can be extended for covered members who become disabled. If a covered member becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act during the first 60 days after the employee's termination of employment or reduction in hours, the 18-month period may be extended to 29 months or the date the disabled individual 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 this disability extension to apply, members must notify the PEEHIP office of Social Security's determination within 60 days after the date of the determination and before the expiration of the 18-month period. They must also notify PEEHIP within 30 days of any revocation of Social Security disability benefits.

The cost for COBRA coverage after the 18th month will be 150% of the full COBRA cost of coverage under the plan if the disabled individual 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 spouses 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. The 36-month period will run from the original date of the termination of employment or reduction in hours.

For the disability extension of COBRA coverage to apply, members must give the PEEHIP office timely notice of the Social Security Administration's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the latter 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.

The member or another person on their behalf must also notify PEEHIP within 30 days of any revocation of Social Security disability benefits.

Provision for Medicare-Eligible Active Members

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 their 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 an active employee 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, and home health services.) This means that the plan will pay the covered claims and those of the active employee'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 active employee's spouse is not eligible for Medicare and has no other coverage, the PEEHIP 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, an active employee aged 65 or older may decide to defer enrolling for Part B until they actually reach retirement, at which point Medicare will become the primary payer and the retired member must enroll in Medicare Part B effective the date of retirement to have coverage with PEEHIP. However, a member and their Medicare-eligible spouse can enroll in Medicare Part B only during certain times allowed by Medicare. **Medicare-eligible members must contact their local Social Security office at least two months prior to retiring to enroll in both Medicare Part A and Part B so that the Medicare Part A and Part B coverage is effective no later than the date of retirement of the policyholder.**

The Social Security Administration handles Medicare enrollments. If a member has questions about when to enroll in Medicare Part B, they should contact the Social Security Administration at 800.772.1213. A Medicare-eligible retired member and/or spouse must have both Medicare Part A and Part B to have coverage with PEEHIP. **If they do not have both Medicare Part A and Part B, you will not be eligible for the PEEHIP Group Medicare Advantage (PPO) Plan, and they will not have hospital medical or prescription drug coverage with PEEHIP.**

Working after Medicare-Eligible

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

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

Medicare rules require a Medicare-eligible, active PEEHIP member covered as a dependent on their spouse's PEEHIP **retired** contract to have Medicare as the primary payer. **In this scenario, the active, Medicare-eligible dependent must have both Medicare Part A and Part B coverage.**

If the active member referenced above does not want Medicare as their primary payer and does not want to enroll in Medicare Part B until retirement, they will have to enroll in a PEEHIP active contract as the subscriber and will not be able to remain on the contract as a dependent with the retired PEEHIP eligible spouse. When the active Medicare-eligible member retires, **they must enroll in both Medicare Part A and Part B to have coverage with PEEHIP**. The effective date of both Medicare Part A and Part B must be effective no later than the date of retirement to avoid a lapse in coverage.

Other Medicare Rules

Individuals with Disabilities - If a member or their spouse is eligible for Medicare due to disability and also covered under the plan by virtue of their current employment status with the employer, the plan will be primary, and Medicare will be secondary. **If they are retired, they must be enrolled in both Medicare Part A and Part B to be eligible for the PEEHIP Group Medicare Advantage (PPO) Plan. If they do not have Medicare Part A and Part B, they will not have hospital medical or prescription drug coverage with PEEHIP.**

End-Stage Renal Disease - If members 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.

Members can contact PEEHIP for further information or with questions about coordination of coverage with Medicare. 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.

Health Insurance Policies for Retired Members

A **retired member** is any person receiving a monthly benefit from the TRS who at the time of their retirement was employed by a public institution of education within the state of Alabama which provided instruction at any combination of grades K through 14, exclusively, under the auspices of the State Board of Education or pursuant to Section 16-25A-11. Any person receiving a monthly benefit from the TRS who at the time of their retirement was employed by a state-supported postsecondary institution and any person receiving a monthly benefit from the ERS whose retirement under the ERS was from a local board of education or a state-supported postsecondary institution who participated pursuant to Section 36-27-6.

TRS Application for Service Retirement

To file for retirement benefits, members must complete a TRS Application for Service Retirement. The law provides that an application for retirement must be filed with the TRS Board of Control no less than 30 days and no more than 90 days before the first of the month in which retirement is to be effective.

Members must complete the PEEHIP Insurance Authorization page of the TRS Application for Service Retirement to authorize continuation of or cancellation from PEEHIP coverage. This section cannot be used as a PEEHIP enrollment form. If members are enrolled in a PEEHIP hospital medical plan and one or more Optional Coverage Plans, they cannot drop the Optional Coverage Plans until the Open Enrollment period.

Retired members are eligible for two of the Optional Coverage Plans without a payroll deduction if not enrolled in any other PEEHIP coverage as a subscriber or dependent. Members must indicate which Optional Coverage Plans they want to keep on their date of retirement.

Members Retiring from a Non-Participating System

Members who retire from a non-participating system are eligible to enroll in the PEEHIP Hospital Medical Plan or the PEEHIP Supplemental Medical Plan on the date of retirement. Members who are not enrolled in a hospital medical plan with their non-participating system, or only had individual coverage, can only enroll in individual hospital medical coverage on the date of retirement and must wait until the Open Enrollment period to add family coverage. The non-participating system is required to certify if the member had a hospital medical plan and whether the plan was for individual or family coverage.

Vested Members Not Currently Enrolled

Members who are retiring that have had a break in their employment and retire outside of the Open Enrollment period (vested retiree) can only enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Medical Plan and not the Optional Coverage Plans on their date of retirement.

Vested members may only enroll in individual coverage effective date of retirement and may add family coverage during Open Enrollment.

Vested members who are retiring can wait to enroll in the PEEHIP Hospital Medical Plan during Open Enrollment and can enroll in the Optional Coverage Plans for an effective date of October 1.

Members Retiring from a Participating System

Members who are retiring from a participating system that were enrolled in the four Optional Coverage Plans on their date of retirement can continue coverage under all four Optional Coverage Plans or can reduce coverage to two plans on their date of retirement. Members cannot reduce to three Optional Coverage Plans outside of Open Enrollment.

Members who are enrolled in the PEEHIP Hospital Medical Plan and one or more Optional Coverage Plans cannot drop the Optional Coverage Plans until the Open Enrollment period. Also, a member cannot add Optional Coverage Plans on the date of retirement. Retired members are eligible for two of the Optional Coverage Plans without a payroll deduction if not enrolled in any other PEEHIP coverage as a subscriber or dependent.

Members who are retiring from a participating system and are only enrolled in the Optional Coverage Plans on their date of retirement cannot enroll in a PEEHIP hospital medical plan until the Open Enrollment period.

Example 1: Mr. Smith retired from Jefferson County school system on January 1. Mr. Smith was enrolled in the four individual Optional Coverage Plans on his date of retirement. Mr. Smith can drop two of the Optional Coverage Plans on January 1, or Mr. Smith can retain all four Optional Coverage Plans and pay the applicable premium for the Optional Coverage Plans. Mr. Smith cannot add the PEEHIP Hospital Medical Plan, nor is he allowed to drop only one Optional Coverage Plan until the Open Enrollment period.

Example 2: Mrs. Scott retired from the University of Alabama (a non-participating system) on January 1. Mrs. Scott was enrolled in the BCBS health insurance plan with the University of Alabama. Therefore, Mrs. Scott can enroll in the PEEHIP Hospital Medical Plan on January 1. If Mrs. Scott was enrolled in the family BCBS plan with the University of Alabama, Mrs. Scott could add her dependents. However, if Mrs. Scott only had the individual BCBS plan, Mrs. Scott could not enroll her family in the PEEHIP Hospital Medical Plan until the Open Enrollment period or if there is another IRS qualifying life event.

Example 3: When Mrs. Sellers was age 55, she terminated her employment with Auburn University with 11 years of service. When she turned age 60, she began drawing a retirement check and became eligible for the PEEHIP Hospital Medical Plan. Mrs. Sellers is eligible to enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Medical Plan effective the date of her retirement or she could wait until the Open Enrollment period. Mrs. Sellers must wait until the Open Enrollment period to enroll in any of the Optional Coverage Plans.

Medicare-Eligible Retired Members and Medicare-Eligible Dependents

If a member and/or their dependent(s) are Medicare-eligible due to disability or age, the member and/or their dependent(s) are required to be enrolled in both Medicare Part A and Part B effective on the member's date of retirement to be eligible for the PEEHIP Group Medicare Advantage (PPO) Plan. If the member and/or their dependent(s) are not enrolled in both Medicare Part A and Part B on the member's date of retirement, the member and/or their dependent(s) will not be eligible for the PEEHIP Group Medicare Advantage (PPO) Plan, and they will not have hospital medical or prescription drug coverage with PEEHIP.

It is extremely important for the Medicare-eligible member and/or dependent to have Medicare Part A and Part B to assure coverage with PEEHIP. In addition, the member should notify Medicare of their retirement date and request Medicare to change their records to reflect that Medicare should be the primary payer on the member's date of retirement. Medicare-eligible members and Medicare-eligible dependents who are covered on a retiree contract will be automatically enrolled in the PEEHIP UnitedHealthcare® or Humana Group Medicare Advantage (PPO) Plan. **It is important to know that Medicare-eligible retired members and Medicare-eligible covered dependents must be enrolled in both Part A and Part B of Medicare to have coverage with the PEEHIP UnitedHealthcare® Group Medicare Advantage (PPO) Plan (or Humana as of January 1, 2026).** For more information, please contact UnitedHealthcare® by calling 877.298.2341 **(or Humana after January 1, 2026, at 800.747.0008)**.

Members Who Want Medical Coverage Only

Members who have TRICARE or a different Medicare Part D Group Prescription Drug plan or other creditable* prescription drug coverage and want to keep that coverage for their prescription drugs can choose to opt-out of the PEEHIP prescription drug coverage and keep the UnitedHealthcare® (or Humana as of January 1, 2026) that only includes hospital medical coverage.

Creditable prescription drug coverage means that it is at least as good as what Medicare Part D offers. If a member is unsure whether their prescription drug coverage, outside of PEEHIP, is creditable, they can contact the prescription drug plan's administrator.

Members will receive an ID card from UnitedHealthcare® (and Humana as of January 1, 2026) to use for their hospital medical services. Members are responsible for any premium and drug costs associated with their separate prescription drug plan. This coverage is outside of what is offered by PEEHIP.

Important Reminders

- Members who choose to opt-out of the PEEHIP UnitedHealthcare® or Humana prescription drug coverage and enroll in the PEEHIP UnitedHealthcare® or Humana Group Medicare Advantage (PPO) Plan with hospital medical only, should make sure they continue their TRICARE or other creditable prescription drug coverage. If they do not have continuous prescription drug coverage, they could risk paying a penalty should they choose later to join a plan that has Medicare prescription drug coverage.
- Medicare only allows an individual to be enrolled in one Medicare Part D prescription drug plan at a time either as a separate (stand-alone) prescription drug plan or included as part of a Medicare Advantage Plan. The plan they enroll in last is the plan that Medicare considers to be their final choice. So if a member enrolls in the PEEHIP UnitedHealthcare® (or Humana as of January 1, 2026) Group Medicare Advantage (PPO) Plan that already includes prescription drug coverage and then enrolls in an individual Medicare Part D prescription drug plan, Medicare will automatically disenroll them from PEEHIP UnitedHealthcare® or Humana Group Medicare Advantage (PPO) Plan and they will lose their hospital medical and prescription drug coverage.

Non-Medicare-Eligible Dependents

A Medicare-eligible retired member's spouse and/or other covered dependents who are not Medicare-eligible will remain enrolled in the (non-Medicare) PEEHIP Hospital Medical Plan (BCBS) with prescription drug coverage.

Insurance Coverage Periods and Employer Contributions

Retiring members are eligible to receive PEEHIP coverage at the active member rate under the 3-1 Rule. For example:

- A May 1 retiree who works 9 months during the school year will receive PEEHIP coverage at the active member rate through July 31.
- A June 1 retiree who works 9 months during the school year will receive PEEHIP coverage at the active member rate through August 31.
- A July 1 retiree who works the entire school year will receive PEEHIP coverage at the active member rate through August 31.

The school system will continue to provide the appropriate employer contribution earned under the 3-1 Rule. **However, the member must have both Medicare Part A and Medicare Part B effective the date of retirement.** The PEEHIP office assumes that the employer will not pay the August contribution for the May 1 retirees.

A retiring member will be charged an active member rate for the extra coverage months, but if the retired rate is lower, the retiring member may contact the PEEHIP office to request a refund of the difference.

Retiree Other Employer Group Health Insurance Coverage

Legislation requires certain members who retired after September 30, 2005, to take other employer health insurance if they:

1. become employed by another employer who provides at least 50% of the cost of individual health insurance coverage, **and**
2. are eligible to receive the other employer group health insurance coverage.

PEEHIP retirees will be canceled from the PEEHIP coverage once they are enrolled in the new health plan through their new employer. The retiree may enroll in the PEEHIP Supplemental Medical Plan within 30 days of eligibility for other group health insurance coverage if they are not Medicare-eligible. Failure by a retiree to enroll in the other employer's group health plan under the terms of the Act will result in the termination of coverage in PEEHIP. Retired members who retired on or after October 1, 2005, and are ineligible for the PEEHIP coverage can be covered as a dependent on their spouse's PEEHIP plan.

Example: John and Jane are retired spouses who both have individual coverage with PEEHIP. John goes to work for a non-PEEHIP eligible employer and becomes eligible for the new employer's Group Health Plan (GHP). John chooses not to enroll in the new employer's GHP and wants to be covered by Jane's PEEHIP plan. John can be added to Jane's PEEHIP plan within 45 days of the eligibility of the new employer's coverage.

PEEHIP requires all retired members to complete a Retiree Employment Verification form.

PEEHIP Coverage for Medicare-Eligible Retired Members

Retired members 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 their Medicare coverage. Medicare will be the primary payer and PEEHIP will be the secondary payer for retirees and dependents eligible for Medicare. PEEHIP remains primary for retirees until the retiree is Medicare-eligible. A Medicare-eligible retiree and/or Medicare-eligible spouse must have both Medicare Part A and Part B to have coverage with PEEHIP. Medicare-eligible members and dependents should not enroll in a separate Medicare Part D program if they are enrolled in the PEEHIP Group Medicare Advantage (PPO) Plan.

UnitedHealthcare® Medicare Advantage Prescription Drug Plan (or Humana as of January 1, 2026)

The administrator of the Medicare Advantage Plan is UnitedHealthcare® (or Humana as of January 1, 2026). The plan is fully insured, and members can have their Medicare Part A (hospital insurance), Part B (medical insurance), and Part D (prescription drug coverage) in one convenient plan. It is important to know that Medicare-eligible retired members and Medicare-eligible covered dependents must be enrolled in Part A and Part B of Medicare to have coverage with the PEEHIP UnitedHealthcare® Group Medicare Advantage (PPO) Plan (or Humana as of January 1, 2026).

Some other advantages regarding the PEEHIP UnitedHealthcare® Group Medicare Advantage (PPO) Plan (or Humana as of January 1, 2026) include national coverage, so PEEHIP retirees and covered dependents are covered anywhere in the United States; worldwide emergency coverage; and additional benefits such as the Renew Active (or Humana's SilverSneakers® as of January 1, 2026) fitness program, health risk assessments, screening exams, immunization reminders, and discounts on hearing aids. For more information please contact UnitedHealthcare® by calling 877.298.2341 (or Humana after January 1, 2026, at 800.747.0008.).

Plan Costs	In-Network	Out-of-Network
Annual Part B medical deductible	Your plan has an annual Medicare Part B combined in-network and out-of-network medical deductible each plan year. For calendar year **2026**, the deductible is **$257**.	

Medical Benefits	In-Network	Out-of-Network
Doctor's office visit	Primary Care Physician copay: $13 Specialist copay: $18	Same as in-network
Inpatient hospital care	$200 copay per day: day 1 $25 copay per day: days 2-5 $0 copay per day after that	Same as in-network
Lab services	$0 copay	Same as in-network
Outpatient X-rays	$0 copay	Same as in-network
Ambulance	$0 copay	Same as in-network
Emergency room	$35 copay (worldwide)	Same as in-network
Apps available on App Store or Google Play	Medical copay: $0 Behavioral Health copay: $0 Speak to specific doctors using a computer or mobile device. Find participating doctors online for UnitedHealthcare® at retiree.uhc.com/peehip, or your.humana.com/PEEHIP for Humana after January 1, 2026	Same as in-network

If a member or dependent is under age 65 and eligible for Medicare coverage due to a disability, the PEEHIP office must receive a copy of the Medicare card before the premiums can be reduced. Refunds will not be processed for retroactive premiums. Medicare-eligible members and dependents must have both Medicare Part A and Part B to have coverage with PEEHIP.

Retiree Premium Rates

The following hospital medical premiums are the base rates set by the PEEHIP Board. Base rates are before the wellness premiums, tobacco premiums, and the retiree sliding scale adjustments are applied, if applicable.

Premiums not payroll deducted at the proper time will be deducted from the member's next available retirement benefit. Members who do not receive a benefit large enough to cover the amount of their total premium shall submit their monthly premium payment directly to PEEHIP (example: retiree whose premium exceeds their retirement benefit). Failure to pay premiums timely will result in a cancellation of coverage.

The monthly premiums for members who retired prior to October 1, 2005, or members who retired on or after October 1, 2005, and before January 1, 2012, with 25 years of service are listed in the chart below.

In the chart below, NME designates "non-Medicare-eligible" and ME designates "Medicare-eligible."

Coverage Type	Premium if Retiree Subscriber is NME	Premium if Retiree Subscriber is ME
Individual Coverage	$210	$ 25
Family Coverage:		
NME dependent(s) but no spouse	$465	$280
NME dependent(s) and NME spouse	$565	$380
NME dependent(s) and ME spouse	$465	$280
NME spouse only	$540	$355
ME spouse only	$275	$ 90
Non-spousal ME dependent only	$275	$ 90
Non-spousal ME dependent and ME spouse	$340	$155

These rates apply to the PEEHIP Hospital Medical Plan or the VIVA Health Plan, and the Medicare Advantage PPO Plan for Medicare-eligible retired members and Medicare-eligible dependents and is the monthly amount that will be deducted from a retiree's benefit. The VIVA Health Plan is not available to retired members who are Medicare-eligible or retired members with dependents who are Medicare-eligible.

Supplemental Medical and Optional Coverage Plan Premiums

The Supplemental Medical Plan and Optional Coverage Plan premiums are the same for retired members as for full-time active members.

See the **Retiree Sliding Scale Legislation** section for more information about how the sliding scale may affect a member's premium.

Retiree Sliding Scale Legislation

Retiree Sliding Scale Premium - Acts 2004-649 and 2011-704

The premium for retiree coverage is broken down into the employer share (what PEEHIP pays) and the retiree share (retiree's premium). Under the sliding scale, the retiree is still responsible for the retiree share; however, the employer share will increase or decrease by a percentage based upon a retiree's years of service. If the employer share is reduced, then the retiree share will be increased and vice versa.

For members who retired on or after October 1, 2005, PEEHIP premiums are calculated pursuant to the sliding scale law *Ala. Code §16-25A-8.1*. Starting with the base premium as set by the PEEHIP Board of Control, the base premium is adjusted by applying a formula based upon the cost of healthcare to the plan and using a member's specific age and years of service at retirement. Per the law, this premium is subject to change each year.

To calculate or review a premium, a retiree premium calculator is available on our website at www.rsa-al.gov/about-rsa/calculators/.

For more information about the sliding scale law and how retiree premiums are calculated under this law, see the dedicated sliding scale pages with examples on our website at rsa-al.gov/peehip. The information can be located under the Active Members & NME Retirees page and the Medicare-Eligible Retirees page. Additionally, new members applying for retirement are now provided a PEEHIP premium estimate letter along with an explanation of how the sliding scale applies to them. Lastly, in September of each year, PEEHIP will provide additional information to members impacted by the sliding scale prior to any resulting changes to their premium effective October 1.

Act 2004-649

Members who retired before October 1, 2005, are not affected by the Retiree Sliding Scale Premium. **Members who retired on or after October 1, 2005, but prior to January 1, 2012**, are subject to the sliding scale based on years of service under the provisions of Act 2004-649 as follows:

- **Members who retired with 25 years of service** will only be responsible for the retiree share of the premium. PEEHIP will pay 100% of the employer share of the premium.
- **For members who retired with more than 25 years of service**, the employer (PEEHIP) share increases by 2% and the retiree share is reduced accordingly, for each year of service above 25.
- **For members who retired with less than 25 years of service**, the PEEHIP share of the premium is reduced by 2% of the cost for each year less than 25 and the retiree share is increased accordingly.
- **Members who retired on disability** can be exempt from the sliding scale premium for 24 months from their date of retirement if they submit proof of application for Social Security Disability benefits (SSDI) to PEEHIP. The exemption can be extended if the member qualifies for SSDI benefits during the 24 months following their date of retirement and proof of qualifying for the SSDI benefits is provided to PEEHIP.
  - For those who qualify, the adjustment for the **service** premium component will be effective the first day of the second month following the date PEEHIP receives the Social Security notification. It will terminate at the end of the 24-month period if SSDI benefits have not been awarded. The premium reduction can be reinstated prospectively if documentation is provided to PEEHIP showing SSDI benefits were awarded after the 24-month period.
  - Members who retired on disability and are also eligible for service retirement are subject to the sliding scale if the member does not provide proof of application for SSDI benefits to PEEHIP. Members who retired on service and later became disabled are not eligible for this premium reduction.
- **Members who retired on or after January 1, 2012**, are subject to the sliding scale premiums, which are based on age at retirement, years of service, and the cost of the insurance program.

Act 2011-704

On June 14, 2011, Senate Bill 319 (Act 2011-704) was signed into law primarily to address the inequity in the funding of healthcare benefits for non-Medicare-eligible retired members. The law changed the retiree sliding scale premium calculation so that by 2016, the funding level for active members and non-Medicare-eligible retired members would be equal; thereby removing the inequity in funding that existed for non-Medicare-eligible retired members. Under the provisions of this act, **members retiring on or after January 1, 2012,** are subject to the sliding scale based on years of service. An age and subsidy component may also apply. The law has the greatest effect on members who retire with minimal years of service (for example, someone with 10 years of service at age 60). The effect on members who retire with 25 or more years of service is less dramatic.

Under the law, there are three major changes to the retiree sliding scale premium. These changes are related to a retiree's years of service (Service Premium Component), age at the time of retirement (Age Component), and subsidy premium (Subsidy Component).

1. Change in the Service Premium Component

- Members **who retired on or after January 1, 2012 (regardless of age)** - the employer share is decreased by 4% for each year of service under 25 years and increased by 2% for each year of service more than 25 (Service Component).
- Members **who retired on or after January 1, 2012, with more than 25 years of service** will continue to receive a 2% bonus for each year of service over 25 years.

Example: If you retire with 10 years of service, you are 15 years away from having 25 years of service, and the employer share will be reduced by 60% (15 years x 4%), and the retiree share (or retiree's premium) will likewise increase by an amount equal to 60%.

2. Addition of an Age Premium Component

- **Members who retired before January 1, 2012** - there is no age component that is considered in the sliding scale premium.
- **Members who retired on or after January 1, 2012** – the employer share of the sliding scale premium will be reduced by 1% for each year of age of the member at retirement less than the Medicare entitlement age (Age Component). Upon Medicare entitlement, the age component will be removed.

This component applies only to employees who retired without Medicare entitlement on or after January 1, 2012. These retirees will have 1% deducted from the employer share for each year that they are not entitled to Medicare. Age at retirement is what is used to calculate the age premium component.

3. Addition of a Subsidy Premium Component

- **Members who retired before January 1, 2012** - subsidy component is not applicable.
- **Members who retired on or after January 1, 2012** - a subsidy premium is applicable. The subsidy premium is the net difference in the active member's subsidy and the non-Medicare-eligible retired member subsidy. For Fiscal Year 2026, the subsidy component is $151.17. Upon Medicare entitlement, the subsidy will be removed.

The total of the additional service premium, age premium, and subsidy premium resulting from Act 2011-704 was phased in over a 5-year period until 2016. Upon becoming Medicare-eligible, the age and subsidy premium components are no longer applicable.

- **Members with a disability retirement on or after January 1, 2012,** prior to becoming Medicare-eligible, are still subject to the service, age, and subsidy premium components.
  - These members will be exempt from the service premium component for a 24-month period beginning on the first day of the second month that PEEHIP receives proof of application for SSDI benefits. Therefore, these members should provide proof of application for SSDI benefits at the time they apply for retirement from the RSA.
  - This exemption from the service premium component will become permanent once PEEHIP receives proof of award of SSDI benefits.

- If proof of award of SSDI benefits is not received within the initial 24-month exemption window, PEEHIP will remove the exemption and apply the service premium component until such time that the proof of award of SSDI benefits is received.
- Members who retire on a service retirement and later qualify for SSDI benefits cannot then become exempt from the service premium component.

Act 2011-704 and DROP

The sliding scale premium does not apply to members who were participating in the Deferred Retirement Option Plan (DROP) at the time the law was passed unless the DROP participant:

1. Voluntarily terminates participation in the DROP within the first three years, or
2. Does not withdraw from service at the end of the DROP participation period.

This will exempt members who entered the DROP from being subject to the new legislation if they fulfill their DROP obligation and withdraw from service at the end of the DROP participation period.

Surviving Dependent Benefits

PEEHIP law allows covered surviving dependents to be able to continue the PEEHIP coverage in which they were enrolled at the time of the member's death. Surviving dependents must pay the monthly premium by the due date each month.

Survivor policies are as follows:

- New dependents who are not covered on the PEEHIP policies at the time of the member's death cannot be added to the plan and surviving dependents cannot enroll in new PEEHIP plans that they were not covered on at the time of the member's death.
- Surviving dependents do not have Open Enrollment rights.
- Once the insurance is canceled by a surviving dependent, no reinstatement is allowed, and coverage cannot be picked up at a later date.
- The eligible surviving dependent who wants to continue the PEEHIP coverage should notify PEEHIP as soon as possible from the member's date of death to enroll in coverage.
- Surviving children of the deceased member are only eligible to continue PEEHIP coverage until they reach the limiting age.* Once they reach the limiting age, they would need to contact PEEHIP for an application to continue coverage through COBRA.

If the child is incapacitated, the child can keep the coverage if premiums are paid by the due date each month.

PEEHIP law also requires surviving dependents to pay the full cost of the monthly premium without financial assistance from the state.

Premiums Effective October 1, 2025 - September 30, 2026

The following health insurance premiums are the base rates set by law and approved by the PEEHIP Board. Base rates are before the wellness and tobacco premiums are applied, if applicable. **These rates will begin the first of the month following the member's date of death.**

Surviving Dependent Monthly Premiums for PEEHIP Hospital Medical or VIVA Health Plan

Individual Coverage:	
Non-Medicare-eligible (NME) Survivor	$1,014
ME Survivor	$ 260
Family Coverage	
NME Survivor and more than 1 Dependent or Only Dependent NME	$1,715
NME Survivor and ME dependent only	$1,380
ME Survivor and more than 1 Dependent or Only Dependent NME	$1,207
ME Survivor and Only Dependent ME	$ 520
Supplemental Medical Plan (Individual or Family)	$ 198
Optional (Each Plan) - Cancer, Indemnity, Vision, and Individual Dental	$ 38
Optional - Family Dental Premium	$ 50
Tobacco Premium for Survivor Enrolling in Hospital Medical	$ 50
Wellness Premium/NME Survivor	$ 50

If a member or dependent is under age 65 and eligible for Medicare coverage due to a disability, the PEEHIP office **must receive** a copy of the Medicare card before the premiums can be reduced. **Refunds will not be processed for retroactive premiums. Medicare-eligible members and dependents must have both Medicare Part A and Part B to have coverage with PEEHIP.**

Health Insurance Portability & 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. 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: 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, Healthcare Operations, and Treatment

The Plan and its business associates may use your health information without your permission to carry out payment or healthcare operations. The Plan may also disclose health information to the Plan Sponsor, PEEHIP, for purposes related to payment or healthcare 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 pre-authorizations). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

Healthcare 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 healthcare 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 healthcare or payment for that care. For example, the Plan may confirm whether 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, healthcare 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 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.

Important Notices

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 requirement listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from the 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 PEEHIP from the following requirement:

- 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 this federal requirement has been in effect since October 1, 2005. The election has been renewed 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.

Access to Obstetrical and Gynecological (OBGYN) Care Notice

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the BCBS of Alabama network who specializes in obstetrics or gynecology. The healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to the BCBS of Alabama website www.alabamablue.com.

Choice of Primary Care Physician Notice

The Plan generally allows the designation of a PCP. You have the right to designate any PCP who participates in the BCBS 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 BCBS 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. Call BCBS of Alabama at 800.327.3994 for more information.

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 and its regulations provide that health plans and health insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending provider (who may be a physician or nurse-midwife) may decide, after consulting with the mother, to discharge the mother and newborn child earlier. Plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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Want to sit down with a counselor?

Call the RSA Contact Center at **877.517.0020** to schedule your appointment.

Member Services is located in the RSA Headquarters in downtown Montgomery.

201 South Union Street
Montgomery, Alabama

PEEHIP

Mail Public Education Employees' Health Insurance Plan
P.O. Box 302150
Montgomery, AL 36130-2150

Website www.**rsa-al.gov**

7-2025