



PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN



MEMBER HANDBOOK 2016-2017
with **OPEN ENROLLMENT** information





PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN

PHONE 877.517.0020 or 334.517.7000

FAX 877.517.0021 or 334.517.7001

EMAIL peehipinfo@rsa-al.gov
peehip.invoicing@rsa-al.gov
peehipwellness.info@rsa-al.gov
peehip.flexinfo@rsa-al.gov

General Info
Invoices/Billing
Wellness Info
Flexible Spending

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

BUSINESS HOURS
8:00 a.m.-5:00 p.m.
Monday-Friday

Plan Administrator Contact Information

Wellness Programs

ActiveHealth - vendor for Health Questionnaires, Wellness Coaching, and Disease Management
855.294.6580 www.MyActiveHealth.com/peehip

Alabama Department of Public Health (ADPH) - vendor for Wellness Screenings and Flu Shots
334.206.5300 or 800.252.1818 www.adph.org/worksitewellness

Tobacco Cessation Quitline
800.QUIT.NOW or 800.784.8669 www.quitnowalabama.com

ALL Kids - administered by ADPH
888.373.5437 or 888.373.KIDS www.adph.org/allkids

Blue Cross Blue Shield of Alabama - Administrator of Hospital/Medical, Flexible Spending Accts., & Supplemental Plan
450 Riverchase Parkway East
P.O. Box 995
Birmingham, AL 35298

Customer Service	800.327.3994	Preadmission Certification	800.248.2342
Flexible Spending Accounts	800.213.7930 <i>(until 10/1/16)</i>	Fraud Hot Line	800.824.4391
HealthEquity (Flex Accounts)	877.288.0719 - available 24 hours/day <i>(effective 10/1/16)</i>		
Rapid Response	8 00.248.5123 - to order ID cards, claim forms, and directories		
Baby Yourself	800.222.4379 - Prenatal Wellness Program		

MedImpact - Administrator of Core Pharmacy, Specialty Pharmacy, and EGWP Pharmacy Programs
10181 Scripps Gateway Ct
San Diego, CA 92131

Customer Service	877.606.0727 - available 24 hours/day		
Pharmacy Help Desk	800.788.2949 - available 24 hours/day		
Step Therapy Prior Authorization	800.347.5841 - For Physician Use	Fax -	877.606.0728

Medicare GenerationRx *(until 1/1/2017)* www.medicaregenerationrx.com/peehip
Customer Service 877.633.7943 - available 24 hours/day
Pharmacy & Provider Help Desk 888.678.7789

UnitedHealthcare - Administrator of Group Medicare Advantage (PPO) Plan *(beginning 1/1/2017)*
9900 Bren Road East
Minnetonka, MN 55343

Customer Service	877.298.2341 <i>(effective 7/5/16)</i>	TTY	711
Nurse Line	855.202.0710 <i>(effective 1/1/17)</i>		

VIVA Health Plan
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		

Southland Benefit Solutions - Administrator of Cancer, Dental, Indemnity, & Vision Optional Plans
2200 Jack Warner Pkwy, Suite 150
P.O. Box 1250
Tuscaloosa, AL 35401

Customer Service 800.476.0677

Common PEEHIP Acronyms

ADPH	Alabama Department of Public Health	FPL	Federal Poverty Level	OTC	Over the Counter
AHM	ActiveHealth Management	FSA	Flexible Spending Accounts	PMD	Preferred Medical Doctor
BCBS	Blue Cross Blue Shield	HIPAA	Health Insurance Portability & Accountability Act	PPO	Preferred Provider Organization
CHIP	Children's Health Insurance Plan	HMO	Health Maintenance Organization	QLE	Qualifying Life Event
COB	Coordination of Benefits	MOS	Member Online Services	UCR	Usual Customary and Reasonable

PEEHIP Member Handbook

with Open Enrollment Information

Introduction

The Retirement Systems of Alabama (RSA) is pleased to provide you with the 2016-2017 Public Education Employees' Health Insurance Plan (PEEHIP) Member Handbook with Open Enrollment Information. This handbook is an important part of our commitment to provide our members with valuable information about their health care benefits and Open Enrollment. Please read this handbook thoroughly and keep it with your other benefit materials. Your member handbook is a very useful tool when you have questions about your PEEHIP benefits. It will help you make informed decisions about your future.

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 your compensation package. The benefits also provide important protection for you and your family 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 you make an informed choice, PEEHIP makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about health coverage options in a standard format, to help you compare across coverage options available to you in both the individual and group health insurance coverage markets. The SBC is available at www.rsa-al.gov/index.php/members/peehip/benefits-policies/. A paper copy is also available, free of charge, by calling **Member Services toll-free at 877.517.0020**.

Note: The SBC is meant as a summary only and the coverage examples in the SBC on pages 2 and 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/index.php/members/peehip/pubs-forms/.

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. Do not rely solely upon the information provided in this handbook to make any decision regarding your health care benefits, but contact PEEHIP with any questions you may have about your health care benefits.

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Benefit Policy and Premium Changes

Effective October 1, 2016

(unless otherwise notated)

Hospital Medical Plan Changes - Administered by Blue Cross Blue Shield of Alabama (Group #14000)

Outpatient Mental Health Benefits

The outpatient mental health benefits have been enhanced to allow active and non-Medicare retirees and covered dependents to use the Blue Choice Network providers. Eligible providers include psychiatrists, clinical psychologists, and master's level therapists, such as licensed professional counselors (LPC) and licensed clinical social workers (LCSW). There is a twelve visit limit per year. The office visit copay is \$50 per visit with no Major Medical deductible or balance billing. Visit www.AlabamaBlue.com for a list of Blue Choice Network providers.

Maximum Annual Out-of-Pocket Amounts

The combined medical and prescription drug in-network maximum annual out-of-pocket amounts will be increased to \$7,150 per individual and \$14,300 per family per calendar year effective January 1, 2017. This is a benefit enhancement.

Electronic Cigarettes

- ◆ The use of electronic cigarettes also known as e-cigarettes or electronic nicotine delivery systems will be treated in the same manner as other tobacco products. Therefore, members and covered spouses will be required to recertify/update their tobacco status if they have used e-cigarettes in the past 12 consecutive months and will no longer be eligible for the non-tobacco user discount. This decision is consistent with a recent ruling by the FDA to regulate these products.

Premium Rate Changes: Applies to active and retired members

Premiums

- ◆ For single coverage, premiums will increase \$15 per month.
- ◆ For family coverage, premiums will increase \$30 per month.

Spousal Surcharge

- ◆ The surcharge for spousal coverage for active and non-Medicare retired members will be \$100 per month.
- ◆ The surcharge for spousal coverage for retired Medicare members will be \$30 per month.
- ◆ Spousal Surcharge does not apply to spouses who are independently eligible for PEEHIP.

Note: The full three-year phase in of the spousal surcharge will be implemented plus an additional \$25 for active and non-Medicare members to make the total spousal surcharge to be \$100 per month. For retired Medicare members, the total three-year phase in of the spousal surcharge will be implemented plus an extra \$5 for retired Medicare members to make the total spousal surcharge to be \$30.

Pharmacy Plan Changes

- ◆ Various changes have been made to the commercial plan formulary, including prior authorizations and the exclusion of some drugs to drive utilization to lower cost therapeutic alternative drugs. However, there were no changes in the drug copayment tiers.

VIVA Health Plan Benefit Changes

- ◆ The combined medical and prescription drug maximum annual out-of-pocket amounts will be increased to \$6,850 per individual and \$13,700 per family per calendar year.

Supplemental Medical Changes

- ◆ Effective January 1, 2017, the annual maximum amount paid will increase to \$7,150 per individual and \$14,300 per family. This is a benefit enhancement.

Flex Plan Change

- ◆ Blue Cross and Blue Shield of Alabama has a new flexible spending account (FSA) partner, HealthEquity. HealthEquity is an experienced and strong administrator for the Health Care (HSA) and Dependent Care (DCRA) flex plans and is committed to provide the services our actively employed members need. HealthEquity will process the PEEHIP flex claims and reimbursements and handle all customer service issues. However, PEEHIP members will not see any changes to the enrollment process.

New Group Medicare Advantage (PPO) Plan with Prescription Drug Coverage for Medicare-eligible Retirees - Effective January 1, 2017

Effective January 1, 2017, Medicare-eligible members and Medicare-eligible dependents who are covered on a retiree contract will be enrolled in the new UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP retirees. The Group Medicare Advantage (PPO) plan will be fully insured by UnitedHealthcare® and members will be able to have all of their Medicare Part A (hospital insurance), Part B (medical insurance) and Part D (prescription drug coverage) in one convenient plan.

You will be Automatically Enrolled

Medicare-eligible retired members who are currently enrolled in the PEEHIP Hospital Medical Plan and EGWP Prescription Drug Plan (PDP) plan do not need to do anything to transfer over to the new UnitedHealthcare® Group Medicare Advantage (PPO) plan. Your enrollment process will be handled automatically for an effective date of January 1, 2017 unless you choose to opt-out.

It is important to know that Medicare-eligible retired members and dependents must be enrolled in Part A and Part B of Medicare to have coverage with the new UnitedHealthcare® Group Medicare Advantage (PPO) plan offered by PEEHIP.

Plan Highlights

Some important advantages regarding the UnitedHealthcare® Group Medicare Advantage (PPO) plan include:

- ◆ national coverage so PEEHIP retirees and covered dependents are covered anywhere in the United States
- ◆ worldwide emergency coverage
- ◆ additional benefits that go beyond Medicare including:
 - ◇ the SilverSneakers® fitness program
 - ◇ 24/7 nurse line
 - ◇ health risk assessments
 - ◇ screening exams
 - ◇ immunization reminders
 - ◇ discount on hearing aids
 - ◇ an annual in-home, health and wellness visit.

How the Plan Works

The UnitedHealthcare® Group Medicare Advantage (PPO) plan will work a little differently than the PEEHIP Hospital Medical Plan and EGWP Prescription Drug Plan (PDP).

- ◆ **One ID Card.** You will have one ID card from UnitedHealthcare®. You will use this ID card for all your medical service and prescription drug needs. You will no longer need to show your red, white and blue Medicare card. You will want to put your Medicare card in a safe place.
- ◆ **Use your new ID card for all medical services and prescription drugs.** It is important to always show your UnitedHealthcare® Group Medicare Advantage (PPO) plan card when receiving medical services or filling prescriptions. This is because your UnitedHealthcare® Group Medicare Advantage (PPO) plan pays directly (primary) for all your medical and prescription drug services. Showing your UnitedHealthcare® ID card will help make sure that your claims are processed quickly and accurately.
- ◆ **Continue to use your doctors and hospitals.** Under the UnitedHealthcare® Group Medicare Advantage (PPO) plan, covered members can continue to see their same doctors and health care providers with no interruption and have the freedom to use any doctor or hospital that participates in Medicare and accepts the plan on a national basis.
- ◆ **You have the same benefits if you use in-network or out-of-network providers.** There is no additional cost share when using an out-of-network provider and any excess charges (balance billing) are paid by the health plan, not the covered member.

What if You Want Medical Coverage Only

If you have TRICARE or a different Medicare Part D Prescription Drug plan or other creditable* prescription drug coverage and you want to keep that coverage for your prescription drugs, you can choose to opt out of the PEEHIP prescription drug coverage and keep the UnitedHealthcare® Group Medicare Advantage (PPO) plan that only includes medical coverage.

**Creditable prescription drug coverage means that it is at least as good as what Medicare Part D offers. If you are unsure whether or not your prescription drug coverage, outside of PEEHIP, is creditable please contact the prescription drug plan's administrator.*

You will receive an ID card from UnitedHealthcare® to use for your medical services. In addition, please remember to keep your other prescription drug card and use it when getting your prescriptions filled. You are responsible for any premium and drug costs associated with your separate prescription drug plan. This coverage is outside of what is offered by PEEHIP.

Important Reminders

- ◆ If you choose to opt out of the PEEHIP prescription drug coverage and enroll in the UnitedHealthcare® Medicare Advantage (PPO) plan with medical only, make sure you continue your TRICARE or other creditable prescription drug coverage. If you do not have continuous prescription drug coverage, you could risk paying a penalty should you choose later to join a plan that has Medicare prescription drug coverage.
- ◆ Medicare only allows you to have one Medicare Part D prescription drug plan at one time either as a separate (stand-alone) prescription drug plan or included as part of a Medicare Advantage plan. The plan you enroll in last is the plan that Medicare considers to be your final choice. So if you enroll in the UnitedHealthcare® Medicare Advantage (PPO) plan that already includes prescription drug coverage and then enroll in a separate Medicare prescription drug plan, Medicare will automatically disenroll you from UnitedHealthcare® Medicare Advantage (PPO) plan and you will lose your medical coverage.

Opting out of the UnitedHealthcare® Medicare Advantage (PPO) Plans

Medicare-eligible retirees and covered Medicare-eligible dependents of retirees have the choice to “Opt Out” of the UnitedHealthcare® Medicare Advantage (PPO) plan offered by PEEHIP. All members are mailed a pre-enrollment packet that includes opt-out instructions. Medicare-eligible retirees and covered Medicare-eligible dependents who are considering opting out should contact PEEHIP to discuss the impact of this important decision. PEEHIP can be reached by calling **334.517.7000** or Toll Free **877.517.0020**.

You have 2 options for opting out of coverage:

1. You can opt-out of the UnitedHealthcare® Medicare Advantage (PPO) plan that includes prescription drug coverage and choose to be enrolled in the UnitedHealthcare® Medicare Advantage (PPO) plan that provides medical coverage only.
2. You can opt-out of both medical coverage and prescription drug coverage offered by PEEHIP and provided through the UnitedHealthcare® Medicare Advantage (PPO) plan.

Important: If you opt out, you will not be permitted to re-enroll until the next PEEHIP Open Enrollment period of July 1 through August 31 for an October 1 effective date. If you have family coverage and choose to opt out of the UnitedHealthcare® Medicare Advantage (PPO) plan altogether you will disenroll the entire family from any medical and prescription drug coverage.

How to Receive Additional Plan Information

UnitedHealthcare® will send detailed information on the UnitedHealthcare® Group Medicare Advantage (PPO) plan directly to you.

- ◆ Current Medicare-eligible retirees and Medicare-eligible dependents will receive information in October 2016.
- ◆ PEEHIP member and dependents who will become eligible for Medicare after January 1, 2017 can expect information approximately 60 days prior to their Medicare effective date or as soon as possible based on retirement date.

In addition to written information, PEEHIP retirees are welcome to call the UnitedHealthcare® dedicated customer service team. These representatives have been specially trained in PEEHIP’s benefit plans and are available to answer your questions. Just call toll-free:

1.877.298.2341, TTY 711 (effective July 5, 2016)
8:00 a.m. – 8:00 p.m. local time
Monday - Friday

UnitedHealthcare® will be contacting providers that PEEHIP retirees are currently utilizing to provide detailed information about the transition to the new plan. Providers will be educated on specific PEEHIP plan benefits and how to file claims on behalf of PEEHIP members.

The UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP is an improvement in benefits for our Medicare retirees and their covered dependents. The July *PEEHIP Advisor* contains more information about the new plan and will answer most questions our retirees may have. More information will be provided through onsite educational meetings and future publications.

These changes were also published in the June 2016 PEEHIP Advisor.

Insurance Eligibility

Guidelines for Insurance Eligibility

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

Full-Time Employees

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

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

Permanent Part-Time Employees

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

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

An eligible permanent part-time employee is eligible for PEEHIP if he or she agrees to payroll deduction for a pro rata portion of the premium cost for a full-time employee. The portion is based on the percentage of time the permanent part-time 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.

Family Coverage Eligibility

Eligible Dependents

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

Spouse

The employee's spouse as defined by Alabama law to whom you are currently and legally married, excludes a divorced spouse. Appropriate documentation will be required by PEEHIP before a spouse can be enrolled. See page 14 for required documentation.

Children

PEEHIP offers dependent coverage to children up to age 26. Appropriate documentation will be required by PEEHIP before dependents can be enrolled. See page 14 for required documentation. **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:

3. A married or unmarried child under the age of 26 if the child is your biological child, legally adopted child, stepchild or foster child without conditions of residency, student status, or dependency. A foster child is any child who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
4. The eligibility requirements for any other children such as grandchildren, for example, must meet the same requirements as foster children and must be placed with you by decree or other order of any court of competent jurisdiction, for example, legal custody or legal guardianship.
5. 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 employee must contact PEEHIP and request an INCAPACITATED DEPENDENT form. Proof of the child's condition and dependence must be submitted to PEEHIP within 45 days after the date the child would otherwise cease to be covered because of age. PEEHIP may require proof of the continuation of such condition and dependence.

If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once he or she reaches the limiting age of 26 as an incapacitated child. For example, approved permanently incapacitated children can continue on any PEEHIP plans they are on at the time they age out, but they are not eligible to be covered on other PEEHIP plans once they reach the limiting age of 26. If the child is approved as 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 VIVA Health Plan or the Optional Coverage Plans if he or she has already reached the limiting age of 26.

Ineligible Family Members (Dependents)

- ◆ An ex-spouse regardless of what the divorce decree may state
- ◆ Ex-stepchildren regardless of what the divorce decree may state
- ◆ Children age 26 and older
- ◆ Disabled children over age 26 who were never enrolled or were deleted from coverage
- ◆ A child of a dependent child cannot both be covered on the same policy
- ◆ A daughter-in-law or son-in-law
- ◆ Grandchildren or other children related to 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 or live-in girlfriend or boyfriend

Ex-Spouse and Ex-Stepchildren Must be Removed from Coverage

Ex-spouses and ex-stepchildren are not eligible dependents even if a member continues to pay for family coverage and regardless of what the divorce decree states. The ex-spouse and ex-stepchildren must be 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 (See pages 47-49).

To remove the ex-spouse from coverage effective the 1st day of the month following the divorce:

- ◆ Click the "View/Change Contact Information" link once you have logged in to Member Online Services (MOS). Select the "Update My Marital Status" option, select "Divorce" from the drop 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. Be sure to get a Confirmation page to ensure this change was saved and submitted to PEEHIP. This will remove the ex-spouse from your coverage.
- ◆ If you do not have access to the Internet, you must timely notify PEEHIP of your divorce by completing and submitting to PEEHIP a NEW ENROLLMENT AND STATUS CHANGE form and a copy of your divorce decree.

Open Enrollment

(Active and Retired Members)

Open Enrollment is your once-a-year opportunity to enroll in or change plans, and add or drop eligible dependents from coverage. Each June, all PEEHIP eligible active and retired members are sent a one-page Open Enrollment notice to their home address. The notice provides information about the Open Enrollment deadlines, how to enroll or make changes online through MOS, and identifies the coverage(s) in which the member is currently enrolled, including the current tobacco status on file with PEEHIP.

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

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

- ◆ The deadline for submitting **online** Open Enrollment changes is midnight of **September 10**. After September 10, online Open Enrollment changes will not be accepted and the Open Enrollment link will be closed.
- ◆ The deadline for submitting **paper** Open Enrollment forms is **August 31** or the last business day of the month. Any paper forms or faxes postmarked after August 31 will not be accepted.
- ◆ The deadline for enrollment or re-enrolling in a **Flexible Spending Account** online or on paper is **September 30**.

Open Enrollment changes cannot be submitted 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.
- ◆ Flexible Spending Accounts require a new enrollment each year. **The preferred method to enroll is online through MOS at <https://mos.rsa-al.gov>.**
- ◆ The Federal Poverty Level discount program requires a new application each year. The member must submit a paper application to PEEHIP to apply for this discount.
- ◆ Members enrolling in new insurance plans should receive their new ID cards from the insurance carrier(s) no later than the last week in September.
- ◆ Payroll deductions for the changes made during Open Enrollment will be reflected in the September paycheck. All members covered by PEEHIP insurance should review their paycheck stub each month to ensure the proper amount has been deducted for their PEEHIP premiums.
- ◆ Members enrolling in the Flexible Spending Account(s) will have their first contribution withheld from their October paycheck.

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

Transfers

Employees who transfer from one system to another system are considered current employees and are not considered new employees for insurance enrollment purposes. Transfers must keep 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 his or her 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. See page 18 for more information about the 3-1 Rule.

Part-Time to Full-Time Employment

Employees who are employed less than full-time and are enrolled in only Optional Coverage Plans cannot add the Hospital Medical Plan outside of the Open Enrollment period if they become full-time. However, members can add the other Optional Coverage Plans when they become full-time.

Full-Time to Part-Time Employment

A member is not eligible to drop the 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 no longer have waiting periods applied on pre-existing conditions.

New Employee Enrollment

(Active Members)

Member Online Services (MOS)

New employees must enroll online through Member Online Services (MOS) within 30 days of their hire date. Using the RSA's MOS eliminates the need for paper forms, envelopes, stamps or last minute runs to the post office. Enroll using MOS at <https://mso.rsa-al.gov>.

Effective dates of coverage will be one of the following (your choice):

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

Premium payments:

- ◆ Premiums are payroll deducted at the end of each month to pay for the following month of coverage.
 - ◇ New employees do not have a paycheck from which to deduct their initial premium and the initial premium payment is due at the time of enrollment. Therefore, the initial payment should be paid through MOS using a credit card, debit card, or e-check.
- ◆ Payment can also be made to PEEHIP by mailing a check or money order payable to PEEHIP.
- ◆ Your account will be placed on claim hold until PEEHIP receives the initial premium.

If online enrollment is not completed within 30 days:

- ◆ The "New Employee" enrollment link within MOS will be removed on the 31st day after the date of employment.
- ◆ The new employee will only be permitted to enroll in single Hospital Medical coverage. The employee will be required to submit a NEW EMPLOYEE AND STATUS CHANGE form to PEEHIP, and the effective date will be the date the form is received by PEEHIP. The employee must wait until Open Enrollment to enroll in family Hospital Medical coverage and/or enroll in the Optional Coverage plans.

Paper enrollment forms should be sent directly to PEEHIP. Your school system is not responsible for sending enrollment forms to PEEHIP.

Hospital/Medical Coverage

New employees can enroll in single, family (without spouse), or family (with spouse) PEEHIP Hospital Medical or VIVA Health Plan.

Family Coverage

New employees can add family hospital/medical coverage to be effective on their date of hire, the first of the month following their date of hire, or effective 60 days from their date of hire. To have the family coverage effective 60 days from the date of hire, the NEW ENROLLMENT AND STATUS CHANGE form must be received by PEEHIP within 30 days of the date of hire.

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 after the hire date 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.

New Employee Enrolling During Open Enrollment

To elect family hospital/medical or optional coverage to begin 60 days from the date of hire, a NEW ENROLLMENT AND STATUS CHANGE form must be submitted within 30 days of the date of hire requesting family coverage to begin 60 days from the date of hire.

Employees not Enrolled in Coverage

Members who are not enrolled in any PEEHIP coverage are allowed to enroll in single hospital/medical coverage effective on the date of notification.

See pages 12-13 for more information regarding Enrollment Procedures.

Enrollment Procedures

Member Online Services (MOS)

(Active and Retired Members)

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 5 digits of your Social Security number
3. Email address
4. Social Security numbers 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 time of enrollment

Register and Enroll

- ◆ Go to www.rsa-al.gov and click “MOS Login” located at the top of the web page.
- ◆ Register as a first time user OR login with your User ID and Password that you created when registering.
- ◆ If you do not remember your User ID and/or Password, you can “Reset Account”.
- ◆ RSA mails new employees a Personal Identification Number (PID). If you do not have your PID, request a PID letter through MOS and one will be mailed to you.
- ◆ Click “Enroll or Change PEEHIP Coverages” from the PEEHIP menu on the left of your screen.
- ◆ Click “New Enrollment” (available for new employees for 30 days from their hire date), or “Open Enrollment” (available during the Open Enrollment period), or “Qualifying Life Event” (to add a newly acquired dependent within 45 days of the qualifying life event).
- ◆ Follow the on-screen prompts to enroll or change PEEHIP coverages.

If you do not receive a confirmation page, your enrollment or changes was not successful.

View/Update Coverage and Information *(year round)*

- ◆ View Current Coverage
- ◆ View and/or Update Contact Information (address, phone number, email and marital status)
- ◆ View Confirmation Page History and Other Important Documents from PEEHIP
- ◆ Update Marital Status
- ◆ Update Member and/or Spouse Tobacco Status
- ◆ Add or Update Other (non-PEEHIP) Insurance Coverage Information
- ◆ Update Retiree Employment Information (only members who retired on or after October 1, 2005)

Enroll, Change or Cancel Coverage *(During Open Enrollment: July 1 - September 10)*

- ◆ Enroll, Change or Cancel your Hospital Medical Plan or your Optional Coverage Plans (Cancer, Dental, Indemnity and Vision)
- ◆ Add or Update Other (non-PEEHIP) Health Insurance Coverage Information (COB)
- ◆ Enroll or Re-enroll in Flexible Spending Accounts (not available to retirees)
- ◆ Add or Update Retiree Employment Information
- ◆ Update Member and/or Spouse’s Tobacco Usage Status
- ◆ Add Dependent(s) to Coverage such as a child or spouse
- ◆ Cancel Dependent(s) from Coverage

Qualifying Life Event (QLE) Special Enrollment

Coverage for new dependents can be added for the following Qualifying Life Events (QLE) for an effective date of the date of the event or the 1st of the month following the date of the event:

- ◆ Adoption of a Child or Placement of Adoption for a Child
- ◆ Birth of a Child
- ◆ Legal Custody of a Child
- ◆ Marriage of a Subscriber

Changes must be submitted within 45 days of the QLE.

New Employee Enrolling During Open Enrollment

To elect family hospital/medical or optional coverage to begin 60 days from the date of hire, a **NEW ENROLLMENT AND STATUS CHANGE** form must be submitted within 30 days of the date of hire requesting family coverage to begin 60 days from the date of hire.

Open Enrollment

The Open Enrollment link to enroll online is available beginning July 1 and remains available through the **entire** online Open Enrollment period ending September 10.

Employees Who Do Not Enroll in PEEHIP Hospital Medical Coverage

Employees who do not enroll in a PEEHIP Hospital Medical plan can enroll in the PEEHIP Supplemental Medical Plan **OR** the four (4) Optional Coverage Plans at no premium cost for single or family coverage. **Note:** Spouses who are independently eligible for PEEHIP coverage cannot be covered on a PEEHIP Hospital Medical plan and enroll in the PEEHIP Supplemental Medical Plan or the Optional Coverage Plans at no cost. If enrolling in any Optional Coverage Plans, they will pay the respective premium(s).

Employees 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. The form is on page 69 or can be obtained upon request by calling Member Services at 877.517.0020.

Enrollment Documentation Required

(Active and Retired Members)

General Information

Every member who enrolls dependent(s) in his or her PEEHIP coverage(s) is required to certify dependent eligibility to PEEHIP. Certification requires submission of appropriate documents to verify dependent eligibility. **Black out Social Security numbers, account numbers, income, or statement balances prior to sending your documents to PEEHIP.** Under no circumstances does PEEHIP solicit this type of information from members.

Documents must be mailed, emailed, or faxed to PEEHIP. See “Contact PEEHIP” information at the front of this guide. Enrollments cannot be processed without the appropriate documentation. PEEHIP is not bound by court order to insure dependents who do not meet PEEHIP guidelines.

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

Spouse

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

- ◆ Marriage certificate
- ◆ **AND one** of the following documents to show marriage is still current:
 - ◆ Page 1 and signature page (if manually completed) of member’s most current Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the spouse
 - ◆ Page 1 and Certificate of Electronic Filing or transmission page (if electronically completed or completed by a tax professional) of member’s most current Federal Income Tax Return (1040, 1040A, 1040EZ) **as filed with the IRS** listing the spouse
 - ◆ Transcript of member’s most current Federal Income Tax Return (1040, 1040A, or 1040EZ) listing the spouse
 - ◆ Current mortgage statement, home equity loan, or lease agreement listing both member and spouse
 - ◆ Current Property Tax documents listing both member and spouse
 - ◆ Automobile registration that is currently in effect listing both member and spouse
 - ◆ Current utility bill listing both member and spouse
 - ◆ Current utility bill listing spouse at the same address as the member

“Current” is defined as within the last six months, and supporting documents must be dated within the last six months to qualify as appropriate documentation.

Separated Spouse

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

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

Biological Child

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

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

Foster Child

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

- ◆ Placement Authorization signed by a judge **OR**
- ◆ Final Court Order with presiding judge’s signature and seal

Adopted Child

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

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

Step Child

A step child is defined as a child under age 26 who is the natural offspring or adopted child of the covered member's spouse.

Required documents for step children are:

- ◆ Birth certificate of stepchild showing member's spouse's name **AND**
- ◆ Marriage certificate showing stepchild's biological parent is married to member

If the spouse is not covered under the PEEHIP plan, in addition to the above documents, you must submit proof that your marriage is still current. Please refer to the "Spouse" category on page 15 for a list of acceptable documentation.

Incapacitated Child

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

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

Two Exceptions:

1. New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment; or
2. Existing member requests coverage of an incapacitated child over the age of 26 within 45 days of the qualifying life event of loss of other hospital medical group coverage.

If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once he or she reaches the limiting age of 26 as an incapacitated child. Required documents for incapacitated children are:

- ◆ INCAPACITATED DEPENDENT form. Proof of the child's condition and dependence must have been submitted to PEEHIP within 45 days after the date the child would otherwise have ceased to be covered because of age.
- ◆ Proof of the required documents(s) for one of the dependent categories as noted above to show the child is your biological child, adopted, or stepchild **AND**
- ◆ Medicare card (if eligible)

Other Child

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

Required documents for other children are:

- ◆ Placement Authorization signed by a judge **OR**
- ◆ Final Court Order with presiding judge's signature and seal

HIPAA Special Enrollment Outside of Open Enrollment

(Active and Retired Members)

HIPAA requires group health plans to provide special enrollment periods during which certain individuals who previously declined health coverage are allowed to enroll. A special enrollee is not treated as a late enrollee.

Examples of situations that qualify for special enrollment are:

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

These individuals are not required to wait until the Open Enrollment period to enroll in the Hospital Medical Plan but must submit the request for special enrollment within 45 days of each scenario.

This special enrollment period is available to employees and their dependents who meet certain requirements:

- ◆ The employee or dependent must otherwise be eligible for coverage under the terms of their plan.
- ◆ When the PEEHIP coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage.
- ◆ If the other coverage is COBRA, the special enrollment can only be requested after exhausting COBRA even if the employer pays the COBRA premiums for any length of time.
- ◆ If the other coverage is not COBRA, special enrollment can only be requested after losing eligibility for the other coverage or after cessation of employer contributions for the other coverage.

An individual **does not** have a special enrollment right if the individual loses the other coverage in certain situations.

Examples of coverage loss situations that do not qualify for special enrollment:

- ◆ As a result of the individual's failure to pay premiums
- ◆ For cause – such as making a fraudulent claim
- ◆ If other coverage has an increase in premiums or a change in benefits
- ◆ If other coverage is changed to a Marketplace Exchange plan and employer continues to subsidize the premium
- ◆ Voluntarily removing an eligible dependent from another plan

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

Enrolling Due to a Loss of Coverage

When enrolling in a Hospital Medical plan due to a loss of coverage, the member must submit to PEEHIP a **NEW ENROLLMENT AND STATUS CHANGE** form **AND** a letter on company letterhead from the employer through which coverage was lost indicating the reason for the loss of eligibility of coverage (Examples: termination of employment, resignation, retirement with no insurance benefits), and the date coverage ended. Proof of loss of coverage must be submitted for each dependent who has lost coverage. Enrollment due to loss of coverage may not be done online through MOS.

When the loss of coverage is due to divorce, in addition to proof of loss of coverage, the member requesting coverage must submit to PEEHIP a **NEW ENROLLMENT AND STATUS CHANGE** form **AND** provide a copy of the divorce decree signed by a judge of a court of competent jurisdiction.

If PEEHIP is not notified within 45 days of the date of the loss of coverage, the member is required to wait and enroll during the Open Enrollment period (July 1 – August 31) with a coverage effective date of October 1. Members must wait until Open Enrollment to enroll in the Optional Coverage Plans. The member cannot enroll in dental or vision outside of Open Enrollment even if it was part of the plan in which they lost coverage. **A member is eligible to drop any of the Optional Coverage Plans when enrolling in a Hospital Medical plan due to a loss of other coverage if he/she had the Optional Coverage Plans for at least one year.**

Cancelling or Changing Coverage Due to a Qualifying Life Event (QLE)

All active members pay their premiums using pre-tax dollars. Therefore, active members must have an IRS Qualifying Life Event (QLE) before they can be allowed to cancel their Hospital Medical plan, change the status of their coverage, or drop/add dependents outside of the Open Enrollment period.

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.

Members can submit requests **online through MOS** to change coverage for the following QLE's to **add** new dependents to coverage:

- ◆ Adoption of a child
- ◆ Birth of a child*
- ◆ Legal custody of a child
- ◆ Marriage of the subscriber

**Birth is not a QLE to cancel coverage*

Requests for change for QLE's that **cannot be submitted online through MOS** are the following. A **NEW ENROLLMENT AND STATUS CHANGE** form must be submitted to PEEHIP within 45 days of the QLE. Appropriate documentation must be received and approved before the change can be made.

- ◆ Death of a spouse or dependent
- ◆ Divorce or annulment
- ◆ Marriage of dependent child
- ◆ Spouse/dependent loss of coverage
- ◆ Commencement of spouse/dependent employment
- ◆ Termination of spouse employment and loss of insurance coverage
- ◆ Medicaid and Medicare entitlement
- ◆ FMLA/LOA
- ◆ Spouse's employer has a different Open Enrollment period than PEEHIP's Open Enrollment.

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.

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 single coverage or drop the PEEHIP hospital medical coverage altogether outside of the PEEHIP open enrollment. Timely notification and appropriate documentation must be provided to PEEHIP in accordance with applicable regulations.

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 cancelled effective on the first day of the month and cannot be cancelled in the middle of the month.

Changing Single to Family Coverage

Members enrolled in single Hospital Medical coverage who marry can request to change coverage to family adding their newly acquired dependents within 45 days of the date of marriage. Members can add all eligible dependents when changing to family coverage. Enroll online through MOS at <https://mos.rsa-al.gov> and mail a copy of the marriage certificate (and birth certificates, if applicable) to PEEHIP. The effective date of coverage can be the date of marriage or the first of the following month. A member who is only enrolled in the Optional Coverage Plans cannot enroll in the Hospital Medical plan due to a QLE. **Members will be required to make payment for the additional family premium at the time of enrollment.** Prior notification is not required. *However, if coverage is not added within 45 days of the date of marriage, the member must wait until the following Open Enrollment period.*

Adding Dependents to Family Coverage

Members can add a new dependent(s) to existing family coverage through MOS at <https://mso.rsa-al.gov> within 45 days of acquiring the dependent(s) and mail a copy of the marriage certificate and/or birth certificate to PEEHIP. Prior notification is not required. *However, if coverage is not added within 45 days of the date the dependents are acquired, the member must wait until the following Open Enrollment period.*

Employer Contributions

(Active Members)

An active member is eligible to receive PEEHIP coverage at the member premium rates during each month the member is in pay status at least one-half of the working days of that month. (As set forth on pages 47-49, 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.)

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.)

Note that 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 he or she is 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 twenty (20) hours per week (excluding bus drivers who are full-time, by law) to receive 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 Hosp/Med or HMO Plan	Entitlement if Enrolled in Optional Coverage Plans
Professional/Administrative Employee Works		
Less than 1/4 time	0	0
At least 1/4 time but < 1/2 time	1/4 insurance coverage	1 Plan
At least 1/2 time but < 3/4 time	1/2 insurance coverage	2 Plans
At least 3/4 time but < Full-time	3/4 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.)	
Support Worker Works		
0 to 4.9 hours/week	0	0
5.0 to 9.9 hours/week	1/4 insurance coverage	1 Plan
10.0 to 14.9 hours/week	1/2 insurance coverage	2 Plans
15.0 to 19.9 hours/week	3/4 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 using a September through September 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 September 30.
- ◆ 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 he or she has exhausted their extra coverage months, the employee will not have a lapse in coverage and the same insurance plans will automatically get reinstated. These employees are treated as existing not new employees and will not be allowed to pick up or drop 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.

The table below should be used when calculating the number of months an employee is entitled to receive insurance coverage.

Service Months	Coverage Months
1	1
2	2
3	4
4	5
5	6
6	8
7	9
8	10
9	12
10	12
11	12
12	12

Leave

A member can use his or her 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 his or her 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 insurance contribution when a member is on military leave status in the Employer Portal.

Terminated Employee

The school system is not required to pay the September contribution amount for an employee terminating the end of May when the employee has worked September through May. These employees are eligible to receive insurance coverage through August, 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. A contribution can be used for the month of September. **Example:** An employee has been in hire status for 9 consecutive months and terminates employment after June 16. The member will be eligible for coverage for July, August, and September.

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 after August 1 but prior to August 15 is eligible for full coverage in August.

Members Enrolled in the PEEHIP Basic Hospital Medical Group #14000 or VIVA Health Plan

If a member enrolls in the PEEHIP Basic Hospital Medical Plan Group #14000 (administered by BCBS) or the VIVA Health Plan, they can enroll in any number of the Optional Coverage Plans at their respective costs.

Members Not Enrolled in the PEEHIP Basic Hospital Medical Plan Group #14000 or VIVA Health Plan

If a member does not enroll in the PEEHIP Hospital Medical Plan Group #14000 (administered by BCBS) or the VIVA Health Plan, there is no premium cost to enroll in either the PEEHIP Supplemental Medical Plan or the Optional Coverage Plans. Members should 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** of the employee's contract and all additional months of coverage, thereafter.

Death

Extra insurance contributions earned under the 3-1 Rule can only be used by the employee and cannot be used by the employee's family in the event of the employee's death.

Active Employees Not Enrolled in Coverage

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

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 insurance contribution amount for the full month of September.

Members who are not enrolled in any insurance coverage are allowed to enroll in single medical coverage effective on the date of notification.

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

Retiring Members

Retiring members are eligible to receive the extra coverage months earned under the 3-1 Rule.

Example:

- ◆ A June 1 retiree who works 9 months during the school year may receive coverage through August 31.
- ◆ A July 1 retiree who works the entire school year may receive coverage through September 30.

The school system is required to provide the appropriate insurance contribution earned under the 3-1 Rule. PEEHIP assumes that the system will not pay the September contribution for June 1 retirees, in most cases. June 1 retirees should continue to receive coverage through August.

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 Medicare Part 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 at the time of his or her retirement, Medicare will become the primary payer and PEEHIP the secondary payer **effective on the date of the member's retirement**.

It is extremely important for the member and/or dependent to have Medicare Part A and Part B to assure coverage with PEEHIP. The member will continue to earn the extra coverage months under the 3-1 Rule, but Medicare will be the primary payer for claims beginning the date of retirement for Medicare-eligible members or dependents. If the member and only dependent are both eligible for Medicare, the reduced Medicare out-of-pocket cost will be deducted.

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

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

Medicare-eligible members and Medicare-eligible dependents should not enroll in a separate standard Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. Until January 1, 2017, all retired Medicare-eligible members and Medicare-eligible dependents on retired contracts are enrolled in the Medicare GenerationRx Medicare Part D program offered by PEEHIP unless they are enrolled in a separate standard Medicare Part D plan or they choose not to participate/opt out.

UnitedHealthcare® Group Medicare Advantage (PPO) Plan with Prescription Drug Coverage
Effective January 1, 2017, the Medicare-eligible members and Medicare-eligible dependents who are covered on a retiree contract will be enrolled in the new UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP retirees. The Group Medicare Advantage (PPO) plan will be fully insured by UnitedHealthcare® and members will be able to have all of their Medicare Part A (hospital insurance), Part B (medical insurance) and Part D (prescription drug coverage) in one convenient plan. However, 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 new UnitedHealthcare® Group Medicare Advantage (PPO) plan offered by PEEHIP.

Some other important advantages regarding the UnitedHealthcare® Group Medicare Advantage (PPO) plan 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 Silver Sneakers fitness program, a 24/7 nurse line, health risk assessments, screening exams, immunization reminders, discount on hearing aids, and even house calls if necessary. Medicare-eligible retired members who are currently enrolled in the PEEHIP hospital medical plan and EGWP plan do not need to do anything to transfer over to the new UnitedHealthcare® Group Medicare Advantage (PPO) plan. The enrollment process will be handled automatically for an effective date of January 1, 2017 unless you choose to opt-out.

With the new UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP, retirees can continue to see their same doctors and providers with no interruption and have the freedom to see any doctor or provider who accepts Medicare on a national basis. Retirees have the same benefits in and out-of-network and there is no additional retiree cost share if a retiree uses an out-of-network provider and no balance billing from the provider. UnitedHealthcare® will be contacting providers that PEEHIP retirees are currently utilizing to provide detailed information about the transition to the new plan. Providers will be educated on specific PEEHIP plan benefits and how to file claims on behalf of PEEHIP members.

The UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP is an improvement in benefits for our Medicare retirees and their covered dependents. More information will be provided through onsite educational and future publications.

PEEHIP Hospital Medical Plan Group #14000

(Active Members and Non-Medicare-Eligible Retirees)

Hospital Benefits (Administered by Blue Cross)

- ◆ Inpatient Hospitalization: Plan pays 100% of the allowed amount for the first 365 days subject to a \$200 per admission deductible and \$25 per day copayment for days 2-5 (maximum copayment of \$300). The plan allows for a semi-private room. The member is responsible for the difference in cost of a private and semi-private room and other non-medical items, such as TV, phone, etc.
- ◆ Preadmission Certification (PAC): All hospital admissions require preadmission certification. To obtain PAC, call 800.248.2342.
- ◆ Inpatient Rehabilitation: Plan pays 100% of the allowed amount, subject to a \$200 per admission copayment and a \$25 per day copayment for days 2-5 (maximum copayment of \$300). Coverage in a rehabilitation facility requires Preadmission Certification and is limited to a lifetime maximum of 60 days per member.
- ◆ Outpatient Hospital Benefits: Plan pays 100% of the allowed amount, subject to a \$150 facility copayment for outpatient surgery and \$150 facility copay for medical emergencies, and accidents.
- ◆ Hemodialysis: \$25 copay
- ◆ Non-medical Emergencies: Plan pays 80% of the allowed amount, subject to the \$300 calendar year deductible.

Major Medical Benefits (Administered by Blue Cross)

- ◆ Calendar Year Deductible: \$300 per person; \$900 maximum per family per year.
- ◆ 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 plan year.
- ◆ Covered Services: Physician services for medical and surgical care when a PMD physician is not used; laboratory and X-rays, (outpatient MRI's must be pre-certified); ambulance service; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; podiatrist services; physical therapy; and allergy testing and treatments.
- ◆ Sleep Studies: Services are covered when rendered by a Blue Cross approved sleep facility. The following copayments apply:
 - ◆ Free-standing sleep clinic: \$10 facility copayment
 - ◆ Hospital outpatient facility: \$150 facility copayment for adults and \$10 copay for children 18 and under
- ◆ **Medical and prescription calendar year out-of-pocket combined maximum is \$6,600 for individual and \$13,200 for family for calendar year 2015; the combined maximum is \$6,850 for individual and \$13,700 for family coverage for year 2016; and \$7,150 for individual and \$14,300 for family for calendar year 2017.**

Major medical claims incurred in the 4th quarter of the calendar year are not carried over and applied towards the following year's deductible.

Preferred Medical Doctor (PMD)

- ◆ Office Visit and Consultations: \$30 copayment per visit
- ◆ Routine Preventative Office Visit: No copayment for one routine preventative visit per year (adults 19 and older)
- ◆ Specialist Office Visit and Consultations: \$35 copayment per visit (Does not apply to Family/General Practice, Internal Medicine, Gynecology, Obstetrics, Pediatrics, Certified Nurse Practitioner, Physician Assistant, Clinic and Midwives)
- ◆ Outpatient Diagnostic Lab and Pathology: \$5 copayment per test (including pap smears)
- ◆ Outpatient Diagnostic X-ray: No deductible or copayment

PPO Blue Card Benefits (Out-of-State Providers)

- ◆ 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 Blue Cross 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.

Non-Participating Hospitals and Outpatient Facilities

- ◆ Currently there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are a Blue Cross and Blue Shield participating provider. With your health plan benefits, you have the freedom to choose your health care provider.

- ◆ To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don't have to worry about extra out-of-pocket expenses.

Out-of-Country Coverage

- ◆ If you receive medical treatment 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 Blue Cross of Alabama.

Excluded Services and Prescription Drugs

- ◆ Excluded services include but are not limited to nursing home costs, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids and experimental procedures. Certain prescription drugs may be excluded to drive utilization to lower cost therapeutic alternative drugs. Bulk chemical powders **are not** covered under PEEHIP.

Prescription Drug Benefits – Participating Pharmacy *(Administered by MedImpact)*

All drug lists can be found on the PEEHIP website at www.rsa-al.gov.

- ◆ Participating Pharmacy Copayments:

Tier Number/Drug Type	Day Supply: 1-30 Copay	Day Supply: 31-60 Copay	Day Supply: 61-90 Copay
Tier 1: Generic	\$ 6	\$ 12	\$ 12
Tier 2: Preferred Brand	\$40	\$ 80	\$120
Tier 3: Non-Preferred Brand	\$60	\$120	\$180
Tier 4: Specialty Drug	20% coinsurance with a minimum copay of \$100 and a maximum copay of \$150. The Dispense As Written (DAW) cost differential applies for multi-source brand drugs with a generic chemical equivalent.		

The drug must be on the approved maintenance list and must be prescribed as a maintenance drug. First fill for a maintenance drug will be a 30-day supply.

- ◆ Participating pharmacies will file all claims electronically for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP MedImpact prescription drug plan.
- ◆ The PEEHIP prescription drug plan includes Step Therapy, Prior Authorization, and Quantity Level Limitations for certain medications.
- ◆ Refills on Retail and Specialty drugs (30-day supply) are allowed only after 75% of the previous prescription has been used (for example, 23 days into a 30-day supply). Refills are allowed for maintenance drugs (90-day supply) only after 75% of the previous prescription has been used (for example, 67 days into a 90-day supply).
- ◆ Pharmacists must dispense generic drugs unless physician indicates in longhand "Do not substitute."
- ◆ Drug benefits for medically necessary fertility drugs are covered at 50% copay for any fertility drug up to a lifetime maximum of \$2,500 cost to the PEEHIP plan.
- ◆ Over-the-counter (OTC) medications are not covered even if prescribed by a physician unless mandated by the Affordable Care Act. The prescription version of an OTC medication is not covered. OTC equivalent drugs, vitamins, food supplements, and medical foods are not covered even if prescribed by a physician unless mandated by the Affordable Care Act.

Flu vaccines are allowed at most participating retail pharmacies at no cost.

DAW (Dispense as Written) Cost Differential

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

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

Three (3) copayments are charged for a 3-month supply of all brand drugs on the PEEHIP Maintenance Drug List. Two copayments are charged for a 3-month supply of all generic drugs on the list. The DAW cost differential applies for multi-source brand drugs with a generic chemical equivalent.

Specialty Drugs – New 4th Tier

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

Specialty Drugs – Copay Assistance Programs

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

Additional PEEHIP Changes - Compounds

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

Drug Utilization Management

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

Excluded Drugs

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

Non-Participating Pharmacy *(Coverage at a non-participating pharmacy in or outside Alabama)*

If members use a non-participating pharmacy they will be required to pay the full cost of the prescription. Members can submit a claim form to MedImpact to be reimbursed at the Participating Pharmacy rate. All PEEHIP copayments and clinical utilization management programs will apply. The member out-of-pocket expenses will be higher when using a non-participating pharmacy.

Step Therapy Prescription Program

The PEEHIP prescription drug program includes Step Therapy for certain medications. The Step Therapy program was implemented to keep PEEHIP sound and to keep premiums and copayments at a reasonable and affordable level. The Step Therapy program applies to “new” prescriptions that have not been purchased in over 130 days. Step Therapy is organized in a series of “steps” with your doctor approving your medication every step of the way. It is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts. Together, with MedImpact, Inc., they review the most current research on thousands of drugs tested and approved by the Food and Drug Administration (FDA) for safety and effectiveness. Member can reference the *Summary Plan Description* at www.rsa-al.gov/index.php/members/peehip/pubs-forms/ for detailed information about the Step Therapy program.

This is Only a Summary of Benefits

Members should refer to the *Summary Plan Description* for detailed information and limitations.

VIVA Health Plan

(Active Members and Non-Medicare-Eligible Retirees)

Description of Plan

The VIVA Health Plan is a Hospital Medical plan option available to active employees and non-Medicare-eligible retirees who do not have Medicare-eligible dependents; in addition, the members must live in the VIVA Health service area listed below and use providers in the VIVA Health network. Participating providers can be located at www.vivahealth.com.

In addition to medical benefits, the VIVA Health plan option also includes dental benefits, vision benefits, and an extensive drug formulary. Except in situations described below, all care must be received from Participating Physicians. With VIVA Health, PEEHIP members have access to 70 hospitals and over 7,000 physicians statewide. A brief explanation of benefits is below, and a comparison of the two plan options starts on page 30.

Note: This plan is not available to Medicare-eligible retired members or Medicare-eligible dependents covered on a retired account.

Hospital Benefits

- ◆ Inpatient Hospitalization: Services are covered in full without a dollar limit.
- ◆ Copay: \$200 for each admission. You are also responsible for the difference between private and semi-private accommodations and other non-medical items such as TV, phone, etc. There will be an additional copay of \$50 per day for days 2-5.
- ◆ Prior Authorization: All inpatient admissions require authorization from VIVA Health prior to receiving services. Emergency admissions must be certified within 24 hours or as soon as reasonably possible for the admission to a covered service.
- ◆ Inpatient Rehabilitation: Coverage in a rehabilitation facility requires a referral from a Participating Physician and prior approval of the Medical Director. Coverage is limited to 60 days per calendar year and is covered 80% by VIVA Health.
- ◆ Outpatient Hospital Charges: \$150 facility copay for outpatient services at an ambulatory surgical center; outpatient services conducted in the outpatient hospital setting covered at 90% subject to the deductible; and \$200 copay for emergency room services. The emergency room copay is waived if admitted to hospital within 24 hours.
- ◆ Skilled Nursing Facilities, Speech, Occupational and Physical Therapy: member coinsurance is 20%.
- ◆ Outpatient mental health copay is \$40.

Major Medical Benefits

- ◆ Major medical deductible per calendar year is \$300 per person; \$900 maximum per family.
- ◆ Medical and prescription calendar year out-of-pocket combined maximum is \$6,600 for individual and \$13,200 for family coverage for calendar year 2015; **\$6,850 for individual and \$13,700 for family coverage for calendar year 2016; and \$7,150 for individual and \$14,300 for family coverage for calendar year 2017.**
- ◆ There is no lifetime maximum on this plan.
- ◆ Covered Services: Physician service for medical and surgical care when you use a Participating Physician; diagnostic, x-ray, and laboratory procedures; ambulance services; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; physical therapy; allergy testing and physician services; semi-private room and other hospital care after basic hospital benefits expire.

Participating Physicians

- ◆ \$7.50 copay per lab test at independent labs; 90% coverage per test at hospital-based labs
- ◆ \$20 copay for Primary Care Physician visit
- ◆ \$40 copay for Specialty Care, Telemedicine consultation and eye exam; No referral required.
- ◆ \$40 copay for Chiropractic Care with a maximum of 25 visits per calendar year
- ◆ Preventive services are covered at 100% with no copay.

Dental Benefits

- ◆ Deductible: \$50 per person/\$150 per family deductible applies to Basic & Major Services
- ◆ Maximum coverage: \$500 Calendar year maximum
- ◆ Type I Diagnostic/Preventive Services: 100% coverage of maximum plan allowance (MPA). Services include routine oral exams, fluoride treatments (children under 19), cleanings, x-rays (limitations may apply), sealants, and space maintainers.
- ◆ Type II Basic Services: 50% coverage of MPA. Services include fillings, simple extractions, palliative services, general anesthesia, and non-surgical periodontics.

- ◆ Type III Major Services: 25% coverage of MPA and a 12 month waiting period. Services include major restorative (crowns, bridges, and dentures), denture repair, endodontics (root canals), surgical periodontics, and surgical oral surgery (includes surgical extractions).

Vision Exam Benefits

- ◆ Copay: One routine exam per year is covered in full after member pays a \$40 copay. Other treatments are covered when medically necessary for the treatment of illness or injury.

Prescription Drug Benefits

- ◆ When you choose a Participating Pharmacy you pay the following:
 - ◇ \$5 preferred generic drugs
 - ◇ \$20 non-preferred generic drugs
 - ◇ \$60* preferred brand drug
 - ◇ \$80* non-preferred brand drug

** When an appropriate grade generic is available and a brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs.*
- ◆ Mail order pharmacy is available.
 - ◇ \$12 preferred generic drug for 90-day supply through mail order
 - ◇ \$43 non-preferred generic drug for 90-day supply through mail order
 - ◇ \$150 preferred brand drug for 90-day supply through mail order
 - ◇ \$200 non-preferred brand drug for 90-day supply through mail order
- ◆ Participating pharmacies will file all claims for you.
- ◆ 70% coverage for self-administered injectibles, bio-technical, biological and specialty drugs

Non-Participating Hospitals and Outpatient Facilities

- ◆ When choosing a Hospital, Outpatient Facility, or Provider you should first check to see if they are a participating provider/ facility with VIVA Health. Your health plan gives you the freedom to choose your healthcare provider among VIVA Health’s contracted providers/facilities.
- ◆ To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out- of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don’t have to worry about extra out-of-pocket expenses.
- ◆ Emergency medical care, including Hospital emergency room services and emergency ambulance services will be covered twenty four hours per day, seven days per week, if provided by an appropriate health professional whether in **OR** out of the Service Area if the following conditions exist:
 1. The member has an emergency medical condition;
 2. Treatment is medically necessary; and
 3. Treatment is sought immediately after the onset of symptoms (within twenty-four hours of occurrence) or referral to a Hospital emergency room is made by a participating physician.

Non-Participating Pharmacy

- ◆ There are no VIVA benefits if you use a non-participating pharmacy in Alabama.

Excluded Services

- ◆ Coverage is not provided for cosmetic surgery, hearing aids, or experimental procedures. Other excluded services are listed in the Certificate of Coverage.

Service Area

Coverage with VIVA Health is available in the following areas. You can also find providers in the VIVA Health network on the VIVA website at www.whyviva.com.

Autauga	Butler	Clay	Cullman	Fayette	Jefferson	Madison	Perry	Tallapoosa
Baldwin	Calhoun	Cleburne	Dale	Franklin	Lauderdale	Marion	Pickens	Tuscaloosa
Barbour	Chambers	Colbert	Dallas	Geneva	Lawrence	Mobile	Pike	Walker
Bibb	Cherokee	Conecuh	DeKalb	Hale	Lee	Monroe	St. Clair	Washington
Blount	Chilton	Coosa	Elmore	Henry	Lowndes	Montgomery	Shelby	Wilcox
Bullock	Clarke	Crenshaw	Etowah	Houston	Macon	Morgan	Talladega	Winston

This is Only a Summary of Benefits
Members should refer to the Certificate of Coverage for detailed information and limitations.

PEEHIP Supplemental Medical Plan (Active Members and Non-Medicare-Eligible Retirees)

Blue Cross and Blue Shield of Alabama administers the PEEHIP Supplemental Medical Plan. The PEEHIP Supplemental Medical Plan is designed to only be a supplemental plan to other eligible primary coverage. It does not cover the cost of services excluded by the member's eligible primary group plan.

PEEHIP Supplemental Medical Plan Guidelines:

- ◆ There is no monthly premium for a single or family plan when the member uses the employer contribution amount for the PEEHIP Supplemental Medical Plan.
- ◆ The PEEHIP Supplemental Medical Plan provides secondary coverage to the member and covered dependent(s) when eligible primary coverage is provided by another employer.
- ◆ The PEEHIP Supplemental Medical Plan 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.
- ◆ PEEHIP Hospital Medical Plan limitations and exclusions will apply.
- ◆ The PEEHIP Supplemental Medical Plan will not pay for amounts in excess of the allowed amount for services rendered by a non-preferred provider, amounts in excess of 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 plans with deductibles greater than \$1,450 for individual or \$2,700 for family are also not eligible for the PEEHIP Supplemental Medical Plan.
- ◆ 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.
- ◆ For inpatient mental health and substance abuse services, there is a maximum allowance of 30 total days per member per plan year. Inpatient substance abuse services are limited to one admission per plan year and a maximum of two admissions per lifetime.
- ◆ For outpatient mental health and substance abuse services, there is a maximum allowance of 10 visits per member per plan year.
- ◆ The annual maximum amount paid from the PEEHIP Supplemental Medical Plan will be limited to \$6,600 for individual and \$13,200 for family coverage for calendar year 2015; \$6,850 for individual and \$13,700 for family coverage for calendar year 2016; and **\$7,150 for individual and \$14,300 for family coverage for calendar year 2017**.
- ◆ Only active employees and non-Medicare-eligible retirees and dependent(s) are eligible to enroll in this plan.
- ◆ **Members who are only enrolled in the PEEHIP Hospital Medical Plan can switch and enroll in the PEEHIP Supplemental Medical Plan* at any time during the year, prospectively, without a Qualifying Life Event (QLE).** *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 Board (LGB), Medicare, Medicaid, ALL Kids, Tricare or Champus as their primary coverage **cannot 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).

Members who enroll in the plan will receive more detailed information.

This is Only a Summary of Benefits
Members should refer to the *Plan Matrix* for detailed information and limitations.

Optional Coverage Plans

(Active and Retired Members)

Southland Benefit Solutions administers the Optional Coverage Plans offered through PEEHIP. Optional Coverage Plans in which the member enrolls must be all single or all family, with the exception of the dental plan. In the event that the member's only dependent wears dentures, the member may carry single dental while other plans remain family. Enrollment in Optional Coverage Plans 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 employment and cancel the plans October 1 of that same year. Members enrolled in family Optional Coverage Plans cannot change to single Optional Coverage Plans outside of the Open Enrollment period unless all dependent(s) become ineligible due to age, death or divorce.

A summary of benefits is listed below. Members who enroll in the Optional Coverage Plans should refer to their benefit booklet for detailed information and limitations.

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.

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 (3) 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 have the opportunity to use network dentists but still have the freedom to use any dentist.

Remember: Dental benefits under this plan will always be paid secondary to other dental plans.

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 and \$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.

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 single 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.

Southland will provide, at **no cost**, its Vision Choice plan to all PEEHIP members who participate in any of the Optional Coverage Plans. Members who use Vision Choice providers will save approximately 20%.

There is no premium cost to enroll in the four Optional Coverage Plans for a full-time active employee who is not enrolled in one of the PEEHIP Hospital Medical Plans. If an employee is enrolled in a PEEHIP Hospital Medical Plan or HMO Plan, he or she can purchase one or more Optional Coverage Plan (see Premium Rates for details).

This is Only a Summary of Benefits

Members should refer to the *Optional Plan Booklet* for detailed information and limitations.

Comparison of Benefits

Effective October 1, 2016 – September 30, 2017 (changes are in bold)

This is a summary of your group benefits. Please be sure to read the entire “*Summary Plan Description*” document on the website for a complete list of benefits, limitations and exclusions.

www.rsa-al.gov/index.php/members/peehip/pubs-forms/

	PEEHIP - Hospital Medical (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only) (Active and Non-Medicare Members Only)
Preventive Medical	\$0 copayment then covered in full	\$0 copayment then covered in full
Well Baby Care	Covered at 100% of the allowed amount with no deductible or copayment. See AlabamaBlue.com/preventiveservices for a listing of the specific immunizations and preventive services.	\$0 copayment then covered in full
Routine Immunizations	\$0 copayment then covered in full	\$0 copayment then covered in full
Office Care		
Physician’s Care	\$30 copayment per visit	\$20 per visit for primary care.
Specialist	\$35 copayment per visit	\$40 copayment per visit
Lab/Diagnostic Procedures	\$5 per test	\$7.50 per lab test at independent labs 90% coverage for x-ray 90% coverage per test at hospital based labs
Telemedicine Consultation	Not covered	\$40 copay
Inpatient Facility (including Maternity)**		
Physician’s Care	Covered in full	Covered in full
Inpatient/ Hospital Services	\$200 hospital copayment per admission and \$25 per day for days 2-5	Covered in full after \$200 copayment per admission and \$50 per day for days 2-5
Outpatient Surgery	\$150 copayment	\$150 copayment for services performed at an ambulatory surgical center 90% coverage for services performed at other facilities
In-Hospital Care		
Surgeon	Covered in full	Covered in full
Physician Visits	Covered in full	Covered in full
Anesthesiologist	Covered in full	Covered in full
Emergency		
In Area/Out of Area Emergency Room Facility Charge	\$150 per visit; Members are also responsible for the physician copayment and lab fees. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to calendar year deductible. Accidents treated as any other illness; all applicable copays will apply.	\$200 emergency room visit for facility, waived if admitted through the ER; Physician’s charges covered at 100%
Calendar Year Deductible for Major Medical Services		
	Calendar year deductible \$300 per individual; \$900 maximum per family.	Calendar year deductible \$300 per individual; \$900 maximum per family.

* *VIVA Health Plan: No referral from a primary care physician (PCP) is required.*

Members must use providers and facilities in the VIVA Access Network.

**** Maternity benefits are not available to children of any age.**

	PEEHIP - Hospital Medical (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only) (Active and Non-Medicare Members Only)
Major Medical Services and Coinsurance		
	After you pay the \$300 deductible, the plan pays 80% of the allowed amount of covered expenses for the first \$2,000 and 100% of the allowed amount, thereafter. Therefore, you will have a \$400 individual annual out-of-pocket maximum plus the \$300 calendar year deductible. 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.	After you pay the \$300 deductible, the plan pays 80% of the allowed amount of covered expenses.
Mental Health and Substance Abuse		
Inpatient	Copayments: \$0/day for days 1-9, \$15/day for days 10-14, \$20/day for days 15-19, \$25/day for days 20-24, \$30/day for days 25-30. Maximum of 30 days per member per plan year at approved facilities. Limit of one substance abuse admission per plan year and a lifetime maximum of two admissions per member. Benefits not provided for substance abuse facility except when provider is a PPO facility.	Covered in full after \$200 copayment and a \$25 copayment for days 2-5.
Outpatient	\$50 copay for up to 12 visits per year. No Major Medical deductible or balance billing. For a list of in-network providers, see AlabamaBlue.com. Members can continue to use the applicable mental health centers for outpatient benefits at \$10 copay per visit and 20 visit maximum per plan year.	Covered in full after \$40 copayment
Prescription Drugs	(Administered by MedImpact) Generic – \$6 copay (1-30 day supply) \$12 copay (31-90 day supply) Formulary (preferred brand name) - \$40 copay (1-30 day supply) \$80 copay (31-60 day supply) \$120 copay (61-90 day supply) Non-formulary (non-preferred brand name) - \$60 copay (1-30 day supply) \$120 copay (31-60 day supply) \$180 copay (61-90 day supply) Pharmacists must dispense a generic equivalent medication when one is available unless the physician indicates on the prescription “medically necessary”, “dispense as written”, or “do not substitute”.	Preferred Generic - \$5 copay, \$12 Mail Order 90-day supply Generic - \$20 copay, \$43 Mail Order 90-day supply Preferred Brand (formulary)- *\$60 copay, \$150 Mail Order 90-day supply Non-Preferred Brand (non-formulary) - *\$80 copay, \$200 Mail Order 90-day supply *When an appropriate grade generic is available and a brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs. Mail order pharmacy is available. 90-day supply available with mail order - 2.5x copay. 90-day supply at retail pharmacy - 3x copay.

	PEEHIP - Hospital Medical (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only) (Active and Non-Medicare Members Only)
<p>Prescription Drugs (cont.)</p>	<p>Approved Maintenance drugs must be on the approved maintenance list of drugs and must be prescribed for 90 days. First fill for a new maintenance drug will be a 30-day supply.</p> <p>DAW (Dispense as Written) Cost Differential: Members will be subject to the difference between the cost of the brand drug and its generic equivalent, regardless of whether the physician indicates the brand must be taken.</p> <p>Specialty Drugs – 4th Tier: Member are responsible to pay the 20% coinsurance with a minimum copay of \$100 and maximum copay of \$150. The DAW cost differential applies for multi-source brand drugs with a generic chemical equivalent.</p> <p>Certain prescription drugs and medications are excluded from PEEHIP coverage. To verify the formulary and coverage status of a medication, please visit the MedImpact website at https://mp.medimpact.com/ala.</p> <p>Contraceptives are covered. \$0 copay-Generic; applicable copay for brand-name.</p> <p>Flu vaccine covered at no cost when administered by a participating retail pharmacy.</p> <p>Certain medications have quantity level limits to comply with the FDA guidelines and to ensure drug safety for our members. Certain medications are subject to Step Therapy. Prior authorizations are required before covered members can receive certain medications.</p> <p>In-state and out-of-state non-participating pharmacies: Members must pay the full amount of the prescription and then file the claim to be reimbursed at the participating pharmacy rate. Members pay the difference in cost plus appropriate copayments. All PEEHIP, clinical utilization management programs will apply. Out-of-pocket expenses will be higher if you use a non-participating pharmacy.</p>	<p>Contraceptives are covered. \$0 copay-Generic; applicable copay for brand-name.</p> <p>70% coverage for self-administered injectable, bio-technical and biological drugs and maximum out-of-pocket is combined with the major medical out-of-pocket for a total combined out-of-pocket of \$6,600 per member or \$13,200 per family for calendar year 2015; \$6,850 per member and \$13,700 per family for calendar year 2016; and \$7,150 for individual and \$14,300 for family for calendar year 2017.</p> <p>Participating pharmacies only.</p> <p>VIVA provides no pharmacy benefits when a non-participating pharmacy in Alabama is used.</p>

	PEEHIP - Hospital Medical (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only) (Active and Non-Medicare Members Only)
Prescription Drugs (cont.)	<p>Until 1/1/2017, Medicare-eligible retired members and Medicare-eligible covered dependents are provided prescription drug coverage through the PEEHIP Medicare Part D plan administered by Medicare GenerationRX.</p> <p>Effective 1/1/2017, Medicare-eligible retired members and Medicare-eligible covered dependents will be provided prescription drug coverage through the UnitedHealthcare Group Medicare Advantage (PPO) plan for PEEHIP retirees. Visit www.uhcretiree.com/peehip for more information.</p>	
Other Services		
Out-of-state Coverage for Non-PPO Provider	Major Medical benefits apply – payable at 80% of the allowed amount after paying the \$300 yearly deductible	Only Emergency and Urgent Care Services and Prescription Benefits available
Out-of-state Coverage for PPO Provider	\$30 copayment per visit. Members must use providers participating in the Blue Cross plan of that state.	Only Emergency and Urgent Care Services and Prescription Benefits available.
Vision Examinations	Not Covered	Covered in full once each 12 months after a \$40 copayment with participating provider
Dental	Not Covered	<p>(Administered by Delta Dental)</p> <p>The Dental Plan allows you to seek treatment from any licensed dentist. The plan reimburses a percentage of eligible expenses based on usual, customary and reasonable (UCR) fees.</p> <p>Type I – Preventative & Diagnostic – 100% of UCR Type II – Basic Services – 50% of UCR Type III – Major Services** - 25% of UCR</p> <p>Deductible (applies to Basic & Major Services) - \$50 per person/\$150 per family; Calendar Year Max - \$500 **12-month Waiting Period applies to Major Services</p>
Spinal Service & Chiropractic Services	<p>Participating Chiropractor – Covered at 80% of the allowed amount with no deductible. After 18 visits in a calendar year, services are subject to precertification. Member will owe 20% coinsurance.</p> <p>Non-participating Chiropractor – Covered under major medical at 80% of allowed amount. Member will owe 20% coinsurance, major medical deductible of \$300 and charges over allowed amount. Limited to 12 visits in a calendar year per member.</p>	<p>Limited to 25 visits per calendar year</p> <p>\$40 copayment per visit</p>

	PEEHIP - Hospital Medical (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only) (Active and Non-Medicare Members Only)
Infertility Services	<p>Benefits for infertility services are limited to a lifetime maximum of 8 artificial insemination attempts (whether successful or not). Benefits are not provided for IVF, ART, or GIFT.</p> <p>Benefits for medications for infertility treatment are provided with a 50% copay 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.</p>	<p>Coverage for infertility services is limited to initial consultation and one counseling session only. Testing is limited to semen analysis, HSG and endometrial biopsy (covered once during the Member's lifetime). Treatment for infertility is not a Covered Service.</p>
Annual Out-Of-Pocket Maximums for In-Network Services	<p>Covered members will pay no more than: \$6,600 for individual coverage and \$13,200 for family coverage for calendar year 2015; \$6,850 for individual coverage and \$13,700 for family coverage for calendar year 2016; and \$7,150 for individual and \$14,300 for family coverage for calendar year 2017.</p> <p>Out-of-pocket maximums apply to in-network combined medical and prescription drugs during the calendar year.</p>	<p>Covered members will pay no more than: \$6,600 for individual coverage and \$13,200 for family coverage for calendar year 2015; \$6,850 for individual coverage and \$13,700 for family coverage for calendar year 2016; and \$7,150 for individual and \$14,300 for family coverage for calendar year 2017.</p> <p>Out-of-pocket maximums apply to in-network combined medical and prescription drugs during the calendar year.</p>

** VIVA Health Plan: No referral from a primary care physician (PCP) is required. Members must use providers and facilities in the VIVA Access Network.*

This is Only a Summary of Benefits

Members should refer to the *Summary Plan Description* for detailed information and limitations.

Coordination of Benefits (COB)

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 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 cancelled, 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 form regarding their other coverage. The member must also send PEEHIP a letter from the other insurer as legal proof of cancellation (i.e. Certificate of Creditable Coverage or Proof of Prior Coverage letter). Documentation must show a cancellation date.

Dental and Vision Plans

If an employee 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 covered 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. For more information on the COB rules, refer to the *PEEHIP Summary Plan Description*.

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.

PEEHIP Wellness Programs

(Active Members and Non-Medicare-Eligible Retirees)

Team Up For Health

PEEHIP has *Teamed Up For Health* with the Alabama Department of Public Health (ADPH) and ActiveHealth as our strategic partners and administrators of PEEHIP's comprehensive and industry-leading *Team Up for Health* Wellness Program. This program offers **FREE** services for members and their covered spouse. In accordance with healthcare reform law, there is no required health standard which must be met.

The goals of the program are to:

- ◆ Help members and their families achieve or maintain good health,
- ◆ Promote the early detection and identification of chronic disease,
- ◆ Encourage lifestyle changes that lower the risk of chronic disease and illnesses,
- ◆ Enhance wellness and productivity,
- ◆ Significantly reduce healthcare spending by the PEEHIP plan and by PEEHIP members by reducing the number and severity of negative health outcomes.

This program and its **free** services are designed to help PEEHIP members live happier, healthier and more satisfying lives. Healthier members typically get sick less often and visit the doctor less frequently. This leads to lower healthcare costs for our members and the plan while providing an invaluable benefit to members.

Wellness Premium Waiver

The following members **enrolled in the PEEHIP Hospital Medical Group #14000 Plan** administered by Blue Cross Blue Shield are required to complete the applicable wellness activities by August 31 of each year in order to earn a waiver of the \$50 monthly wellness premium. If all required activities are not completed by the August 31 deadline, the \$50 monthly wellness premium will be charged beginning October 1.

- ◆ **Members currently employed by a PEEHIP participating system and their covered spouse, regardless of Medicare eligibility**
- ◆ **A retired employee who is not Medicare eligible**
- ◆ **A non-Medicare-eligible spouse covered on a retiree contract**
- ◆ **Members on COBRA, Leave of Absence and surviving spouses who are non-Medicare-eligible**

The wellness premium applies separately to covered members and their covered spouse. Covered members and their covered spouse can each earn the wellness premium waiver of \$50 for a potential combined wellness premium waiver of \$100 each month. The wellness premium will be applied to the monthly PEEHIP premium beginning each October 1 for members and spouses who do NOT participate or who do not complete all of the required wellness activities by the annual August 31 deadline.

Newly Enrolled PEEHIP Members

All newly enrolled PEEHIP members and covered spouses have the same August 31 due date as the existing PEEHIP membership, unless their new effective date of coverage occurs between June 2 and September 30. If their effective date of coverage falls within this time period, then their due date to complete their required activities will be August 31 of the following year, rather than the year in which they enroll. This means that no PEEHIP member will ever have less than 3 months to complete his/her wellness program requirements.

Newly enrolled PEEHIP members have the same wellness screening and HQ requirement as existing PEEHIP members, and health coaching may also be applicable to them if they receive a health coaching invitation letter from ActiveHealth. ActiveHealth sends health coaching invitation letters once per year in October. The "My Required Activities" link at the www.MyActiveHealth.com/PEEHIP website also shows the specific activities required to earn the \$50 monthly wellness premium waiver. New members will receive introductory letters to the wellness program and reminder letters of their required activities and specific due dates.

The following members are NOT required to participate in the wellness program:

- ◆ Children
- ◆ PEEHIP members or spouses who are only enrolled in the Optional Coverage Plans, the PEEHIP Supplemental Medical Plan, or the VIVA Health Plan
- ◆ Medicare-eligible retirees and Medicare-eligible spouses covered on a retiree contract (even if enrolled in the PEEHIP Hospital Medical Plan Group #14000)

Required Wellness Activities

If you are required to participate in *Team Up for Health*, you must complete these minimum wellness activities by August 31 each year in order to qualify for the \$50 monthly wellness premium waiver:

- ◆ Wellness Screening
- ◆ Health Questionnaire (HQ)

Participation in one of the following Health Coaching activities is required only if you and/or your covered spouse is identified as a candidate for these programs and receive an invitation letter from ActiveHealth:

- ◆ Wellness Coaching (Available online, telephonic, or onsite)
- ◆ Disease Management Coaching (Available online, telephonic, or onsite)
- ◆ Enhanced Disease Management Coaching (Requires 4 health coaching phone calls with an ActiveHealth nurse)

Wellness Screenings

All PEEHIP members are eligible to receive one FREE annual wellness screening by the ADPH nurses at various sites during the year, with the yearly restart date of August 1 to coincide with the restart of each school year.

Visit the ADPH online screening calendar at www.adph.org/worsitewellness to learn when and where screenings will be offered at your workplace or in your area. Members will be required to show their PEEHIP ID card at the screening.

Wellness Screenings will measure:

- ◆ Blood pressure
- ◆ Height, weight, waist, waist to height ratio, and body mass index (BMI)
- ◆ Total cholesterol (HDL and LDL)
- ◆ Triglycerides
- ◆ Blood glucose

Also, *no copay* is required if an ADPH wellness coach gives the member and/or covered spouse an Office Visit Referral form to take to a physician's office to follow up with the abnormal results or risk factors identified during the screening process. The *no copay* referral is only good for 60 days from the screening date. Please 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.

Healthcare Provider Screenings

If you are required to participate in *Team Up for Health* and prefer for your primary care physician to do your screening, you will need to have your doctor complete the Healthcare proVider ScreenIng form which is located on the PEEHIP website at www.rsa-al.gov/index.php/members/peehip/pubs-forms/. Your **doctor's office** must complete and fax or mail the form to ADPH. 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 your 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, and 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, in order to complete your wellness screening requirement, only one wellness screening is required per year by each August 31.

Health Questionnaire (HQ)

The Health Questionnaire (HQ) provides an assessment of your overall health and helps find ways to improve your health and well-being. Log in to www.MyActiveHealth.com/PEEHIP with your self-selected user ID and password to complete the HQ online using your computer, smart phone or tablet. If you do not have access to the Internet, you can call ActiveHealth toll-free at 855.294.6580 to complete the HQ over the phone.

Wellness Coaching

Wellness Coaching, available through ActiveHealth, connects members with registered dietitians, nutritionists, exercise physiologists, or other licensed counselors who can help members to build a plan for achieving healthier lifestyles. Want to eat healthier? Lose weight? Stop smoking? The coaching process offers numerous resources and services to help you maintain or improve upon a healthy lifestyle.

Disease Management

PEEHIP's Disease Management program is provided by ActiveHealth for members required to participate in *Team Up for Health*. The Disease Management program focuses on five chronic illnesses and the reduction of future complications associated with these diseases: asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease (COPD). ActiveHealth connects you with a licensed nurse to work with you one on one to help manage

these long term conditions. You are required to participate in Disease Management only if you receive an invitation letter from ActiveHealth.

Disease Management for children and adult child dependents covered by PEEHIP's Hospital Medical Plan Group #14000 is provided by Blue Cross Blue Shield of Alabama.

Enhanced Disease Management

Some PEEHIP members will be identified as candidates for a higher level of personalized health coaching care from a licensed ActiveHealth nurse. These members will be invited to complete an enhanced Disease Management program which requires completing 4 telephonic health coaching calls before the August 31 deadline. These members with a specific 4 coaching call requirement will be notified of their specific requirement by mail in October each year, and their dedicated nurse coach will work with them to develop a call schedule that is most convenient and helpful for them.

Options to Complete Wellness or Disease Management Coaching

1. **Online:** Log in to www.MyActiveHealth.com/PEEHIP to earn 100 heartbeat units (which equals 1 heartbeat goal) of online coaching to complete required wellness coaching or disease management.
2. **Telephonic:** If you do not have access to the Internet, you may call ActiveHealth toll-free at 855.294.6580 to complete your coaching requirement on the phone.
 - ◇ **Note:** Members identified for the enhanced 4 phone call disease management requirement may only complete their health coaching telephonically at 855.294.6580.
3. **On-site health coaching clinics:** PEEHIP now offers group health coaching sessions as another option for members to complete their health coaching requirement. Three ActiveHealth wellness coaches are available to travel the state and lead on-site group coaching classes for any PEEHIP member, covered spouse, or retiree that would like to attend. By attending one of these one-hour or less coaching sessions, PEEHIP participants will be given credit for their coaching requirement. These sessions will be held on demand at locations all over the state, so ask your school's insurance coordinator about requesting a coaching session in your area! Retirees or spouses can call PEEHIP for available locations.

24-Hour Nurse Line

ActiveHealth provides a 24-hour nurse line for members required to participate in *Team Up for Health*. Members can speak with a registered nurse 24 hours per day, 7 days per week to inquire about a health related matter. Your personal health facts will be kept private and confidential. To reach the nurse line, call ActiveHealth at 855.294.6580.

Care Considerations and Health Actions

ActiveHealth continuously analyzes healthcare information to look for opportunities to recommend certain tests, or medications, or treatments. All care considerations encourage members to first speak with their healthcare provider about the recommendation.

MyActiveHealth Website

Visit this website at www.MyActiveHealth.com/PEEHIP for tools designed to help you reach your health goals. These include the HQ, a Personal Health Record, Online Health Coaching, videos, quizzes, and other interactive tools.

Track Your Completion Status of Your Required Wellness Activities

Your Progress Wheel is available on your "My Wellness Rewards and My Required Activities" web page and shows the percentage of completion of all your required activities. Once you have completed all required wellness activities, your Progress Wheel will show 100% complete. All of your required activities are shown on your action cards on this web page.

If you would like additional confirmation of your wellness premium waiver status, you can also view your status on the PEEHIP member online services web page at <https://mso.rsa-al.gov>.

Tobacco Cessation Programs

ActiveHealth offers a free tobacco cessation program with live and online counseling to those members listed above who are eligible for their services. For more information visit www.MyActiveHealth.com/PEEHIP or call 855.294.6580. The ADPH also offers Alabama Tobacco Quitline, a free service for all Alabamians. Alabama Tobacco Quitline offers live and online counseling, and is available toll free at 1.800.QUIT.NOW (800.784.8669) or online at www.quitnowalabama.com. For more information on the services provided by the PEEHIP *Team Up for Health* Wellness Program, visit www.rsa-al.gov/index.php/members/peehip/health-wellness/.

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 per month tobacco premium. The tobacco premium does not apply to the PEEHIP Optional Coverage Plans or the PEEHIP Supplemental Medical Plan. **Members who do not use tobacco or electronic smoking devices** can have the \$50 premium waived 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 spouse if there is a tobacco status change during the year, when members make changes to their coverages, and at the time of the wellness screening. Members can certify their non-tobacco use either online through Member Online Services (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 our automated premium invoice generation, and these discounts are prospectively applied to member accounts beginning with the first full month after PEEHIP has received certification that a member and/or covered spouse has been a non-tobacco user for the previous consecutive 12 months.

If you do not qualify for the non-tobacco user discount due to your tobacco-use within the past 12 months, eligibility for the discount can be obtained via completion of one of PEEHIP's tobacco cessation programs. However, 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, you may become eligible to receive the discount for either the entire plan year or prospectively from the time you complete the program through the end of the plan year.

To seek the premium discount from the beginning of the plan year, you must first complete PEEHIP's Commitment to Participate in Tobacco Cessation form. This form must be completed and sent to PEEHIP with a post-marked date of no later than October 31. Upon receipt of this form, PEEHIP will notate that you are in pending status for a tobacco cessation program. If you complete the cessation program before the end of the plan year, you must then send your completion certificate to PEEHIP along with a signed letter requesting to have your tobacco premium removed based on your completion of the tobacco cessation program. The completion certificate and written request must have a post-marked date prior to the end of the plan year. If PEEHIP receives all of the required documentation by the time periods previously specified, then you will be eligible to receive reimbursement of the tobacco premiums that you paid since the beginning of the plan year. You will also receive a prospective tobacco premium discount through the end of the plan year.

If you do not send a Commitment to Participate in Tobacco Cessation form to PEEHIP by October 31, then you will not be eligible to receive the tobacco premium discount for the entire plan year. If you proceed to complete the tobacco cessation program prior to the end of the plan year, then you will only be eligible to receive the premium discount prospectively from the time PEEHIP receives your tobacco cessation completion certificate and signed written request to have your tobacco premium removed. Your discount will then 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 in order 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 months, the premium discount will be applied and no further cessation program participation will be required if their status remains tobacco free. If you would like to receive more information about the tobacco cessation program, you can contact the PEEHIP Wellness Coordinator toll free at 877. 517.0020.

New employees who enroll in the PEEHIP Hospital Medical 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 Member Online Services (MOS) at the time of enrollment.

Baby Yourself Program

Baby Yourself is a prenatal wellness program, administered by Blue Cross and Blue Shield of Alabama, for expectant mothers. This program is part of your PEEHIP Hospital Medical coverage and is available at no cost to you. PEEHIP strongly encourages all expectant mothers covered under the PEEHIP Hospital Medical plan to sign up for *Baby Yourself* today. If you are a soon-to-be expectant mother, please sign up as soon as you confirm your pregnancy. PEEHIP encourages you to sign up for the program with each pregnancy even if you have already participated. When you sign up, you will receive:

- ◆ Support from an experienced Blue Cross registered nurse
- ◆ Educational information by telephone and email during your pregnancy
- ◆ Useful gifts that encourage healthy habits, proper prenatal care, and help you understand the changes and challenges of pregnancy

PEEHIP will waive the \$200 copayment for the delivery of your baby for those members **enrolling in the first trimester** and who complete the program. The \$25 per day copayment for days 2 through 5 will apply (maximum of \$100 copayment). The vast majority of mothers who delivered premature babies did not participate in the PEEHIP *Baby Yourself* program. The goal of *Baby Yourself* is to have healthy mothers and babies at delivery.

If you are pregnant, please enroll today in *Baby Yourself* by calling 800.222.4379 or registering online at www.bcbsal.com/baby.

ALL Kids Children's Health Insurance Program (CHIP)

(Active Members)

The Federal Health Care Reform legislation allows public education employees to participate in the ALL Kids CHIP program administered by the Alabama Department of Public Health (ADPH).

Members must re-apply for ALL Kids each year to continue to receive coverage.

Children may be eligible if they are:

- ◆ An Alabama resident,
- ◆ Under age 19,
- ◆ A U.S. Citizen or an eligible immigrant,
- ◆ Not covered or eligible for Medicaid,
- ◆ Not a resident in an institution,
- ◆ Not covered by other group health insurance for 30 days, and
- ◆ Within the income ranges established for participation (see income guidelines)

How to apply:

- ◆ Complete an application online at www.adph.org or download a paper application from the ADPH website. You can also call 888.373.KIDS (5437) to have an application mailed to you.
- ◆ ALL Kids will determine eligibility for your children and will let you know if your child is:
 - ◇ eligible and is being enrolled in ALL Kids,
 - ◇ under income and your application is being forwarded to Medicaid, or
 - ◇ over income and not otherwise eligible.

Monthly Gross Income Guidelines for Medicaid and ALL Kids
Children Under 19 Years

Family Size	Medicaid	ALL Kids
1	0-\$1,446	\$1,447-\$3,139
2	0-\$1,950	\$1,951-\$4,232
3	0-\$2,453	\$2,454-\$5,326
4	0-\$2,957	\$2,958-\$6,420
5	0-\$3,461	\$3,462-\$7,513

Becoming eligible for ALL Kids is not a Qualifying Life Event to drop children from PEEHIP coverage outside of Open Enrollment. If you wish to enroll your eligible children in ALL Kids, you will need to cancel their PEEHIP coverage during Open Enrollment and apply for ALL Kids for an October 1 effective date.

For more information about ALL Kids, go to www.adph.org or call 888.373.KIDS (5437).

Federal Poverty Level Assistance Program (FPL)

(Active and Retired Members)

PEEHIP provides assistance to PEEHIP members with a total combined family income of less than or equal to 300% of the Federal Poverty Level (FPL), as defined by federal law, by giving a discount on hospital/medical premiums. To qualify for the FPL premium discount, PEEHIP members must submit the FEDERAL POVERTY LEVEL ASSISTANCE APPLICATION and furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Active and retired employees may apply and the FPL premium discount will be effective the first day of the second month after the receipt and approval of the application. Certification of income level will be effective for the current plan year only. The premium reduction does not renew each year.

The premium discount will apply only to the PEEHIP Hospital Medical premium or VIVA Health Plan premium and only applies to active and retired members. The premium discount does not apply to the Tobacco Premium or the Wellness Premium for those who are subject to these premiums. The FPL premium discount is not available to members who are on a Leave of Absence, COBRA, or surviving dependent contract. The FPL application can be received and/or postmarked after the close of Open Enrollment (September 1), but the premium reduction will not be effective until the first day of the second month after receipt and approval of the application.

Federal Poverty Level Premium Discount

Over 300% of the FPL	member pays 100% of the member contribution	
equal to or less than 300% but more than 250% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 250% but more than 200% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 200% but more than 150% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 150% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2016 Federal Poverty Levels (FPL)

Family Size	100% of FPL	150% of FPL	200% of FPL	250% of FPL	300% of FPL
1 member	\$11,880	\$17,820	\$23,760	\$29,700	\$35,640
2 members	\$16,020	\$24,030	\$32,040	\$40,050	\$48,060
3 members	\$20,160	\$30,240	\$40,320	\$50,400	\$60,480
4 members	\$24,300	\$36,450	\$48,600	\$60,750	\$72,900
5 members	\$28,440	\$42,660	\$56,880	\$71,100	\$85,320
6 members	\$32,580	\$48,870	\$65,160	\$81,450	\$97,740
7 members	\$36,730	\$55,095	\$73,460	\$91,825	\$110,190
8 members	\$40,890	\$61,335	\$81,780	\$102,225	\$122,670

The FPL application can be downloaded from the PEEHIP website at www.rsa-al.gov. If you do not have access to the internet, the application is also included at the back of this handbook. Members are not able to apply for the FPL discount online through MOS.

Flexible Spending Accounts (FSA)

(Active Members Only)

PEEHIP Flexible Spending Accounts (FSA) are available to all actively employed members of PEEHIP. Participation in a Flexible Spending Account allows members to save tax dollars on money that they will spend on copays, deductibles and other covered services each plan year. **Effective 10/1/2016, Blue Cross and Blue Shield of Alabama has a new FSA partner, HealthEquity. HealthEquity is an experienced and strong administrator for the Health Care and Dependent Care flex plans and is committed to providing the services our actively employed members need. HealthEquity will process the PEEHIP flex claims and reimbursements and handle all FSA customer service issues. PEEHIP members will not see any changes to the enrollment process.**

The PEEHIP Flexible Spending Accounts consist 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 Flexible Spending 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. **Health Care Flexible Spending Account (Health FSA)** allows active members to set aside up to a maximum of \$2,550 of pre-tax contributions each year to pay themselves back for eligible health care 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 your Flexible Benefits Accounts for you and your dependents as defined by IRS Section 152:

Dependent Care Flexible Spending Account:

- ◆ Licensed nursery school and day care facilities for children
- ◆ Child care in or outside the home
- ◆ Day care for elderly or disabled dependents

Health Care Flexible Spending Account:

- ◆ Physician office copayments
- ◆ Prescription drug copayments
- ◆ Dental copayments
- ◆ Orthodontia
- ◆ Deductibles
- ◆ Vision care including Lasik and Prelex surgery
- ◆ Hearing care
- ◆ OTC medications (only with a prescription)

More information is available at www.rsa-al.gov and www.healthequity.com.

Flex Enrollment and Cancellation

The Open Enrollment period for the Flexible Spending Accounts begins July 1 and extends through September 30. Accounts become effective at the start of the plan year, October 1. **Participation in the PEEHIP Flexible Spending Accounts program does not automatically renew each year.** Members currently enrolled in the PEEHIP Flexible Spending Accounts 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.

New employees are allowed to enroll in the Flexible Spending Accounts within 30 days of their date of hire. Members who are currently enrolled in another FSA through their employer are allowed to enroll in the PEEHIP Flexible Spending Accounts 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 Flexible Spending Accounts cancel at the end of the plan year, 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 Qualifying Life Event (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 Flexible Spending Account 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. Therefore, members should carefully plan the annual amount they elect to contribute to each Flexible Spending Account. A Tax Savings Calculator is available at www.rsa-al.gov and 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.

Traditional Bump Reimbursement: This method is available only for the Health FSA. The Health FSA is linked to the member's PEEHIP hospital/medical or optional dental plan. When the member pays eligible expenses not covered by their insurance, the funds are automatically reimbursed to the member. No necessary forms to file.

Manual Reimbursement: This method is available for the DCRA and Health FSA. The member must submit a REIMBURSEMENT form along with an itemized receipt indicating the charges that were incurred. The request may be submitted through the Health Equity member portal or by completing a FSA or DCRA Reimbursement form. Recurring orthodontics and DCRA claims can be scheduled for the duration of the plan year. 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.

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/Funds Roll-Over

The Flexible Spending Account plan year ends September 30. Members have until January 15 to submit a REIMBURSEMENT form along with receipts for eligible expenses that occurred during the plan year (October through September). No reimbursement will be allowed for funds remaining in the DCRA after the deadline of January 15. Remaining funds will be forfeited.

\$500 Carryover Provision (Applicable to Health FSA Only)

PEEHIP allows members up to \$500 of unused funds remaining in a Health FSA at the end of the plan year to be carried over and used for eligible Health FSA expenses in the following plan year, upon re-enrollment. The carry over funds do not affect the annual maximum contribution amount nor is it cumulative. The carry over provision will apply to all plan participants that are in active status at the beginning of the following plan year, actively employed plan participants that re-enroll during Open Enrollment for the following plan year. This provision is in accordance with guidelines set by The Department of Treasury Notice 2013-7 issued by the Internal Revenue Service on October 31, 2013. Any funds remaining in the Health FSA, after all claims received by HealthEquity, in excess of \$500 at the end of the plan year will be forfeited.

Retired Members

Retired members are not eligible to participate in the Flexible Spending Accounts due to the fact that their premiums are not pre-taxed.

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

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 Employer 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 leave of absence cannot pick up new insurance coverage that they did not have while on leave. (See **Exception**)

Employees who do not pay for their insurance while on an official leave of absence 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 online 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 Plan while on leave of absence can add the remaining Optional Coverage Plans when he or she returns to work and becomes eligible for a full employer contribution. However, employees enrolled in one or more Optional Coverage Plan while on leave cannot enroll in a Hospital Medical Plan until Open Enrollment.

When the employee returns to work, the employer must update the Employer Portal and enter the hire status as the date the leave of absence terminated.

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 member is required to be at work.
- ◆ Employees on FMLA do accrue extra months of coverage while on leave under FMLA. Therefore, 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 Employer Portal when an employee is granted FMLA.
- ◆ Employers must enter the new status and FMLA ending date in the Employer 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 the opportunity for a temporary extension of health coverage. The continuation of coverage is offered at group rates in certain instances where coverage under PEEHIP would otherwise end.

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

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

- ◆ Death,
- ◆ Termination of employment, or
- ◆ Reduction in hours.

COBRA also provides that you may have other health coverage alternatives for you and your family that may be available to you through the Health Insurance Marketplace at www.healthcare.gov or by calling 800.318.2596. You may be able to buy coverage through the Health Insurance Marketplace and could be eligible for a new kind of tax credit that lowers your monthly premiums right away. You can see what your premiums, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you will also learn if you qualify for free or low cost coverage through Medicaid or the CHIP.

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

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 greatly important. It is the employer's responsibility to notify PEEHIP within a maximum of 30 days of an employee's termination, death or reduction in hours. The employer must notify the PEEHIP office by entering a termination date in the employer portal before the next payroll cycle. Employers must key the termination date in the employer portal for each employee who loses insurance coverage due to termination or resignation of employment or 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 employer 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. PEEHIP may be notified by phone or in writing.

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 before he or she would be required to enroll in continuation of coverage under the COBRA provisions. A member on an approved leave of absence can continue the health insurance coverage for two years and then can continue the health insurance coverage for an additional 18 months under the COBRA provisions.

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

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

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

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

Continuation of Coverage

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

COBRA requires that the eligible member be afforded the opportunity to maintain continuation of coverage for 18 months due to a termination of employment or reduction in hours. COBRA requires that eligible dependents who become 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:

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

An eligible member does not have to show that he or she is insurable to choose continuation of coverage. However, under COBRA, he or she is required to pay the full 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, he or she has the right to continuation of coverage if group health coverage under the Plan is lost for any of the following reasons:

- ◆ Death of a parent
- ◆ Termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer
- ◆ Parents' divorce or legal separation
- ◆ Parent becomes eligible for Medicare
- ◆ Dependent ceases to be an eligible child under the Plan

Members on COBRA Who Return to Work

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

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

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

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 11 (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 on 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 coverages, regardless of whether the disabled individual elects the 29-month period for him or herself.

In order for this disability extension to apply, you 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. You 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, assuming that 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.

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 his or her spouse with benefits which supplement Medicare. The member has the right to elect coverage under PEEHIP on the same basis as any other employee.

If 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, 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 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 age 65 or older may decide to defer enrolling for Part B until he or she actually reaches retirement, at which point Medicare will become the primary payer and the retired member must enroll in Medicare Part B effective the date of retirement to have coverage with PEEHIP. However, a member and his or her Medicare-eligible spouse can enroll in Medicare Part B only during certain times allowed by Medicare. **Medicare-eligible members must contact their local Social Security office at least two months prior to retiring to enroll in 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. Therefore, if you have questions about when to enroll in Medicare Part B, you should contact the Social Security Administration at 800.772.1213. A Medicare-eligible retiree and/or spouse must have both Medicare Part A and Part B to have coverage with PEEHIP. If you do not have Part B, PEEHIP will only pay 20% of the Medicare allowable fee (subject to a \$30 copay on office visits, emergency room visits and outpatient consultations) as if you had Part B.

Working after Medicare-Eligible

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

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

Other Medicare Rules

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

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

If you have any questions about coordination of coverage with Medicare, please contact PEEHIP for further information. PEEHIP members who retired on disability after September 30, 2005, but are also eligible for service retirement are subject to the Sliding Scale for PEEHIP premiums.

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

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

Health Insurance Policies for Retired Members

Form 10 – Application for Retirement

In order to file for retirement benefits, a member must complete a FORM 10 - APPLICATION FOR RETIREMENT. The law provides that an application for retirement must be filed with the Teachers' Retirement System Board of Control no less than thirty (30) days or more than ninety (90) days before the first of the month in which retirement is to be effective.

The member must complete the PEEHIP INSURANCE AUTHORIZATION section on the back of Form 10 to authorize health insurance coverage. However, this section cannot be used as a PEEHIP enrollment form.

If a member is enrolled in the PEEHIP Hospital Medical Plan and one or more Optional Coverage Plan, he or she cannot drop the Optional Coverage Plan(s) until the Open Enrollment period.

The insurance contribution for retired members will pay the premium for two of the Optional Coverage Plans without a payroll deduction for those retired members enrolled in only the Optional Coverage Plan(s). The member must indicate which Optional Coverage Plan(s) he or she wants to keep on his or her date of retirement.

A Member Retiring from a Non-Participating System

A member who retires from a non-participating system is eligible to enroll in the PEEHIP Hospital Medical Plan or the PEEHIP Supplemental Medical Plan on the date of retirement. If the member did not have a Hospital Medical Plan with his or her school system, or only had single coverage, he or she can only enroll in single coverage on the date of retirement and must wait until the Open Enrollment period to add family coverage. The school system must certify if the member had a Hospital Medical Plan and whether the plan was for single or family coverage.

Vested Members Not Currently Enrolled

A retiring employee who has had a break in his or her employment and retires outside of the Open Enrollment period (vested retiree) can only enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Plan and not the Optional Coverage Plans on his or her date of retirement.

A vested retiring employee 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.

A Member Retiring from a Participating System

If a member retires from a participating system and was enrolled in the four Optional Coverage Plans on his or her date of retirement, the member can continue coverage under all four Optional Coverage Plans or can reduce coverage to two plans on his or her date of retirement. The member cannot reduce to three Optional Coverage Plans outside of Open Enrollment.

If a member has the PEEHIP Hospital Medical Plan and one or more Optional Coverage Plans, he or she cannot drop the Optional Coverage Plan(s) until the Open Enrollment period. **Also, a member cannot add Optional Coverage Plans on the date of retirement.** The insurance contribution will cover the full cost of two Optional Coverage Plans for retirees.

A member who is retiring from a participating system and is only enrolled in the Optional Coverage Plans on the date of retirement cannot add the 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 \$76.00 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 Blue Cross and Blue Shield Health Insurance Plan with the University of Alabama. Therefore, Mrs. Scott can enroll in the PEEHIP plan on January 1. If Mrs. Scott was enrolled in the family Blue Cross and Blue Shield plan with the University of Alabama, Mrs. Scott could add her dependents. However, if Mrs. Scott only had the single Blue Cross plan, Mrs. Scott could not enroll her family in the PEEHIP plan until the Open Enrollment period.

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 PEEHIP Optional Coverage Plans.

A Medicare-Eligible Retiree and Medicare-Eligible Dependent

If a member and dependent is Medicare-eligible due to age or disability at the time of his or her retirement, Medicare will become the primary payer and PEEHIP the secondary payer effective on the member's date of retirement. The PEEHIP Hospital Medical Plan will supplement the Medicare coverage. The member must notify Medicare and PEEHIP. The member and dependent must have Medicare Part A and Part B effective on the member's date of retirement. Medicare-eligible members and dependents should not enroll in a separate Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage.

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 his or her retirement date and request Medicare to change their records to reflect that Medicare should be the primary payer and PEEHIP the secondary payer effective on the member's date of retirement.** Medicare-eligible members and dependents should not enroll in a separate Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. Until January 1, 2017, PEEHIP automatically enrolls all Medicare-eligible members and Medicare-eligible dependents in the Medicare GenerationRx Medicare Part D Employer Group Waiver Program (EGWP) offered by PEEHIP unless already enrolled in a separate Medicare Part D plan or they choose not to participate/opt out. **Effective January 1, 2017, Medicare-eligible members and Medicare-eligible dependents who are covered on a retiree contract will be enrolled in the new UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP retirees. The Group Medicare Advantage (PPO) plan will be fully insured by UnitedHealthcare® and members will be able to have all of 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 new UnitedHealthcare® Group Medicare Advantage (PPO) plan offered by PEEHIP. Some other advantages regarding the UnitedHealthcare® Group Medicare Advantage (PPO) plan 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 Silver Sneakers fitness program, a 24/7 nurse line, health risk assessments, screening exams, immunization reminders, discount on hearing aids, and even an annual in-home health and wellness visit. More information will be provided through onsite educational meetings and future publications.**

What if You Want Medical Coverage Only

If you have TRICARE or a different Medicare Part D Prescription Drug plan or other creditable* prescription drug coverage and you want to keep that coverage for your prescription drugs, you can choose to opt out of the PEEHIP prescription drug coverage and keep the UnitedHealthcare® Group Medicare Advantage (PPO) plan that only includes medical coverage.

**Creditable prescription drug coverage means that it is at least as good as what Medicare Part D offers. If you are unsure whether or not your prescription drug coverage, outside of PEEHIP, is creditable please contact the prescription drug plan's administrator.*

You will receive an ID card from UnitedHealthcare® to use for your medical services. In addition, please remember to keep your other prescription drug card and use it when getting your prescriptions filled. You are responsible for any premium and drug costs associated with your separate prescription drug plan. This coverage is outside of what is offered by PEEHIP.

Important Reminders

- ◆ If you choose to opt out of the PEEHIP prescription drug coverage and enroll in the UnitedHealthcare® Medicare Advantage (PPO) plan with medical only, make sure you continue your TRICARE or other creditable prescription drug coverage. If you do not have continuous prescription drug coverage, you could risk paying a penalty should you choose later to join a plan that has Medicare prescription drug coverage.
- ◆ Medicare only allows you to have one Medicare Part D prescription drug plan at one time either as a separate (stand-alone) prescription drug plan or included as part of a Medicare Advantage plan. The plan you enroll in last is the plan that Medicare considers to be your final choice. So if you enroll in the UnitedHealthcare® Medicare Advantage (PPO) plan that already includes prescription drug coverage and then enroll in a separate Medicare prescription drug plan, Medicare will automatically disenroll you from UnitedHealthcare® Medicare Advantage (PPO) plan and you will lose your medical coverage.

Non-Medicare-Eligible Dependents

The Medicare-eligible retiree's spouse or other covered dependents who are not Medicare eligible will remain in the PEEHIP (non-Medicare) prescription drug plan.

Insurance Coverage Periods and System Contributions

Retiring members are eligible to receive the extra coverage months under the 3-1 Rule.

Examples:

- ◆ A June 1 retiree who works 9 months during the school year may receive coverage through August 31.
- ◆ A July 1 retiree who works the entire school year may receive coverage through September 30.

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

Retiree Other Employer Group Health Insurance Coverage

Legislation requires certain members who retired after September 30, 2005, to take other employer health insurance. PEEHIP members who (1) retired after September 30, 2005, (2) become employed by another employer and (3) the other employer provides at least 50% of the cost of single health insurance coverage, and (4) are eligible to receive the other employer group health insurance coverage, must use the other employer's health benefit plan for primary coverage.

PEEHIP retirees must drop the PEEHIP coverage as their primary coverage and enroll 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. 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:

Two retired spouses are both eligible for PEEHIP. The husband goes to work for a non-PEEHIP eligible employer and becomes eligible for the Group Health Plan (GHP) through his new employer. The husband chooses not to enroll in his new employer's GHP and wants to be covered by his wife's PEEHIP plan. The husband can be added to his wife's PEEHIP plan.

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 his or her Medicare coverage. Medicare will be the primary payer and PEEHIP will be the secondary payer for retirees and dependents eligible for Medicare.

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.

After Medicare pays 80% of the approved amount after the Part B deductible, PEEHIP will pay the remainder of the Medicare approved amount without a Major Medical deductible (subject to applicable copays for office visits, emergency room visits and outpatient consultations) on PEEHIP approved services. In rare situations some services are covered by Medicare and are not by PEEHIP.

Medicare-eligible members and dependents should not enroll in a separate standard Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. Prior to January 1, 2017, all Medicare-eligible members and Medicare-eligible covered dependents were automatically enrolled in the Medicare GenerationRx Medicare Part D Employer Group Waiver Program (EGWP) offered by PEEHIP unless already enrolled in a separate standard Medicare Part D plan or they choose not to participate/opt out.

Effective January 1, 2017, Medicare-eligible members and Medicare-eligible dependents who are covered on a retiree contract will be enrolled in the new UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP retirees. The Group Medicare Advantage (PPO) plan will be fully insured by UnitedHealthcare® and members will be able to have all of 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 new UnitedHealthcare® Group Medicare Advantage (PPO) plan offered by PEEHIP.

Some other advantages regarding the UnitedHealthcare® Group Medicare Advantage (PPO) plan 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 Silver Sneakers fitness program, a 24/7 nurse line, health risk assessments, screening exams, immunization reminders, discount on hearing aids, and even an annual in-home health and wellness visit. More information will be provided through onsite educational meetings and future publications.

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. However, PEEHIP will pay secondary to Medicare once PEEHIP becomes aware of your Medicare eligibility regardless of whether or not PEEHIP has received your Medicare card. Medicare-eligible members and dependents must have Medicare Part A and Part B to have coverage with PEEHIP.

Important Notice About Your Prescription Drug Coverage and Medicare

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

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

Effective January 1, 2017, Medicare-eligible members and Medicare-eligible dependents who are covered on a retiree contract will be enrolled in the new UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP retirees. The Group Medicare Advantage (PPO) plan will be fully insured by UnitedHealthcare® and members will be able to have all of 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 new UnitedHealthcare® Group Medicare Advantage (PPO) plan offered by PEEHIP.

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

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

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

Medicare Drug Plan Enrollment Period

You can join a standard Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. If you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a standard Medicare drug plan.

Standard Medicare Drug Plan and PEEHIP Drug Plan

If you decide to join a standard Medicare drug plan and drop your PEEHIP drug plan, your current PEEHIP drug coverage will terminate on the date that you enroll in a standard Medicare drug plan. Please be aware that you and your covered dependents will lose the PEEHIP drug coverage and will not be able to get this coverage back until you drop the other standard Medicare Part D coverage. You cannot have PEEHIP prescription drug coverage and a standard Part D coverage plan at the same time. If you enroll in a standard Medicare drug plan, you and your covered dependents will still be eligible for your current PEEHIP health benefits but will have no prescription drug coverage under PEEHIP.

Medicare Drug Plan Penalty when Joining Outside of the Enrollment Period

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

Example:

If you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About Options Under Medicare Prescription Drug Coverage

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

For more information about standard Medicare prescription drug coverage:

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

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

For More Information about This Notice or Current Prescription Drug Coverage

Contact the PEEHIP office at 877.517.0020 for further information. You will receive this notice each year and you can request a copy of this notice at any time.

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

Medicare Part D Prescription Drug Benefit Resources

Telephone Number/Website	Description
Medicare 800-MEDICAR; 800.633.4227 Social Security Administration 800.772.1213	Medicare Help Line Recorded information and services are available 24 hours a day, including weekends and holidays.
Medicare www.medicare.gov Centers for Medicare and Medicaid Services www.cms.gov	Provides access to information about Medicare and Medicare health plans. CMS administers Medicare and Medicaid programs. A database of frequently asked questions is available.
Social Security Administration www.ssa.gov	Link to the Social Security Administration’s site for information on low-income subsidies and other resources.
AARP www.aarp.com/bulletin	Access the Medicare Benefit Drug Calculator, which illustrates what the Medicare drug benefit means to you.
Access to Benefits Coalition www.accesstobenefits.com	Prescription drug savings for those who need them most.
Aging Parents and Elder Care www.todaysseniors.com	Senior Solutions is an independent organization providing information on issues to help seniors get the most out of retirement.
Benefits Check Up https://benefitscheckup.org	A service of the National Council on Aging; helps find programs for people ages 55 and over that may pay some costs of prescription drugs, health care, utilities, and other essential items or services.
Destination Rx www.destinationrx.com	Provides a pharmacy discount buying service.
Medicare Rights Center www.medicarerights.org	Medicare Rights Center (MRC) is the largest independent U.S. source of health information and assistance for people with Medicare.
Needymeds.com www.needymeds.com	Find information on patient assistance programs that provide no cost prescription medications to eligible participants.
Rxaminer.com www.rxaminer.com	Prescription drug comparison tool to find lower-cost prescription drugs.
Together Rx www.togetherrx.com	Offers a prescription drug savings program.

Premium Rates (Retired Members)

The following health insurance 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. 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 and show a retiree's out-of-pocket cost after subtracting the retiree insurance contribution.

Type of Contract	*Retiree Monthly Out-of-Pocket Premium	Family Premium with Covered ME Spouse	Family Premium with Covered NME Spouse
Individual Coverage/NME Retired Member	\$166	N/A	N/A
Family Coverage/NME Retired Member & More Than 1 Dependent or Only Dependent NME	\$421	\$451	\$521
Family Coverage/NME Retired Member & Only Dependent ME	\$280	\$310	N/A
Individual Coverage/ME Retired Member	\$ 25	N/A	N/A
Family Coverage/ME Retired Member & More Than 1 Dependent or Only Dependent NME	\$280	\$310	\$380
Family Coverage/ME Retired Member & Only Dependent ME	\$139	\$169	N/A

Note: For purposes of this chart, NME designates "non-Medicare-eligible" and ME designates "Medicare-eligible"

**This rate applies to the PEEHIP Hospital Medical or the VIVA Health Plan and is the monthly amount that will be deducted from a retiree's check. The VIVA Health Plan is not available to retired members who are Medicare-eligible or retired members with dependents who are Medicare-eligible.*

Retiree Sliding Scale Premium

The premium for retiree coverage is broken down into the employer share (what PEEHIP pays) and the retiree share. Under the sliding scale, the retiree is still responsible for the retiree share; however, the employer share will increase or decrease based upon a retiree's years of service. **The sliding scale premium rates can be found on the PEEHIP website at www.rsa-al.gov.** A retiree premium calculator is available for your review on our website at <http://www.rsa-al.gov/index.php/members/peehip/calculators/peehip-premium-calculator>.

- ◆ **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**, are subject to the Retiree Sliding Scale premium based on years of service. Members who retire on disability and are also eligible for service retirement are subject to the sliding scale.
- ◆ **Members who retired on or after October 1, 2005, with 25 years of service**, PEEHIP will pay 100% of the employer share of the premium. The member will only be responsible for the employee share of the premium.
- ◆ **Members who retired on or after October 1, 2005, with more than 25 years of service**, for each year of service above 25, the employer (PEEHIP) share increases by 2% and the retiree share is reduced accordingly.
- ◆ **Members who retired prior to January 1, 2012 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 prior to January 1, 2012**, are not affected by the sliding scale premiums **for twenty-four (24) months** from the member's date of retirement, provided the member submits to PEEHIP proof of application for Social Security Disability benefits. The exemption from the sliding scale premium can be extended beyond twenty-four (24) months from the member's date of retirement if the member qualifies for Social Security Disability benefits during the twenty-four (24) months following the member's date of retirement and proof of the Social Security Disability is provided to PEEHIP. For those qualifying, the premium adjustment will be made effective the first day of the second month following receipt of the Social Security notification by PEEHIP. It is important to send in your proof of application for Social Security disability and subsequent approval for Social Security disability as soon as you receive it in order to receive a premium reduction.
- ◆ **Members who retired on disability on or after January 1, 2012**, are subject to the age and subsidy component prior to becoming Medicare eligible even if they are not affected by the years of service component.
- ◆ **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. See page 59.

Optional Coverage Plan Premium

Optional Coverage Plan premiums are the same for retirees as for full-time active employees.

Retiree Sliding Scale Legislation Effective January 1, 2012

On June 14, 2011, Senate Bill 319 (Act 2011-704) was signed into law. The law was enacted primarily to address the inequity in the funding of health care benefits for non-Medicare retirees. The law changed the retiree sliding scale premium calculation so that by 2016 the funding level for active and non-Medicare would be equal; thereby removing the inequity in funding that currently exists for non-Medicare retirees. The major provisions of Act 2011-704 are summarized below. A retiree premium calculator is available for your review on the PEEHIP website at www.rsa-al.gov.

Changes to the Retiree Sliding Scale Premium Calculation

It is important to note that the changes in the retiree sliding scale premium calculation due to Act 2011-704 only apply to those who retired on or after January 1, 2012. The law has the greatest effect on employees who retire with minimal years of service (for example, someone with 10 years of service at age 60). The effect on employees who retire with 25 or more years of service is less dramatic. A retiree's cost of coverage is equal to the employer's contribution (state funding amount) plus the employee's contribution (premium). Under the sliding scale premium calculation, the employer contribution is adjusted up or down by a percentage based on years of service. If the employer contribution is reduced then the employee contribution (premium) will be increased and vice versa.

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:

- ◆ Employees who **retired before January 1, 2012** - the amount the state contributes to the cost of retiree health care (employer contribution) is decreased by 2% for each year of service less than 25 and increased by 2% for each year of service more than 25.
- ◆ Employees who **retired on or after January 1, 2012 (regardless of age)** - the amount the state contributes to the cost of retiree health care (employer contribution) 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 Premium Component**).
- ◆ Employees who retired on or after January 1, 2012 – will see no change in the service component of the sliding scale premium and 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 contribution will be reduced by 60% (15 years x 4%). The employee contribution (or premium) will increase by an amount equal to 60% of the employer contribution.

2. Addition of an Age Premium Component:

- ◆ Employees **who retired before January 1, 2012** - there is no age component that is taken into account in the sliding scale premium.
- ◆ Employees **who retired on or after January 1, 2012** - state contribution for the sliding scale premium will be reduced by 1% for each year of age of the employee 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 on or after January 1, 2012. These retirees will have 1% deducted from the employer contribution 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:

- ◆ Employees who **retired before January 1, 2012** - subsidy component is not applicable.
- ◆ Employees who **retired on or after January 1, 2012** - a subsidy premium is applicable. The subsidy premium is the net difference in the active employee's subsidy and the non-Medicare retiree subsidy. For Fiscal Year 2016, the subsidy component is \$157.42. Upon Medicare entitlement, the subsidy will be removed.

Note: The total of the additional service premium, age premium, and subsidy premium resulting from the new law will be phased-in over a 5-year period until 2016. Upon becoming Medicare-eligible, the age and subsidy premium components are no longer applicable.

Act 2011-704 and DROP

The sliding scale premium does not apply to employees 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 employees 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 insurance plans that they are covered on at the time of the member's death. The insurance plan(s) can be continued as long as the surviving dependents 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 at a later date.
- ◆ Surviving dependents do not have Open Enrollment rights.
- ◆ Once the insurance is cancelled by a surviving dependent, no reinstatement is allowed, and coverage cannot be picked up at a later date.
- ◆ Surviving dependents cannot enroll in new PEEHIP plans that they were not covered on at the time of the member's death.
- ◆ 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 and avoid a lapse in coverage.

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

Surviving Dependent Premiums Effective October 1, 2016 - September 30, 2017

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.**

Type of Contract	Monthly Premium for PEEHIP Hospital Medical or VIVA Health Plan
Individual Coverage/Non-Medicare-eligible (NME) Survivor	\$ 816
Family Coverage/NME Survivor & More Than 1 Dependent or Only Dependent NME	\$1,028
Family Coverage/NME Survivor & Only Dependent Medicare-eligible (ME)	\$1,067
Individual Coverage/ME Survivor	\$ 430
Family Coverage/ME Survivor & More Than 1 Dependent or Only Dependent NME	\$ 720
Family Coverage/Medicare-eligible Survivor & Only Dependent ME	\$ 759
Supplemental Medical Plan (Single or Family)	\$ 152
Optional (Each) - Cancer, Indemnity, Vision, and Single 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.** However, PEEHIP will pay secondary to Medicare once PEEHIP becomes aware of your Medicare eligibility regardless of whether PEEHIP has received your Medicare card. Medicare-eligible members and dependents **must have** Medicare Part A **and** Part B to have coverage with PEEHIP.

Updating Personal Contact Information

(Active and Retired Members)

Name and Social Security Number

PEEHIP determines a member's name for insurance purposes from the TRS FORM 100 ENROLLMENT form, enrollment through Member Online Services (MOS), or the NEW ENROLLMENT AND STATUS CHANGE form. PEEHIP updates names from information received from the Social Security office. **Therefore, the name on all insurance and TRS forms must be the same as the name on the Social Security card.**

PEEHIP requires a copy of the member's Social Security card before a name or Social Security number can be made. Active employees 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 your Social Security number is mandatory for PEEHIP coverage so that PEEHIP may ensure compliance with the federal Medicare Secondary Payee rules created by 42 USC 1395y(b).** Your Social Security number will be used by PEEHIP for the purpose of Coordination of Benefits

Address Changes

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

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

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

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 health care operations. The Plan may also disclose health information to the Plan Sponsor, PEEHIP, for purposes related to payment or health care operations.

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

Health care operations include but are not limited to underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services and auditing functions, including fraud and abuse programs, business planning and development, business management and general administrative activities. It also includes quality assessment and improvement and reviewing competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to conduct a review of the accuracy of how benefit claims are being paid. However, in no event will Benefit Staff use PHI that is genetic information for underwriting purposes.

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

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

Other Uses and Disclosures that do not Require Your Written Authorization

The Plan may disclose your health information to persons and entities that provide services to the Plan and assure the Plan they will protect the information or if it:

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

Additional Disclosures to Others Without Your Written Authorization

The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Official.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan an authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Official.

Your Privacy Rights

This section of the notice describes your rights with respect to your health information and a brief description of how you may exercise these rights. To exercise your rights, you must contact the Plan's Privacy Official at 877.517.0020.

Restrict Uses and Disclosures

You have the right to request that the Plan restricts uses and disclosure of your health information for activities related to payment, health care operations and treatment. The Plan will consider, but may not agree to, such requests.

Alternative Communication

The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plan to send health information to a different address than that of the Employee. The Plan must accommodate your reasonable request to receive communication of PHI by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of the information through normal processes could endanger you in some way.

Copy of Health Information

You have a right to obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You may also be asked to pay a fee of \$1.00 per page based on the Plan's copying, mailing, and other preparation costs.

Amend Health Information

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

Right to Access Electronic Records

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

List of Certain Disclosures

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

Right to A Copy of Privacy Notice

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

Complaints

You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

The Plan's Responsibilities

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

This Notice is Subject to Change

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

Your Questions and Comments

If you have questions regarding this notice, please contact PEEHIP's Privacy Official at 877.517.0020.

Purpose of the Plan

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

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 (OB/GYN) Care Notice

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

Choice of Primary Care Physician Notice

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

Women’s Health and Cancer Rights Act Notice

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

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

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

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your state for more information on eligibility.

State	Program	Contact Information (Website; Phone)
Alabama	Medicaid	http://myalhipp.com/ ; 855.692.5447
Alaska	Medicaid	http://health.hss.state.ak.us/dpa/programs/medicaid/ ; (Outside of Anchorage) 888.318.8890; (Anchorage) 907.269.6529
Colorado	Medicaid	www.colorado.gov/hcpf ; 800.221.3943
Florida	Medicaid	flmedicaidtprecovery.com/hipp/ ; 877.357.3268
Georgia	Medicaid	www.dch.georgia.gov/medicaid (Click on Health Insurance Premium Payment (HIPP)); 404.656.4507
Indiana	Medicaid	www.hip.in.gov (Healthy Indiana Plan for low-income adults 19-64); 877.438.4479 www.indianamedicaid.com (All other Medicaid); 800.403.0864
Iowa	Medicaid	www.dhs.state.ia.us/hipp/ ; 888.346.9562
Kansas	Medicaid	www.kdheks.gov/hcf/ ; 785.296.3512
Kentucky	Medicaid	www.chfs.ky.gov/dms/default.htm ; 800.635.2570
Louisiana	Medicaid	https://dhh.louisiana.gov/index.cfm/subhome/l/n/331 ; 888.695.2447
Maine	Medicaid	www.maine.gov/dhhs/ofi/public-assistance/index.html ; 800.442.6003 TTY: Maine relay 711
Massachusetts	Medicaid and CHIP	www.mass.gov/MassHealth ; 800.462.1120
Minnesota	Medicaid	http://mn.gov/dhs/ma/ ; 800.657.3739
Missouri	Medicaid	www.dss.mo.gov/mhd/participants/pages/hipp.htm ; 573.751.2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP ; 800.694.3084
Nebraska	Medicaid	http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx ; 855.632.7633

State	Program	Contact Information (Website; Phone)
Nevada	Medicaid	http://dwss.nv.gov/ ; 800.992.0900
New Hampshire	Medicaid	www.dhhs.nh.gov/oii/documents/hippapp.pdf ; 603.271.5218
New Jersey	Medicaid and CHIP	Medicaid: www.state.nj.us/humanservices/dmahs/clients/medicaid/ ; 609.631.2392 CHIP: www.njfamilycare.org/index.html ; 800.701.0710
New York	Medicaid	www.nyhealth.gov/health_care/medicaid/ ; 800.541.2831
North Carolina	Medicaid	www.ncdhhs.gov/dma ; 919.855.4100
North Dakota	Medicaid	www.nd.gov/dhs/services/medicalserv/medicaid/ ; 800.755.2604
Oklahoma	Medicaid and CHIP	www.insureoklahoma.org ; 888.365.3742
Oregon	Medicaid	www.oregonhealthykids.gov ; www.hijossaludablesoregon.gov ; 800.699.9075
Pennsylvania	Medicaid	www.dhs.pa.gov/hipp ; 800.692.7462
Rhode Island	Medicaid	www.eohhs.ri.gov/ ; 401.462.5300
South Carolina	Medicaid	www.scdhhs.gov ; 888.549.0820
South Dakota	Medicaid	http://dss.sd.gov ; 888.828.0059
Texas	Medicaid	www.gethipptexas.com/ ; 800.440.0493
Utah	Medicaid and CHIP	http://health.utah.gov/medicaid/ ; http://health.utah.gov/chip ; 877.543.7669
Vermont	Medicaid	www.greenmountaincare.org/ ; 800.250.8427
Virginia	Medicaid and CHIP	Medicaid: www.coverva.org/programs_premium_assistance.cfm ; 800.432.5924 CHIP: www.coverva.org/programs_premium_assistance.cfm ; 855.242.8282
Washington	Medicaid	www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx ; 800.562.3022 ext. 15473
West Virginia	Medicaid	www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx ; 877.598.5820; HMS Third Party Liability
Wisconsin	Medicaid and CHIP	www.dhs.wisconsin.gov/publications/p1/p10095.pdf ; 800.362.3002
Wyoming	Medicaid	https://wyequalitycare.acs-inc.com/ ; 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Forms

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

Please do not send any forms to Blue Cross Blue Shield, VIVA, or Southland National. When completing these forms, make sure the name of the subscriber and dependents is the same as the name on their Social Security card. Forms can also be downloaded from our website at www.rsa-al.gov. In lieu of using a paper form, the preferred method of enrolling or changing coverage is online at <https://mso.rsa-al.gov>.

NEW ENROLLMENT AND STATUS CHANGE – This form can be used if you are: an active or retired member who is **not** enrolled in any coverage; or an active or retired member who wants to **enroll** in one or more Optional Coverage Plans that you are not enrolled in, or are not enrolled in a Hospital Medical Plan and want to enroll.

This form can be used if you are an active or retired member currently enrolled in PEEHIP and you want to make changes to your existing coverage, and/or to certify or change your or your spouse's tobacco status. Examples: change from single to family coverage or vice-versa; cancel coverage; change your Hospital Medical Plan; add or cancel a dependent to or from family coverage. You must provide the **Requested Effective Date** or the form will be returned to you.

FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION – This form can be used if you are an **active** member and you wish to enroll or re-enroll in the Health Care and/or Dependent Care Flexible Spending Accounts. **Important:** You must re-enroll in these programs **every year** as these programs will **not** automatically renew each year without a new enrollment application. The **Health Care Account** allows members to pay for non-covered health care expenses with pre-tax dollars. The **Dependent Care Account** allows members to pay for dependent care expenses with pre-tax dollars.

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE – This form can be used if you are an **active** member and you enrolled or re-enrolled in a Flexible Spending Account(s) during Open Enrollment and subsequently wish to make a **change** to the annual contribution amount of your Flexible Spending Account(s) **before** the end of Open Enrollment or during the year if you have a qualifying life event.

FEDERAL POVERTY LEVEL ASSISTANCE (FPL) APPLICATION – This form is to be used by eligible active and retired members to apply for the FPL premium discount. **Members must re-enroll in this program every year.** This program will not automatically renew each year without a new application. This form cannot be completed online through MOS. You must submit the paper form.

COORDINATION OF BENEFITS (COB) FORM – This form can be used by an active or retired member if you, your spouse, and/ or dependent children are covered under PEEHIP and have any other hospital/medical/prescription coverage or dental or vision insurance coverage. This form is a request for other coverage information PEEHIP must have in order to provide proper coverage.

RETIREE EMPLOYMENT VERIFICATION – This form can be used by a retired member who is currently employed to verify employer health insurance benefits offered to its employees. All newly retired members must complete this form within 30 days after retirement.

Important for New Employees

Enrollment in PEEHIP coverage must be completed within **30 days** of the member's employment date. **The required method of enrollment for new employees is through Member Online Services (MOS) at <https://mso.rsa-al.gov>.**

NEW ENROLLMENT AND STATUS CHANGE



Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334.517.7000 or 877-517-0020; Fax: 334.517.7001 or 877.517.0021
 You may submit information online at <https://mso.rsa-al.gov>

Check One:

- Active Member
 Retired Member

PEEHIP Subscriber Information					
<i>Name must be entered as shown on your Social Security card.</i>					
Social Security # or PID	First Name	Middle Initial	Last Name	Date of Birth ____/____/____	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed					Date Married: ____/____/____
Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does your spouse have other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing Address		City		State	ZIP Code
Is this a change of address? <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Phone ____-____-____	Cell Phone ____-____-____	Work Phone ____-____-____	
Employer/School System			Date of Employment ____/____/____	Email Address	

Have you or your spouse used tobacco products or an electronic smoking device within the last 12 months?* **This information is required for enrollment.*

Member Spouse
 Yes No Yes No

PEEHIP Coverage Information

(You will be billed for prorata premiums or premiums that are not deducted from your payroll or retirement check.)

Section A. New Enrollment

Hospital/Medical

(PEEHIP plans are administered by Blue Cross and Blue Shield of AL)

- Coverage Type: *(Select only one of the three plans)*
- PEEHIP Hospital/Medical
 VIVA Health Plan (HMO) (Primary Care Physician _____)
 PEEHIP Supplemental Medical***(Secondary Medical)*
 **Complete Primary Insurance Information in Section D if choosing this plan.
 This plan is not a Medicare supplement & differs from Optional Coverage Plans.
- Single or Family *(complete Section C)*

Requested Effective Date ____/____/____ *(required)*

Optional Coverage Plans

(administered by Southland National)

- Note:** *Optional plans must be all Single or all Family*
- Coverage Type(s):
- Cancer Dental Indemnity Vision
- Single or Family *(complete Section C)*

These plans must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s).

Requested Effective Date ____/____/____ *(required)*

Section B. PEEHIP Coverage Information (Only check boxes requiring a change to existing coverage.)

Coverage Type:	PEEHIP Hosp/Med	**PEEHIP Supplemental	VIVA HMO	Cancer	Dental	Indemnity	Vision
Change from Single to Family Coverage	<input type="checkbox"/>						
Add dependent(s) listed in Section C to Family Coverage	<input type="checkbox"/>						
Cancel Coverage	<input type="checkbox"/>						
Change from Family to Single Coverage	<input type="checkbox"/>						
Cancel dependent(s) listed in Section C from Family Coverage	<input type="checkbox"/>						

Requested Effective Date ____/____/____ *(required) QLE changes must be submitted within 45 days of the QLE.*

Reason for Status Change(s) *(check all that apply)*

Changes cannot be processed without the appropriate documentation as explained in the Member Handbook for starred () items.*

Date change occurred (Required) ____/____/____

- | | |
|--|---|
| <input type="checkbox"/> Open Enrollment – Change effective October 1st
<input type="checkbox"/> Adoption of a child* <i>(need adoption papers)</i>
<input type="checkbox"/> Birth of a child* <i>(need birth certificate)</i>
<input type="checkbox"/> Death of spouse/dependent* <i>(need death certificate)</i>
<input type="checkbox"/> Qualifying loss of coverage* <i>(need proof of loss of coverage)</i>
<input type="checkbox"/> Divorce/Annulment/Legal Separation* <i>(need divorce decree)</i>
<input type="checkbox"/> FMLA/LOA | <input type="checkbox"/> Legal custody of a child* <i>(need legal custody papers)</i>
<input type="checkbox"/> Marriage* <i>(need marriage certificate & add'l proof of marriage)</i>
<input type="checkbox"/> Marriage of dependent child* <i>(need marriage certificate)</i>
<input type="checkbox"/> Termination of member/spouse/dependent employment*
<input type="checkbox"/> Commencement of spouse/dependent employment*
<input type="checkbox"/> Spouse's employer with different open enrollment period*
<input type="checkbox"/> Medicare/Medicaid entitlement* <i>(need copy of card)</i>
<input type="checkbox"/> Enrolling in PEEHIP Supplemental Medical Plan |
|--|---|

Note: Active members must have an IRS qualifying life event (QLE) to cancel their Hospital/Medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed. QLE changes must be submitted within 45 days of the QLE.

Section C. Dependent Information *(only required for family coverage)*

Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card. Appropriate eligibility documents are required for all dependents: All children – birth certificates; spouses – marriage certificate & additional current marriage document; adopted children – certificate of adoption or papers from adoption agency showing intent to adopt; step children – also required is the marriage certificate showing member's spouse is married to member; foster and other children – also required is the placement authorization signed by a judge or final court order with judge's signature and seal. *(See handbook for more detail.)*

Name of Dependent <i>(First, Middle, Last)</i>	Social Security #	Date of Birth	Relation to Subscriber	Sex	Handicapped
			<input type="checkbox"/> Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	N/A
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Biological <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section D. Primary Insurance Information** *(Must be completed if choosing PEEHIP Supplemental Medical)*

Name of Insurance Company	Phone Number ____-____-____	Contract/Policy #	Effective Date of Coverage ____/____/____
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Section E. Other Health Insurance Information *(Must be completed for enrollment)*

Are you, your spouse, or dependent children covered under any other Hospital, Medical, Dental, or Vision plan(s)? Yes* No

*If you answered yes, you must complete a separate COORDINATION OF BENEFITS (COB) form, available at www.rsa-al.gov.

Section F. Retiree Other Employer Information *(Must be completed if you retired after September 30, 2005)*

Are you a retiree and employed by another employer? Yes* No

*If you answered yes and you retired after September 30, 2005, and became employed by another employer, you must complete a separate RETIREE EMPLOYMENT VERIFICATION form available at www.rsa-al.gov.

Section G. Medicare Information

Are you or your covered dependent(s) eligible for Medicare? Yes* No

*If you answered yes, you must complete this section and provide a copy of the Medicare card(s) to PEEHIP before your monthly retiree premium can be reduced. **Note: As a retiree or a dependent on a retired account, you MUST have BOTH Part A and Part B to have adequate coverage with PEEHIP.** If you fail to timely enroll in Part A and B, you will have a lapse in coverage if your effective date for Part A and B is after your date of retirement. You are financially liable for medical costs incurred as PEEHIP will only pay 20% of the Medicare allowable fees.

Name	Medicare Card Number
Check the Medicare Part(s) for which you are eligible: <input type="checkbox"/> Part A-Effective: ____/____/____ <input type="checkbox"/> Part B-Effective: ____/____/____ <input type="checkbox"/> Part D**-Effective: ____/____/____	

Name	Medicare Card Number
Check the Medicare Part(s) for which you are eligible: <input type="checkbox"/> Part A-Effective: ____/____/____ <input type="checkbox"/> Part B-Effective: ____/____/____ <input type="checkbox"/> Part D**-Effective: ____/____/____	

**If you are enrolled in another Medicare Part D plan (other than PEEHIP's group Part D plan), you are not eligible for the PEEHIP prescription drug plan coverage.

Section H. PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review, and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan's behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse's tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Member Signature _____ Date Signed ____/____/____

Please mail the completed form to the address located on the front of this form.

FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION

Public Education Employees' Health Insurance Plan

P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150

334.517.7000 or 877.517.0020; Fax: 334.517.7001 or 877.517.0021

Website: www.rsa-al.gov

You can enroll online at <https://mso.rsa-al.gov>



**ACTIVE MEMBERS
ONLY**

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name
Mailing Address	City	State	ZIP Code
Date of Birth ____/____/____	Home Phone ____-____-____	Work Phone ____-____-____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed			
Employer/School System	Email Address	Date of Employment ____/____/____	

Healthcare Flexible Spending Account Information

I wish to enroll in the Health Care Flexible Spending Account for an Annual Contribution Amount of \$_____.

Annual amount cannot be less than \$120 or more than \$2,550.

Choose One: Traditional Reimbursement (bump) **OR** Manual Reimbursement

I understand that:

- The annual amount will be divided by the number of months I am an active employee in this plan year (Oct. 1 – Sep. 30). If I sign up during Open Enrollment, I will be enrolled for a full plan year and the annual amount will be divided by 12.
- Funds cannot be used to pay for health insurance premiums or non-prescription over-the-counter medication.

Dependent Care Flexible Spending Account Information

I wish to enroll in the Dependent Day Care Flexible Spending Account for an Annual Contribution Amount of \$_____.

Annual amount cannot be less than \$120 or more than \$5,000 (\$2,500 if married filing a separate tax return).

I understand that:

- The annual amount will be divided by the number of months I am an active employee in this plan year (Oct. 1 – Sep. 30). If I sign up during Open Enrollment, the annual amount will be divided by 12.
- **This account cannot be used for reimbursement of medical, dental or vision expenses for me or my dependents.**
- This account is for reimbursement of **daycare expenses**.

PEEHIP Subscriber Certification

I understand that:

- I cannot change or revoke any of my elections on this compensation redirection agreement at any time during the plan year (Oct. 1 – Sep. 30) unless I have a qualifying change in status.
- Funds in my Dependent Care FSA cannot be transferred to my Healthcare FSA, or vice-versa, for any reason.
- Participation for subsequent years is not automatic. For continual participation I must re-enroll during the Annual Open Enrollment Period even if I want to contribute the same amount as the previous year.
- Any funds remaining in the Dependent Care FSA that are not used during the plan year will be forfeited.
- I am allowed to roll over up to \$500 of unused funds in the Healthcare FSA to the subsequent plan year. Funds remaining in excess of \$500 at the end of the plan year (Sep. 30) will be forfeited.
- Reimbursement requests and documentation for eligible expenses for both the Healthcare Flexible Spending Account and Dependent Care Flexible Spending Account must be submitted to Blue Cross no later than January 15 following the end of the plan year to be eligible for reimbursement.

I hereby certify that I have completely read and fully understand the terms and conditions of the Flexible Spending Account and all information furnished is true and complete.

Employee Signature _____ Date Signed ____/____/____

Flexible Spending Accounts

Participation in a Flexible Spending Account allows you to save tax dollars on money you will spend on copays, deductibles and other covered services each plan year.

Health Care Flexible Spending Account (Health FSA) allows active members to set aside up to a maximum of **\$2,550** of pre-tax contributions each year to pay themselves back for eligible health care expenses incurred by them and their dependents. The minimum annual election to participate in the PEEHIP Health FSA is plan is \$120. For more information concerning eligible expenses see *IRS Publication 502*, Medical and Dental Expenses.

Dependent Care Flexible Spending 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. DCRA funds can only be used for reimbursement of payment for **day care expenses** (i.e., licensed nursery school or daycare for children under 13, or daycare for elderly or disabled dependents). The minimum annual election to participate in the PEEHIP DCRA plan is \$120. For more information concerning eligible expenses and guidelines governing a DCRA see *IRS Publication 503*, Child and Dependent Care Credit.

Members who participate in a Health FSA or DCRA with another sponsor, in addition to a PEEHIP account, should be mindful not to exceed the IRS yearly allowable maximum amount per tax payer.

Elected Amounts and Reimbursement

You 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. Therefore, you should carefully plan the annual amount you elect to contribute to each Flexible Spending Account. To assist in determining the contribution amount a Tax Savings Calculator is available at www.rsa-al.gov and www.healthequity.com/PEEHIP. 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. For members who plan to be employed for the full plan year and sign up during Open Enrollment, the annual amount will be divided by 12. For members that plan to retire before the end of the plan year, an adjustment will be made accordingly.

Traditional Bump Reimbursement: This method is available only for the Health FSA. The Health FSA is linked to your PEEHIP hospital / medical and Southland dental and vision coverage. When you pay for eligible out-of-pocket expenses, such as copays, the funds are automatically reimbursed to you without having to file a receipt.

Manual Reimbursement: This method is available for the DCRA and Health FSA. You must submit a Request for Reimbursement form along with an itemized receipt indicating the charges that were incurred and the dates of services. Health FSA funds are available for reimbursement up to the annual amount elected as of the first effective day of the plan. Funds for reimbursement from the DCRA become available only after contributions have been withheld from your paycheck.

PEEHIP does not offer a Flexible Spending Account Credit / Debit Card.

Timely Filing Period Deadline / Carryover

The PEEHIP Flexible Spending Account plan year ends September 30. You have until January 15 following the end of the plan year to submit a Request for Reimbursement form along with receipts for eligible expenses that occurred during the plan year (October through September). Funds remaining in the DCRA after the filing deadline will be forfeited.

\$500 Carryover Provision (applicable to Health FSA only)

PEEHIP allows members up to \$500 of unused funds remaining in a Health FSA at the end of the plan year to be carried over and used for eligible Health FSA expenses in the following plan year. Remaining Health FSA funds will be forfeited. This provision is in accordance with guidelines set by the Department of Treasury Notice 2013-7 issued by the IRS on October 31, 2013.

PEEHIP Flexible Spending Accounts are administered by Health Equity and are available to all actively employed members of PEEHIP. For a complete summary of the PEEHIP Flexible Spending Account Plan please go to www.rsa-al.gov.

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE
Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334.517.7000 or 877.517.0020; Fax: 334.517.7001 or 877.517.0021
Website: www.rsa-al.gov



**ACTIVE MEMBERS
ONLY**

PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name
--------------------------------------	------------	---------------------	-----------

Mailing Address	City	State	ZIP Code
-----------------	------	-------	----------

Date of Birth ____/____/____	Home Phone ____-____-____	Work Phone ____-____-____	Email Address
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Marital Status

Single Married Divorced Legally Separated Widowed

Reason for Status Change

I certify that I have incurred the following change in status:

- | | |
|---|--|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Dependent no longer in daycare (<i>Dependent Care FSA only</i>) |
| <input type="checkbox"/> Marriage of dependent | <input type="checkbox"/> Significant change in medical benefits or premiums |
| <input type="checkbox"/> Birth of a child | <input type="checkbox"/> Termination of spouse/dependent employment |
| <input type="checkbox"/> Adoption of a child | <input type="checkbox"/> Commencement of spouse/dependent employment |
| <input type="checkbox"/> Legal custody of a child | <input type="checkbox"/> Taking leave under the Family and Medical Leave Act |
| <input type="checkbox"/> Divorce/annulment | <input type="checkbox"/> Medicare/Medicaid entitlement |
| <input type="checkbox"/> Death of spouse/dependent | <input type="checkbox"/> Unpaid Leave of Absence |
| <input type="checkbox"/> Dependent loss of coverage | <input type="checkbox"/> Short plan year |

Date qualifying event occurred (Required) ____/____/____

Note: PEEHIP must be notified within 45 days of the occurrence of the qualifying event. Changes cannot be processed without the appropriate documentation.

Healthcare Flexible Spending Account Information

Healthcare Flexible Spending Account Change Request: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

New Annual Election Amount \$ _____

Maximum amount cannot exceed \$2,550 and the minimum annual amount is \$120. New monthly contribution amount will be determined by dividing the remaining election amount by the total months remaining in this plan year.

Stop Payroll Deductions

Reimbursement Option Change can only be made by calling PEEHIP Flex Plan at 877.288.0719.

Dependent Care Flexible Spending Account Information

Dependent Care Flexible Spending Account Change Requested: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

New Annual Election Amount \$ _____

Maximum amount cannot exceed \$5,000 if single or married filing a joint return, \$2,500 if married filing separate returns. The minimum annual amount is \$120. New monthly contribution amount will be determined by dividing the remaining election amount by the total months remaining in this plan year.

Stop Payroll Deductions

PEEHIP Subscriber Certification

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify under penalties of perjury that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature _____ Date Signed ____/____/____

Flexible Spending Accounts

Participation in a Flexible Spending Account allows you to save tax dollars on money you will spend on copays, deductibles and other covered services each plan year.

Health Care Flexible Spending Account (Health FSA) allows active members to set aside up to a maximum of **\$2,550** of pre-tax contributions each year to pay themselves back for eligible health care expenses incurred by them and their dependents. The minimum annual election to participate in the PEEHIP Health FSA is plan is \$120. For more information concerning eligible expenses see *IRS Publication 502*, Medical and Dental Expenses.

Dependent Care Flexible Spending 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. DCRA funds can only be used for reimbursement of payment for **day care expenses** (i.e., licensed nursery school or daycare for children under 13, or daycare for elderly or disabled dependents). The minimum annual election to participate in the PEEHIP DCRA plan is \$120. For more information concerning eligible expenses and guidelines governing a DCRA see *IRS Publication 503*, Child and Dependent Care Credit.

Members who participate in a Health FSA or DCRA with another sponsor, in addition to a PEEHIP account, should be mindful not to exceed the IRS yearly allowable maximum amount per tax payer.

Elected Amounts and Reimbursement

You 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. Therefore, you should carefully plan the annual amount you elect to contribute to each Flexible Spending Account. To assist in determining the contribution amount a Tax Savings Calculator is available at www.rsa-al.gov and www.healthequity.com/PEEHIP. 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. For members who plan to be employed for the full plan year and sign up during Open Enrollment, the annual amount will be divided by 12. For members that plan to retire before the end of the plan year, an adjustment will be made accordingly.

Traditional Bump Reimbursement: This method is available only for the Health FSA. The Health FSA is linked to your PEEHIP hospital / medical and Southland dental and vision coverage. When you pay for eligible out-of-pocket expenses, such as copays, the funds are automatically reimbursed to you without having to file a receipt.

Manual Reimbursement: This method is available for the DCRA and Health FSA. You must submit a Request for Reimbursement form along with an itemized receipt indicating the charges that were incurred and the dates of services. Health FSA funds are available for reimbursement up to the annual amount elected as of the first effective day of the plan. Funds for reimbursement from the DCRA become available only after contributions have been withheld from your paycheck.

PEEHIP does not offer a Flexible Spending Account Credit / Debit Card.

Timely Filing Period Deadline / Carryover

The PEEHIP Flexible Spending Account plan year ends September 30. You have until January 15 following the end of the plan year to submit a Request for Reimbursement form along with receipts for eligible expenses that occurred during the plan year (October through September). Funds remaining in the DCRA after the filing deadline will be forfeited.

\$500 Carryover Provision (applicable to Health FSA only)

PEEHIP allows members up to \$500 of unused funds remaining in a Health FSA at the end of the plan year to be carried over and used for eligible Health FSA expenses in the following plan year. Remaining Health FSA funds will be forfeited. This provision is in accordance with guidelines set by the Department of Treasury Notice 2013-7 issued by the IRS on October 31, 2013.

PEEHIP Flexible Spending Accounts are administered by Health Equity and are available to all actively employed members of PEEHIP. For a complete summary of the PEEHIP Flexible Spending Account Plan please go to www.rsa-al.gov.

FEDERAL POVERTY LEVEL ASSISTANCE APPLICATION (FPL)

ACTIVE OR RETIRED MEMBERS

Public Education Employees' Health Insurance Plan

P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150

334-517-7000 or 877-517-0020

Fax: 334-517-7001 or 877-517-0021

Web site: www.rsa-al.gov



This form is to be used to apply for the Federal Poverty Level Premium Assistance.

PEEHIP Subscriber Information - Required				
<i>Name must be entered as shown on your Social Security card.</i>				
Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name	
Mailing Address		City		State
		ZIP Code		
Home Phone ____-____-____	Work Phone ____-____-____	Date Received <i>(For internal use only)</i> ____/____/____		
Marital Status				
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed				
Instructions				
1. A signed copy of your prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's must be attached. If you were married and did not file a joint return, you must also file a copy of your spouse's prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's in order for this application to be processed. 2. Only one application can be submitted per plan year regardless of income change. 3. You must reapply for this assistance every year during Open Enrollment. 4. Any Federal Poverty Level assistance application received and/or postmarked after the close of Open Enrollment (September 1) will be effective for the first day of the second month after the receipt and approval of the application.				
PEEHIP Subscriber Certification - Required				
I declare that the above information and the accompanying tax returns and supporting 1099's and W-2's are true, complete, and accurate. I understand that submitting false or misleading information on this application is a crime punishable under state and federal law. I also understand that if any statements or accompanying tax returns and supporting 1099's and W-2's are found to be incorrect, incomplete, false, or misleading, I will be required to repay all discounts plus interest. This certification authorizes the Alabama Department of Revenue (or corresponding agency of the state of member's residency) to release to PEEHIP all of the member's and his/her spouse's tax returns in the agency's records for the current and prior tax year.				
Employee Signature _____		Date Signed ____/____/____		
Spouse Signature _____		Date Signed ____/____/____		

**Please mail the completed form to the address located on the top of this form.
See reverse for FPL levels.**

PEEHIP provides premium assistance to PEEHIP members with a total combined family income of less than or equal to 300% of the Federal Poverty Level (FPL) as defined by Federal Law. To qualify for the FPL assistance, PEEHIP members must furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Certification of Income Level will be effective for the plan year only, and re-certification will be required annually during Open Enrollment. The premium reduction does not automatically renew each year. The premium reduction will apply only to the hospital medical premium or HMO premium and only applies to active and retired members. The FPL premium discount is not available to members who are on a Leave of Absence, COBRA or surviving spouse contract.

Federal Poverty Level Premium Discount:

Over 300% of the FPL	member pays 100% of the member contribution	
equal to or less than 300% but more than 250% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 250% but more than 200% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 200% but more than 150% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 150% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2016 Federal Poverty Levels (FPL)

Family Size	100% of FPL	150% of FPL	200% of FPL	250% of FPL	300% of FPL
1	\$11,880	\$17,820	\$23,760	\$29,700	\$35,640
2	\$16,020	\$24,030	\$32,040	\$40,050	\$48,060
3	\$20,160	\$30,240	\$40,320	\$50,400	\$60,480
4	\$24,300	\$36,450	\$48,600	\$60,750	\$72,900
5	\$28,440	\$42,660	\$56,880	\$71,100	\$85,320
6	\$32,580	\$48,870	\$65,160	\$81,450	\$97,740
7	\$36,730	\$55,095	\$73,460	\$91,825	\$110,190
8	\$40,890	\$61,335	\$81,780	\$102,225	\$122,670

COORDINATION OF BENEFITS (COB) FORM

Request for Other Coverage Information



This form is a request for other coverage information we must have in order to update your insurance information and provide proper coverage.

INSTRUCTIONS: Print clearly in black ink. Complete the form in full, sign, and return it to PEEHIP using **one** of the following methods:

Online: <https://mso.rsa-al.gov/> (the fastest, preferred method)

Fax: 877-517-0021 (toll-free) (Please fax front and back of form)

Mail: PEEHIP, P.O. Box 302150, Montgomery, AL 36130

Email: peehipinfo@rsa-al.gov (Scan front and back)

If you, your spouse and/or dependent children are covered under PEEHIP and have any other insurance coverage, **EXCLUDING MEDICARE AND PEEHIP**, please indicate the other coverage on this form or **online** at <https://mso.rsa-al.gov>. Failure to timely submit this form will result in your account being placed on claim hold and may cause a denial of medical and prescription claims.

SECTION A. PEEHIP SUBSCRIBER INFORMATION

SSN or PID:	First and Last Name:	Telephone Number: ()	Cell Phone Number: ()	Email Address:
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SECTION B. OTHER INSURANCE COVERAGE INFORMATION, EXCLUDING MEDICARE AND PEEHIP (Check all that apply)

- Yes No - I have/had other insurance coverage while covered by PEEHIP.
- Yes No - My spouse has/had other insurance coverage while covered by PEEHIP.
- Yes No - My dependent child(ren) has/had other insurance coverage provided by my spouse and/or other insurer while covered by PEEHIP.

**If you answered "Yes" to any of the above, you must complete the Insurance Company information below.
If you answered "No" to all of the above, skip to Section C.**

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)

Name of Policy Holder	Date of Birth	Contract/Policy No.	Effective Date of Coverage	Termination Date (if applicable)	Insurance Co. Phone No. ()
Name of Insurance Company (check one)		Coverage Provided Through	Type(s) of coverage (check all that apply)		
<input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Tricare <input type="checkbox"/> United Health Care <input type="checkbox"/> VA <input type="checkbox"/> SEIB/Local Govt. <input type="checkbox"/> Other: _____		<input type="checkbox"/> Current Employer <input type="checkbox"/> Former Employer <input type="checkbox"/> Other	<input type="checkbox"/> Hospital/Medical with Prescription Drug <input type="checkbox"/> Dental <input type="checkbox"/> Hospital/Medical without Prescription Drug <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug Only Note: HSA, HDHP, and HRA Plans are considered Hospital/Medical with Prescription Drug Coverage		

Are you or any of your PEEHIP dependents covered as **dependents** on this insurance policy? Yes-- ▶ *List each dependent below*
 No

Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policy Holder	Are both parents married or living together?	Based on court decree, who is responsible for health care expenses? (check <u>first</u> that applies)** Copy of Divorce Decree Required
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child---▶ <input type="checkbox"/> Yes <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child---▶ <input type="checkbox"/> Yes <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child---▶ <input type="checkbox"/> Yes <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree



SEE REVERSE SIDE – THIS FORM CONTAINS MORE INFORMATION



LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)

Name of Policy Holder	Date of Birth	Contract/Policy No.	Effective Date of Coverage	Termination Date (if applicable)	Insurance Co. Phone No. ()
-----------------------	---------------	---------------------	----------------------------	----------------------------------	-----------------------------

Name of Insurance Company (check one) <input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Tricare <input type="checkbox"/> United Health Care <input type="checkbox"/> VA <input type="checkbox"/> SEIB/Local Govt. <input type="checkbox"/> Other: _____	Coverage Provided Through <input type="checkbox"/> Current Employer <input type="checkbox"/> Former Employer <input type="checkbox"/> Other	Type(s) of coverage (check all that apply) <input type="checkbox"/> Hospital/Medical with Prescription Drug <input type="checkbox"/> Dental <input type="checkbox"/> Hospital/Medical without Prescription Drug <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug Only <i>Note: HSA, HDHP, and HRA Plans are considered Hospital/Medical with Prescription Drug Coverage</i>
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Are you or any of your PEEHIP dependents covered as **dependents** on this insurance policy? Yes--- ▶ *List each dependent below*
 No

Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policy Holder	Are both parents married or living together?	Based on court decree, who is responsible for health care expenses? (check <u>first</u> that applies)** Copy of Divorce Decree Required
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child---▶ <input type="checkbox"/> Yes / <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child---▶ <input type="checkbox"/> Yes / <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree
		<input type="checkbox"/> Spouse <input type="checkbox"/> Child---▶ <input type="checkbox"/> Yes / <input type="checkbox"/> No-----▶ <input type="checkbox"/> Stepchild-----▶		<input type="checkbox"/> You (PEEHIP Subscriber) or Spouse is responsible <input type="checkbox"/> Policy Holder or their Spouse is responsible <input type="checkbox"/> You (PEEHIP Subscriber) or your Spouse has custody <input type="checkbox"/> Policy Holder or their Spouse has custody <input type="checkbox"/> Joint custody or no court decree

Action Required: If you have indicated that you, your spouse, or your dependent child is insured under another Insurance Plan, you are required to provide a copy of the front and back of the insurance card for each card.

****If applicable, you must provide a copy of the section of the Court Order/Divorce Decree pertaining to health coverage or other documents to support your response.**

SECTION C. SUBSCRIBER CERTIFICATION

Statement: Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. It is fraudulent to submit information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse PEEHIP for any money it was induced to pay as a result of the information I provided. Receipt and/or completion of this form is not a guarantee of eligibility. I further authorize the release of any pertinent information from any source available to PEEHIP to verify the status of my employment.

Subscriber Signature _____ Date ____/____/____

HELPING YOU UNDERSTAND WHY THE INFORMATION IS NEEDED

COORDINATION OF BENEFITS. WHAT IS IT? Coordination of Benefits is designed to keep your rates as low as possible by eliminating excess payments. It keeps the cost of your medical care down without affecting the way you receive care. Oftentimes, members and their dependents are covered by two insurance plans. Working spouses cover each other and children are often covered on both parents' plans. When a PEEHIP member is covered by more than one health plan, the payment of his/her benefits is coordinated between the two plans.

HOW COORDINATION WORKS. If you have more than one plan and you receive services or supplies that are covered under both plans, this is how your benefits are coordinated:

The primary plan pays the full extent of its benefits. PEEHIP uses the first of the following rules that applies:

1. The benefits of the plan that covers you as an employee will be paid before the plan that covers you as a dependent. However, if you are eligible for Medicare coverage and Medicare is primary to your plan and your spouse has active coverage through an employer, then your plan pays third.
2. For claims on dependent children, the benefits of the parent's plan whose birthday falls earlier in the calendar year will be primary (this is known as the birthday rule) unless the parents are separated or divorced, in which case:
 - a. If a court decree specifies one parent cover the child's medical care, that parent's plan is primary.
 - b. If there is no court decree specifying coverage, the plan covering the parent with custody will be primary.
 - c. However, if the parent with custody remarries, the plan covering that parent will be primary, the plan covering the step-parent will be secondary, and the plan covering the parent without custody will be third.
 - d. If a court decree specifies joint custody but does not say which parent covers the child's medical care, then the birthday rule is used.
3. If you are the subscriber on an active contract and the subscriber on a retired contract, the benefits of the plan covering you as an active employee are primary over the benefits of a plan covering you as a retired employee.
4. If you are the policy holder on two active or retired contracts, the plan that has covered you longer is primary.



RETIREE EMPLOYMENT VERIFICATION

This form is to be completed by the PEEHIP Retiree and his/her current employer (if applicable) to verify employer health insurance benefits offered to its employees.

The PEEHIP Retiree must return this completed, signed, and dated form to PEEHIP using one of the following methods:

Online: <https://mso.rsa-al.gov/> **Fax:** 877-517-0021 (toll-free)

Mail: PEEHIP, P.O. Box 302150, Montgomery, AL 36130

SECTION A. PEEHIP RETIREE INFORMATION

Retiree's Name:		Social Security Number or PID:		
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No You must select "Yes" or "No." (If "No," skip to Section B)				
Name of Retiree's Employer: (After date of retirement)		Employer's Telephone #:		Date of Hire (MM/DD/YYYY)
Employer's Address 1:	Employer's Address 2:	City	State	ZIP Code

1. Does your current employer offer health insurance coverage? Yes No (If "No," skip to Section B)
 2. Are you currently eligible, or will become eligible after a specified waiting period, for health insurance benefits through your current employer? Yes No*
 - a. If you are eligible for your employer's health insurance, you must indicate the date you became/will become eligible for benefits (MM/DD/YYYY): _____
 3. Does your employer contribute at least 50% or more of the cost of single health insurance coverage? Yes No*
- *ACTION REQUIRED: If you answered "No" to questions 2 or 3, you must have your current employer complete Section C and D before submitting the completed, signed, and dated form to PEEHIP. Coverage will cancel the first of the following month.**

SECTION B. PEEHIP RETIREE SIGNATURE

Statement: Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. It is fraudulent to submit information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse PEEHIP for any money it was induced to pay as a result of the information I provided. Receipt and/or completion of this form is not a guarantee of eligibility. I further authorize the release of any pertinent information from any source available to PEEHIP to verify the status of my employment.

Retiree's Signature

Date

SECTION C. EMPLOYER INFORMATION (To be completed by Current Employer only)

Employee Hire Date: (MM/DD/YYYY)		Employee Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Is the person, named above as the Employee, eligible for your company's Health Insurance Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," please provide the Single Employee monthly premium contribution information below:			
Important Note: If your company pays for, reimburses, or intends to pay or reimburse the person, named above as the Employee, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan), that amount should be reflected in the monthly premiums.			
Total Monthly Single Premium:	Employee Share of Monthly Single Premium:	Company Share of Monthly Single Premium:	

If "No," please indicate why employee is not eligible:

Benefits not offered Part-time employee (not eligible for benefit) Other, please explain: _____

SECTION D. EMPLOYER SIGNATURE (To be completed and signed by Current Employer only)

Statement: Under penalties of perjury, I hereby certify that the above answers are true and correct. I further understand that omission of important facts, of a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Public Education Employees' Health Insurance Plan (PEEHIP), for a person who is ineligible for such plan, is a violation of the anti-fraud provision of the Health Insurance Portability and Accountability Act, to which civil and criminal penalties, including imprisonment, can apply.

Printed Name of Company Representative Providing Verification

Signature of Company Representative Providing Verification

Title

Date

EMPLOYER: Please return this Employment Verification Form to your Employee. The Employee must submit this form to PEEHIP. Thank you for your cooperation.

Public Education Employees' Health Insurance Plan
P. O. Box 302150
Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov



Under Alabama law, Section 16-25A-5.2(1), *Code of Alabama, 1975*, employees who retire after September 30, 2005, and who become employed by an employer that provides employees at least 50 percent of the cost of single health insurance coverage and that qualify to receive other employer group health insurance coverage through that employer shall be required to use the employer's health benefit plan for primary coverage and the Public Education Employees' Health Insurance Plan may provide supplemental secondary coverage. If you are required to take your new employer's health insurance, the Public Education Employees' Health Insurance Plan (PEEHIP) offers supplemental and optional coverages at little to no cost. Please visit the PEEHIP website, www.rsa-al.gov, or contact PEEHIP for more information on the supplemental and optional coverages.

You can re-enroll in PEEHIP without a break in coverage if your new employer stops paying at least 50% of the cost of single coverage or if you should lose your other employer's health insurance coverage due to termination or ineligibility.

All employees who retired after September 30, 2005, are required to complete the form on the reverse side of this letter and return it to PEEHIP (forms should be faxed to 877.517.0021 or mailed to PEEHIP, P O BOX 302150, Montgomery, AL 36130). Your employer must also complete the Employer Information Sections C and D of the Retiree Employment Verification form (on back) if applicable. You must also contact PEEHIP about subsequent employment changes if other group health insurance coverage is made available to you.

Any employee or retiree who knowingly and willfully submits materially false information to PEEHIP shall repay all claims and other expenses incurred by the plan related to false or misleading information submitted by the employee or retiree, in addition to a charge based on the applicable interest rate (Section 16-25A-20, *Code of Alabama, 1975*).

If you or your covered dependents are under age 65 and Medicare eligible, it is imperative that you notify the PEEHIP office and provide a copy of your or your dependent's Medicare card to ensure that medical and prescription drug claims are being processed correctly and you are paying the lower PEEHIP premium.

Thank you for your cooperation.



SEE REVERSE SIDE AND COMPLETE THE RETIREE EMPLOYMENT VERIFICATION FORM.





THE
RETIREMENT SYSTEMS
OF
ALABAMA

201 SOUTH UNION STREET



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

WEBSITE www.rsa-al.gov

NOTICE OF NON-DISCRIMINATION AND LANGUAGE ACCESS SERVICES:

Discrimination is Against the Law

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

PEEHIP:

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

If you need these services, contact our 1557 Compliance Coordinator, at 1-877-517-0020. If you believe that PEEHIP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Public Education Employees' Health Insurance Plan, 201 South Union Street, Montgomery, Alabama, 36104, Attn: 1557 Compliance Coordinator, 1-877-517-0020, 1-877-517-0021 (fax), PEEHIP.Info@rsa-al.gov (email). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-517-0020.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-517-0020 번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-517-0020。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-517-0020.

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-517-0020.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-517-0020.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-517-0020.

Gujarati: યુના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે.
ફોન કરો 1-877-517-0020.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-517-0020.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-517-0020 पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ນຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-517-0020.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-517-0020.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-517-0020.

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-877-517-0020 irtibat numaralarını arayın.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-517-0020 まで、お電話にてご連絡ください。