



Member Handbook 2019-2020

with Open Enrollment Information



Public Education Employees' Health Insurance Plan

How to reach us.

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

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

Email **peehipinfo@rsa-al.gov**

Because email submissions are unsecured, do not include confidential information like your Social Security number, unless you use the MOS Secure Message Center. 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/peehip/**

Member Online Services (MOS Login)

Enroll in PEEHIP coverage online;

Send **secure emails** in the Secure Message Center by clicking **My Inbox**
<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

Hospital Medical Plans

Blue Cross Blue Shield of Alabama (PPO)

www.alabamablue.com/peehip/

450 Riverchase Parkway East

P.O. Box 995

Birmingham, AL 35298

Customer Service 800.327.3994

Preadmission Certification 800.248.2342

Subrogation 205.220.2744

Fraud Hot Line 800.824.4391

Rapid Response® 800.248.5123

(to order ID cards, claim forms, & directories)

Baby Yourself® 800.222.4379 - Maternity Program

Teladoc® 855.477.4549

www.teladoc.com/alabama

VIVA Health Plan (HMO)

www.vivahealth.com/peehip

417 20th Street North, Suite 1100

Birmingham, AL 35203

Customer Service 205.558.7474 or 800.294.7780

Delta Dental Customer Service 800.521.2651

(dental provider for VIVA Health Plan)

Teladoc® 800.TELADOC (835.2362)

www.teladoc.com

Supplemental Medical Plan

See *Blue Cross Blue Shield of Alabama* information above.

Group Medicare Advantage (PPO) Plans

UnitedHealthcare® - until 1/1/2020

www.uhcretiree.com/peehip

9900 Bren Road East

Minnetonka, MN 55343

Customer Service 877.298.2341 - 8 a.m.-8 p.m.; TTY 711

Nurse Line 855.202.0710

Renew Rewards 888.219.4602

Amwell® and **Doctors on Demand**® 877.298.2341

Humana® - effective 1/1/2020

<https://our.humana.com/peehip>

PO Box 14601

Lexington, KY 40512-4601

Customer Service 800.747.0008 - 7 a.m.-8 p.m.; TTY 711

Go365Rewards® 866.677.0999

Virtual Visits 888.673.1992

Wellness Programs

Sharecare®

Administrator of Wellness Programs

peehip.sharecare.com

Customer Service 855.342.6809

Alabama Department of Public Health (ADPH)

Vendor for Wellness Screenings and Flu Shots

www.alabamapublichealth.gov/worksitewellness/

Flu Shots 844.842.2954

Tobacco Cessation Quitline 800.QUIT.NOW

or 800.784.8669

www.quitnowalabama.com

Flexible Spending Accounts

HealthEquity

www.healthequity.com/peehip

Customer Service 877.288.0719 - 24 hours/day

Optional Coverage Plans

(Cancer, Dental, Indemnity, & Vision)

Southland Benefit Solutions

www.southlandbenefit.com/peehip

2200 Jack Warner Pkwy, Suite 150

P.O. Box 1250

Tuscaloosa, AL 35401

Customer Service 800.476.0677

Core/Speciality Pharmacy Programs

MedImpact

<https://mp.medimpact.com/ala>

10181 Scripps Gateway Ct

San Diego, CA 92131

Customer Service 877.606.0727 - 24 hours/day

Pharmacy Help Desk 800.788.2949 - 24 hours/day

Step Therapy Prior Authorization 800.347.5841

(for physicians)

Fax 877.606.0728

Welcome to the PEEHIP Member Handbook with Open Enrollment Information

The Retirement Systems of Alabama (RSA) is pleased to provide you with the 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 healthcare 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/peehip/publications/. A paper copy is also available, free of charge, by calling Member Services toll-free at 877.517.0020.

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

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

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Benefit Policy & Premium Changes

Effective October 1, 2019

New Wellness Program

- Effective October 1, 2019, the new PEEHIP Wellness Program – *Choose Well, Live Well* – will launch and be administered by Sharecare® and Blue Cross Blue Shield (BCBS) of Alabama. Sharecare® is a company headquartered in Atlanta, GA, and cofounded by Jeff Arnold (founder of WebMD) and Dr. Oz. The Sharecare® concept is an all-in-one-place approach where members have access to a personalized platform that delivers specific content, education, tools, and resources matched to the specific health needs and preferences of the member. BCBS is also contributing in the form of providing expert clinical coaches and proven programs for disease management. The current required activities of the wellness program and the current \$50 monthly wellness premium waiver incentive will remain the same for the fiscal year 2019-2020. For more information, please see the [Wellness Programs](#) section.

Humana® to Administer the PEEHIP Group Medicare Advantage (PPO) Plan as of 1/1/2020

- Humana® will replace UnitedHealthcare® in administering the PEEHIP Group Medicare Advantage (PPO) Plan for our Medicare-eligible retirees and Medicare-eligible dependents of retirees starting January 1, 2020. This will result in additional benefits for members and significant savings for the PEEHIP plan. Although the administrator of the plan is changing from UnitedHealthcare® to Humana®, please be assured this is still a PEEHIP specific plan, meaning the quality of benefit will not lessen as a result of this change. For more information about the PEEHIP Group Medicare Advantage (PPO) Plan, see the [PEEHIP Coverage for Medicare-Eligible Retired Members](#) section.

Flexible Spending Account (FSA) Plan Changes

- The annual maximum Health FSA contribution amount increased to **\$2,700** beginning fiscal year October 1, 2019. This is a benefit enhancement.
- The Dependent Care Reimbursement Account (DCRA) annual maximum contribution remains unchanged at \$5,000 (\$2,500 each if married filing separately).

VIVA Health Plan Benefit Changes

- The combined medical and prescription drug in-network maximum annual out-of-pocket amounts will be **\$7,350** for individual and **\$14,700** per family for the 2019 and 2020 calendar years. Maximum out-of-pocket amounts are a benefit to members because they limit the total amount members will pay out-of-pocket for their in-network healthcare expenses.

Maximum Annual Out-of-Pocket Amounts (BCBS Group 14000 Plan)

- The combined medical and prescription drug in-network maximum annual out-of-pocket amounts will increase to **\$8,150** per individual and **\$16,300** per family for the 2020 calendar year. This is an enhanced benefit for our members enrolled in PEEHIP's Hospital Medical Plan Group #14000 coverage, as they will pay no more than these annual out-of-pocket amounts.

Supplemental Medical Plan Changes

- The annual maximum amount of claims paid under Group #61000 will increase to **\$8,150** per individual and **\$16,300** per family for the 2020 calendar year. This is a benefit enhancement.
- Members enrolled in High Deductible Health Plans (HDHP) are not eligible for the PEEHIP Supplemental Medical Plan. The IRS defines the minimum deductibles for HDHPs for calendar year 2019 as **\$1,350** or more for individual and **\$2,700** or more for family and for calendar year 2020 as **\$1,400** for individual and **\$2,800** for family. *You must provide a copy of your primary plan document for verification of the deductibles.*

Pharmacy Benefits

- Due to the fast-moving nature of both new drugs becoming available and price changes amongst existing drugs, PEEHIP implements various utilization management programs throughout the plan year to the commercial plan formulary, including prior authorizations, step therapy, quantity limits and the exclusion of some drugs to drive utilization to lower cost therapeutic alternative medications. This is to ensure that the PEEHIP formulary covers the most effective drugs at the most reasonable price. No changes were made to the drug copay tiers.
- For more information on PEEHIP's pharmacy benefit, including a formulary list, visit www.rsa-al.gov/peehip/pharmacy-benefits/.

Premium Rate Changes for Fiscal Year 2020

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

Individual	\$ 499
Family	\$1,258
Supplemental Medical Plan (Individual or Family)	\$ 160

Surviving Spouse/Dependent Hospital Medical or VIVA Health Plan Rates

Individual/Non-Medicare-eligible (NME) Survivor	\$ 845
Family/NME Survivor & More Than 1 Dependent or Only Dependent NME	\$1,117
Family/NME Survivor & Only Dependent Medicare-eligible (ME)	\$1,021
Individual/ME Survivor	\$ 355
Family/ME Survivor & More Than 1 Dependent or Only Dependent NME	\$ 724
Family/Medicare-eligible Survivor & Only Dependent ME	\$ 609

These changes were also published in the June 2019 PEEHIP *Advisor*.



Updating Personal Contact Information

(Active and Retired Members)

Name and Social Security Number Changes

The name on all insurance and Teachers' Retirement System (TRS) forms must be the same as the name on the Social Security card. PEEHIP requires a copy of the member's Social Security card before a name or Social Security Number (SSN) can be changed. Active 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 SSN 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 SSN will be used by PEEHIP for the purpose of Coordination of Benefits.

Address Changes

To change an address, use the secure online process from the RSA website at www.rsa-al.gov. Select the Member Log In at the top left of the home page and follow the instructions. This address change will automatically transmit to the insurance carriers and also update your address with the TRS and RSA-1 if you are a participant in those accounts. 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. For those who do not have access to the internet, you may submit a signed, written request. PEEHIP policies do not allow address changes to be made over the phone.**

Your Preferred Method for Receiving Communication from PEEHIP and the RSA

The Member Online Services (MOS) website at <https://mso.rsa-al.gov> provides members **the ability to set their preferred method of receiving communication to email instead of paper mail.** When additional action/information is needed by PEEHIP, members will receive an email notification at the email address indicated in MOS. The email is a notification that you have correspondence that requires your immediate attention. The correspondence will be located in your MOS **Secure Message Center.** Upon logging in, select Secure Message Center to view the document. Please respond to the request in a timely manner. Along with preserving paper and helping PEEHIP and the RSA save on postage cost, this allows you to receive notifications immediately in your email rather than waiting for paper mail. This can be particularly helpful with PEEHIP documents that involve deadlines for response or application.

If you are currently set to receive your communications via email, you will receive an email notification whenever you have an important PEEHIP or RSA document waiting for you in your MOS Secure Message Center. Regardless of your current method of contact, you can change your preferred method of communication at any time by logging into your MOS account and clicking on My Account, then Contact Information, and follow the on screen prompts. **Please be sure to use a valid email address and update it in MOS if it ever changes.**

When you sign up for email notifications, you will receive a confirmation email. If you do not see this confirmation in your email inbox within 24 hours, or if you signed up to receive emails but are not getting them from PEEHIP or the RSA, check your junk mail or spam settings. Make sure that your email settings allow messages from noreply@rsa-al.gov. Even if you choose paper mail, you will be able to access secure communications in your Secure Message Center when using MOS anywhere that you have internet access.

Insurance Eligibility

(Active and Retired Members)

Full-Time Employees

A full-time employee is any person employed on a full-time basis in any public institution of education within the state of Alabama as defined by Section 16-25A-1, *Code of Alabama, 1975*. These institutions must provide instruction for any combination of grades K through 14 exclusively, under the auspices of the State Board of Education or the Alabama Institute for Deaf and Blind. A full-time employee also includes any person who is not included in the definition of employee in Section 16-25A-1, but who is employed on a full-time basis by any board, agency, organization, or association which participates in the TRS and has by resolution pursuant to Section 16-25A-11 elected to have its employees participate in PEEHIP.

Permanent Part-Time Employees

A part-time employee is any person employed on a permanent part-time basis in any public institution of education within the state of Alabama as defined by Section 16-25A-1, *Code of Alabama, 1975*. These institutions must provide instruction for any combination of grades K through 14 exclusively, under the auspices of the State Board of Education or the Alabama Institute for Deaf and Blind. A part-time employee also includes any person who is not included in the definition of employee in Section 16-25A-1, but who is employed on a permanent, part-time basis by any board, agency, organization, or association which participates in the TRS and has by resolution pursuant to Section 16-25A-11 elected to have its employees participate in PEEHIP.

An eligible permanent part-time employee is eligible for PEEHIP if 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.

Retired Employees

Retired employees are defined as follows:

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

Family Coverage Eligibility

Eligible Dependents

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

- **Spouse** - A spouse is defined as the active or retired employee's spouse, as defined by Alabama law, to whom you are currently and legally married, excludes a divorced spouse. Appropriate documentation will be required by PEEHIP before a spouse can be enrolled. Refer to the [Dependent Eligibility Required Documentation](#) section for details.
- **Children** - PEEHIP offers dependent coverage to children up to age 26. Appropriate documentation will be required by PEEHIP before dependents can be enrolled. Coverage cancels the first of the month following the date they turn 26. Refer to the [Dependent Eligibility Required Documentation](#) section for details. **PEEHIP is not required and will not provide coverage for a child of a child receiving dependent coverage. Also, maternity benefits and delivery charges are not covered for children of any age regardless of marital status.**

In accordance with the federal Healthcare Reform Legislation, the following children are eligible for PEEHIP coverage:

1. A married or unmarried child under the age of 26 if the child is your biological child, legally adopted child, stepchild or foster child without conditions of residency, student status, or dependency. A foster child is any child who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
2. The eligibility requirements for any other children such as grandchildren, for example, must meet the same requirements as foster children and must be placed with you by decree or other order of any court of competent jurisdiction, for example, legal custody or legal guardianship.
3. An unmarried incapacitated child 26 years of age or older who:
 - is permanently incapable of self-sustaining employment because of a physical or mental handicap,
 - is chiefly dependent on the member for support, and
 - was disabled prior to the time the child attained age 26, and the child had to be covered as a dependent on the member's PEEHIP policy before reaching the limiting age of 26.

Two Exceptions:

- New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment.
- An existing member requests hospital medical coverage of the incapacitated child over the age of 26 within 45 days of the qualifying life event of loss of other hospital medical group coverage.

The employee must contact PEEHIP and request an INCAPACITATED DEPENDENT CERTIFICATION form. Proof of the child's condition and dependence must be submitted to PEEHIP within 45 days after the date the child would otherwise cease to be covered because of age. PEEHIP may require proof of the continuation of such condition and dependence.

If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once 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 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 whose coverage was previously cancelled
- 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 for other eligible dependents and regardless of what the divorce decree states. The ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of divorce. The member will be responsible for an ex-spouse's and ex-stepchildren's claims when they are not removed from coverage. An ex-spouse and ex-stepchildren are eligible for COBRA if the request to enroll in COBRA is made within 60 days of the cancellation of coverage. Refer to the [COBRA](#) section for details.

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

- Click the Enroll In or Change PEEHIP Coverages link once you have logged in to MOS. Select the QLE option, select Divorce from the drop down box, and provide the date the divorce was final. This is generally the date the judge signed the Final Order of the Divorce Decree. 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/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**. 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 (FSA)** 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.
- FSA require a new enrollment each year. **The preferred method to enroll is online through MOS.**
- The Premium Assistance discount program requires a new application each year. The member must submit a paper application to PEEHIP to apply for this discount. The paper application can be uploaded in MOS.
- 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 effective October 1 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 FSA effective October 1 will have their first contribution withheld from their October paycheck.
- As a new PEEHIP member, see the [Wellness Programs](#) section for details on the wellness benefits and required wellness activities in order to obtain the wellness premium waiver.

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

Transfers

Employees who transfer from one system to another system 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. Refer to the [Employer Contribution](#) section 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 PEEHIP Hospital Medical Plan outside of the Open Enrollment period if they become full-time. Members may add the other Optional Coverage Plans when they become full-time.

Full-Time to Part-Time Employment

A member is not eligible to drop the PEEHIP Hospital Medical Plan outside of the Open Enrollment period when they change from full-time to part-time status.

Pre-Existing Conditions

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



New Employee Enrollment

(Active Members)

Member Online Services (MOS)

New employees who choose to enroll in PEEHIP coverage must do so online through MOS within 30 days of their hire date. Using 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)

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

Premium payments

- PEEHIP premiums for hospital medical and Optional Coverage Plans are deducted in the month prior to the month of coverage. New employees who have enrolled in PEEHIP coverage effective their date of hire or the first of the month following their date of hire must make payment directly to PEEHIP for their initial premiums. Payment can be made through MOS (e-check, debit card, or credit card), or a check can be mailed to PEEHIP.
 - Example 1: An employee who is hired August 4 and elects coverage effective August 4 whose first paycheck is August 31 will have premiums deducted to pay for September coverage but not for August coverage. The August premium must be paid directly to PEEHIP.
 - Example 2: An employee who is hired August 4 and elects coverage effective August 4 whose first paycheck is September 30 will have premiums deducted to pay for October coverage but not for August or September coverage. The August and September premiums must be paid directly to PEEHIP.
- **Failure to timely pay your initial premiums will result in a claim hold being placed on your account. A claim hold will prevent you and your dependents from using your coverage. Once payment is received the hold will be removed.**
- Unlike other PEEHIP coverage premiums, FSA contributions are paid in the current month.
 - Example: Contributions for October are deducted in October.

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 individual hospital medical coverage. The employee will be required to submit a NEW ENROLLMENT 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.

Family Coverage Options

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

Hospital Medical Coverage

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

Optional Plan Coverage

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

Supplemental Medical Coverage

New employees can enroll in the Supplemental Medical Plan if they are enrolled in a primary health plan not affiliated with PEEHIP and which includes prescription coverage. There is no premium charge for this plan. Refer to the [PEEHIP Supplemental Medical Plan](#) section for more information and to see if you qualify.

Employees Not Enrolled in the PEEHIP Hospital Medical Plan

Employees who do not enroll in the PEEHIP Hospital Medical Plan can enroll in the PEEHIP Supplemental Medical Plan **or** up to four Optional Coverage Plans at no premium cost for individual or family coverage.

Spouses Independently Eligible for PEEHIP

Spouses who are independently eligible for PEEHIP who are covered by the PEEHIP Supplemental Medical Plan and Optional Coverage Plans will not be charged a premium.

New Employees under Age 26

Covered children under age 26 who become eligible for PEEHIP coverage can either remain on their parent's PEEHIP coverage **or** enroll in their own coverage.

Children who choose to remain on their parent's coverage cannot do so beyond reaching age 26. Upon reaching age 26, these individuals have 45 days to enroll as a subscriber.

Members on COBRA Who Return to Work

When a member who is enrolled in PEEHIP under COBRA returns to work for a PEEHIP participating employer and wishes to enroll in new coverage, the member must complete a new enrollment request via MOS within 30 days of their hire date. The member may not drop existing coverage until the Open Enrollment period.

Refer to the [Enrollment Procedures and MOS](#) section for more information.



Enrollment Procedures & 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 SSN
3. Email address
4. SSN and dates of birth for each dependent being enrolled in coverage
5. Additional health insurance information under which you and your dependents are covered
6. Credit card, debit card, or e-check to make first premium payment at time of enrollment

To Register as a First Time User

- Go to www.rsa-al.gov and click **Member Log In** located at the top left of the web page.
- Click **Need to Register** or login with your User ID and Password.
 - If you do not remember your User ID and/or Password, you can re-register by clicking **Forgot User ID or Password**.
- The RSA mails new employees a Personal Identification Number (PID).
 - If you do not have your PID, you can request a PID letter through MOS and one will be mailed to you.
 - Click **Need a PID?**
 - Your PID will also be located on all personal correspondence sent to you by PEEHIP.

You must receive a confirmation page verifying your enrollment or change was successfully submitted.

To Enroll or Change PEEHIP Coverages

From the **PEEHIP Services** tab at the top of the screen, select one of the following actions from the menu.

- Click **Enroll or Change PEEHIP Coverages** to enroll in a hospital medical plan, Optional Coverage Plans (dental, vision, cancer, indemnity), or FSA as:
 - Click **New Enrollment** (*available for 30 days from date of hire*) if wanting to enroll as a new hire or newly eligible member.
 - Click **Open Enrollment** (*available July 1 – September 10*) to:
 - Enroll/change/cancel hospital medical coverage
 - Add/update/cancel additional insurance coverage information
 - Enroll/change FSA
 - Add/update Medicare information
 - Update member/spouse tobacco usage status
- Click **Qualifying Life Event (QLE)** to add a newly acquired dependent within 45 days of QLE.
 - Adoption/Placement of adoption for a child
 - Birth of a child
 - Legal custody of a child
 - Marriage of a subscriber

To make changes outside of Open Enrollment for QLE's not listed, members must complete a NEW ENROLLMENT AND STATUS CHANGE form and send it to PEEHIP within 45 days of the QLE (e. g., involuntary loss of eligibility for other hospital medical coverage).

- Select **Other** (available year round) to:
 - Update your and/or spouse's tobacco user status
 - Add or update your and/or your dependents' other medical insurance coverage information
 - Update your Retiree Employment Information

Securely upload required documentation to PEEHIP through MOS. From the [My Account](#) tab at the top of the screen, select [Member Correspondence](#) and [Upload a document to RSA](#).

To View Current Coverages (available year round)

From the [PEEHIP Services](#) tab at the top of the screen, you can:

- View Current Coverages

To Update Contact Information (available year round)

It is important that PEEHIP has your current mailing address, physical address, phone number(s), and email so you receive important correspondence regarding your coverage and critical deadlines. From the [My Account](#) tab at the top of the screen, you can:

- Update [Contact Information](#)
 - Change your current phone or email information
 - View your previous phone or email information
 - Change your address information
 - View your previous address changes
 - Change User ID, Password, or Secret Question

To Correspond with PEEHIP (available year round)

From the [Secure Message Center](#) tab at the top of the screen, you have the following options:

- View [Member Correspondence](#)
 - View Enrollment Confirmation Pages
 - View outgoing correspondence sent to you from PEEHIP and the RSA
 - View account statements
 - View retirement benefit and PEEHIP premium estimates
 - Upload a document to PEEHIP and RSA
- From the [Question Center](#), you can
 - Select a Category from the drop-down menu
 - **Question not answered?** Type your questions and click [Submit](#).
 - By using this method of communication, your personal and private health information is protected and encrypted to safeguard your security. PEEHIP staff members monitor and respond to your questions to give you a timely answer.



- From [My Inbox](#), you can:
 - View secure messages sent to you from PEEHIP and the RSA
 - Submit a question to PEEHIP and the RSA

Additional Information about Enrollment

Dependent Becomes Eligible as Subscriber

When an adult child becomes employed/eligible for PEEHIP as a subscriber, he/she will only be removed from their parent's plan when he/she enrolls in the same identical plan(s) in their own name.

- Example: If an adult child dependent enrolls in their own PEEHIP Hospital Medical Plan, they will be removed from their parent's PEEHIP Hospital Medical Plan. If the adult child dependent is also enrolled in their parent's dental plan, they will not be removed unless they enroll in their own dental plan.

PEEHIP-Eligible Spouses Enrolled in Individual Hospital Medical Plans

Since PEEHIP requires a physical or electronic signature to enroll or cancel coverage, spouses who are independently eligible for PEEHIP, who are both enrolled in their own individual PEEHIP Hospital Medical Plan and whose spouse submits a request to change their coverage to family adding their spouse to their PEEHIP Hospital Medical Plan, will remain covered in their own individual plan until PEEHIP receives their request to cancel their plan. This change must be submitted during Open Enrollment.

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. A NEW ENROLLMENT AND STATUS CHANGE form can be mailed to you by calling Member Services at 877.517.0020.

Dependent Eligibility Verification Required Documentation

(Active and Retired Members)

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. All dependents must have a valid SSN to be eligible and must provide a copy of their Social Security card to PEEHIP. Any dependent without an SSN must provide valid, unexpired immigration documents. An Individual Tax Identification Number can be provided for tax reporting purposes, but it must be accompanied with these required immigration documents.

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

Spouse - A person to whom you are currently and legally married. Ex-spouses and common-law spouses are not eligible dependents even if a member continues to pay for family coverage. The ex-spouse must be deleted from coverage effective the first day of the month following the date of divorce. Required documents are a copy of Social Security card, copy of marriage certificate, **and a copy of one** of the following documents to show marriage is still current (within the last six months). The documents below **must list both member and spouse**:

- Current mortgage statement, home equity loan, or lease agreement
- Current utility bill (water, electric, gas, cellular, etc.)
- Current credit card or account statement
- Current cable or satellite service bill
- Property Tax documents
- Current automobile registration

If a document above listing both member and spouse is unavailable, one of the above may be provided if it lists **only** the spouse, but it must show the **same** address as the member. If the above documents are unavailable, you may provide the transcript of the member's most current Federal 1040 Income Tax Return listing both member and spouse.

Separated Spouse - A legally separated spouse. Required document: Notice of Legal Separation (court documents signed by a judge)

Biological Child - Member's biological child who is under age 26. Required documents: Copy of Social Security card **and** copy of Birth Certificate (issued by a state, county, or vital records office)

Foster Child - A child under age 26 who is placed with a member by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Required documents:

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

Adopted Child - Member's legally adopted child under age 26. Required documents: Copy of Social Security card **and one** of the following documents:

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



Step Child - A child under age 26 who is the natural offspring or adopted child of the covered member's spouse. All of the following documents are required:

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

If the spouse is not covered under the PEEHIP plan, in addition to the above documents, you must submit proof that your marriage is still current. Please refer to the Spouse category for a list of acceptable documentation. **If step child is added at different time than spouse - other current proof of marriage is required.**

Incapacitated Child - An unmarried incapacitated child 26 years of age or older who:

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

Two Exceptions:

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

If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once he/she reaches the limiting age of 26 as an incapacitated child. Once reaching the limiting ages of 26, if the child cancels coverage they cannot re-enroll. All of the following documents are required:

- Copy of Social Security card
- Incapacitated Dependent Certification Form including the Authorization for Disclosure of Protected Health Information. Proof of the child's condition and dependence must have been submitted to PEEHIP within 45 days after the date the child would otherwise have ceased to be covered because of age.
- Proof of the required document(s) for one of the dependent categories as noted above to show the child is your biological child, adopted, or step child.
- Medicare Card, if applicable

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

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

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

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

Resources to Obtain Documents

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

HIPAA Special Enrollment Outside of Open Enrollment

(Active and Retired Members)

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

Taking Advantage of Special Enrollment Opportunities

What is Special Enrollment?

Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period.

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

1. Under the first, employees and dependents who decline coverage due to other health coverage and then lose eligibility have special enrollment rights. For instance, an employee turns down health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan ceases. That employee then can request enrollment in her own company's plan for herself and her dependents. This special enrollment pertains to enrolling in the PEEHIP Hospital Medical Plan. It does not create a special enrollment to enroll in the Optional Coverage Plans. Proof of loss of eligibility must be provided for each person for which enrollment in PEEHIP coverage is requested.
2. Under the second, employees are permitted to special enroll a new dependent because of marriage, birth, adoption, placement for adoption, or legal custody. This special enrollment pertains to adding the new dependent(s) to any existing PEEHIP coverage, such as the PEEHIP Hospital Medical Plan and/or Optional Coverage Plans. **Tag-Along Rule:** When a newly eligible dependent becomes eligible for special enrollment, all eligible dependents can be added to the PEEHIP coverages at that time.

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

What are some examples of events that can trigger a loss of eligibility for coverage?

- Divorce
- Legal separation if it results in you losing coverage under your spouse's health insurance
- A dependent is no longer considered a "covered" dependent under a parent's plan
- Your spouses's company discontinues insurance coverage completely or 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 carriers.
- Your spouse's employment ends, as does coverage under his employer's health plan (i.e., due to layoff, employment strike, involuntary termination, voluntary resignation, or voluntary change in employment).
- Your spouse's death leaves you without coverage under his or her plan
- Total cessation of employer contributions
- Exhaustion of COBRA coverage
- You no longer live or work in the HMO's service area



How long do I have to request special enrollment?

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

After I request special enrollment, how long will I wait for coverage?

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

How do I request special enrollment?

To request special enrollment, you must submit a written request either through MOS or by completing and mailing to PEEHIP a NEW ENROLLMENT AND STATUS CHANGE form.

When requesting special enrollment due to the loss of eligibility for other coverage, PEEHIP requires documentation demonstrating the loss of coverage eligibility, such as a letter on company letterhead from the employer through which coverage was lost indicating the date coverage ended and reason for the loss of eligibility of coverage such as termination of employment, resignation, retirement with no insurance benefits, you no longer work or live in the HMO's service area, or total exhaustion of COBRA coverage. Proof of loss of coverage must be submitted for each individual who has lost coverage. If the loss of eligibility for other coverage is due to divorce or legal separation, a copy of the divorce decree signed by a judge of competent jurisdiction must be submitted to PEEHIP. Enrollment due to the loss of coverage may not be done online through MOS. You must submit your request using the NEW ENROLLMENT AND STATUS CHANGE form.

When requesting special enrollment to add a new dependent due to marriage, birth, adoption, placement for adoption, or legal custody of a child, PEEHIP requires documentation of proof of the new dependent. The enrollment can be submitted online through MOS. Refer the [Dependent Eligibility Verification Required Documentation](#) section for more information. **To avoid missing enrollment deadlines, you should submit enrollment requests to PEEHIP even if you do not yet have all of the appropriate documentation at the time of enrollment.**

When Special Enrollment Rights Do NOT Apply

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

- As a result of the individual's failure to pay premiums
- For cause, such as making a fraudulent claim
- If the other coverage has an increase in premiums or a change in benefits
- Another employer's Open Enrollment period
- If the individual stops paying for COBRA under a prior employer's plan before the maximum period of coverage is exhausted
- Voluntarily removing a dependent from another plan

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

Canceling PEEHIP Hospital Medical Coverage Outside of Open Enrollment

Active Employees

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

- Going on Family Medical Leave Act (FMLA) or Leave of Absence (LOA)
- Commencement of spouse or dependent employment
- Marriage, if enrolling in the new spouse's qualified health plan
- Your spouse's employer has a different Open Enrollment period than PEEHIP.
 - Members can remove their spouse from their PEEHIP Hospital Medical Plan during their spouse's Open Enrollment if the plan year for the other employer group coverage does not coincide with the PEEHIP plan year. This option is available as long as the other employer health plan is a cafeteria plan or qualified benefits plan. This does NOT apply to Medicare's Open Enrollment.
 - Members can use this QLE prospectively at any time during the year at such point that their spouse elects coverage under their employer group health plan with a different plan year than the PEEHIP plan year. This new QLE not only creates a path to remove a spouse as a dependent, but also allows members the option to remove all family coverage and change to individual coverage or drop hospital medical coverage altogether outside of the PEEHIP Open Enrollment. Timely notification and documentation demonstrating the spouse's or dependent's eligibility for their employer group health plan must be provided to PEEHIP within 45 days from the effective date of the new plan year of their employer group health plan.
 - If all dependents on the policy are ineligible, the coverage will automatically change to an individual plan effective the first of the month following the cancellation of the last remaining dependent. Policies are only cancelled effective on the first day of the month and cannot be cancelled in the middle of the month.

Retired Employees

Retirees **do not** pay PEEHIP premiums with pre-tax dollars. A retiree can cancel their PEEHIP Hospital Medical Plan anytime during the plan year on a prospective basis. A written request, signed by the retiree, must be sent to PEEHIP to cancel coverage. The coverage will be cancelled the first day of the month following receipt of the written request. A cancellation does not apply to the Optional Coverage Plans which can only be cancelled during Open Enrollment.

Members Dually Eligible for PEEHIP

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

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



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. An employee may be eligible to extend their PEEHIP coverage through COBRA during a month in which the employee is in pay status less than one-half of the working days of that month. Refer to the **COBRA** section for more information.

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

An employee may get paid for a portion of a month but may not be eligible to receive PEEHIP coverage for the remainder of that month if 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 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 Hospital Medical or HMO Plan	Entitlement if Enrolled in Optional Coverage Plans
Professional/Administrative Employee Works		
Less than ¼ time	0	0
At least ¼ time but < ½ time	¼ insurance coverage	1 Plan
At least ½ time but < ¾ time	½ insurance coverage	2 Plans
At least ¾ time but < Full-time	¾ insurance coverage	3 Plans
Full-time	Full coverage	4 Plans
(Each additional Optional Plan can be purchased for \$38/month or \$50/month for the family dental plan.)		
Support Worker Works		
0 to 4.9 hours/week	0	0
5.0 to 9.9 hours/week	¼ insurance coverage	1 Plan
10.0 to 14.9 hours/week	½ insurance coverage	2 Plans
15.0 to 19.9 hours/week	¾ insurance coverage	3 Plans
20 or more hours/week	Full coverage	4 Plans
(Each additional Optional Plan can be purchased for \$38/month or \$50/month for the family dental plan.)		

3-1 Rule

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

The 3-1 Rule is applied 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 be reinstated. These employees are treated as existing employees and not considered to be new employees for insurance purposes; they will not be allowed to 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	1	2	3	4	5	6	7	8	9	10	11	12
Coverage Months	1	2	4	5	6	8	9	10	12	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 Self-Service (ESS) 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. Examples: An employee has been in hire status for 9 consecutive months and terminates employment after June 16. The member's extra months of coverage will be applied to July, August, and September. Alternatively, if a member terminates employment by June 15, they will have coverage only through August.

A full August contribution is due if the member has had continuous coverage through the summer. A member who has paid a LOA rate or COBRA for July and returns to work after August 1 but prior to August 15 is eligible for full coverage in August.

Members Enrolled in the PEEHIP Hospital Medical Plan or VIVA Health Plan

If a member enrolls in the PEEHIP Hospital Medical Plan 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 Hospital Medical Plan or VIVA Health Plan

If a member does not enroll in the PEEHIP Hospital Medical Plan or the VIVA Health Plan, there is **no premium cost** to enroll in either the PEEHIP Supplemental Medical Plan or the Optional Coverage Plans. 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.

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.

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 individual hospital medical coverage effective on the date of notification.

Retiring Members

Retiring members are eligible to receive the extra coverage months earned under the 3-1 Rule. 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 is required to provide the appropriate insurance contribution earned under the 3-1 Rule. In most cases, PEEHIP assumes that the system will not pay the September contribution for June 1 retirees. 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 both Medicare Parts A and B on their retirement date to have coverage with PEEHIP.

Medicare

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

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

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

If the active member referenced above does not want Medicare as 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 as the subscriber and will not be able to remain on the contract as a dependent 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 as a subscriber in their own PEEHIP hospital medical plan. When the active Medicare-eligible member retires, he or she must enroll in both Medicare Part A and Part B to have coverage with PEEHIP. The effective date of both Medicare Part A and Part B must be effective no later than the date of retirement to avoid a lapse in coverage.

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



PEEHIP Hospital Medical Plan (PPO)

(Active Members and Non-Medicare-Eligible Retirees)

The PEEHIP Hospital Medical Plan is administered by BCBS of Alabama.

Hospital Benefits

- 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 Physical 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, radiation therapy, chemotherapy, and IV therapy: \$25 copay
- Non-medical Emergencies: Plan pays 80% of the allowed amount, subject to the \$300 calendar year deductible.

Major Medical Benefits

- 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 BCBS 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 **\$7,900 for individual and \$15,800 for family coverage for calendar year 2019**; and **\$8,150 for individual and \$16,300 for family coverage for calendar year 2020**.

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
- **Teladoc®: No copayment per Teladoc® consultation**

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 BCBS PPO program in that state. This program allows members to receive PMD benefits such as well baby care, routine physicals, and routine mammograms when accessing out-of-state PPO providers.

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 BCBS participating provider. With your health plan benefits, you have the freedom to choose your healthcare 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 BCBS 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.
- PEEHIP **does not** allow mail order for Retail drugs.

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

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

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). For Opioid and Benzodiazepine prescriptions, refills are allowed only after 90% of the previous prescription has been used (for example, 27 days into a 30-day supply).
- Pharmacists shall dispense a generic equivalent medication when one is available unless the physician indicates in longhand writing on the prescription, indicates by mark or signature in the appropriate place on the prescription, or indicates in an electronic prescription, the following: “medically necessary” or “dispense as written” or “do not substitute.” The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent and contain the same active ingredient(s) and shall be of the same dosage, form, and strength.
- 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 multi-source brand drugs with a generic chemical equivalent, the total amount covered by PEEHIP will not exceed the amount that would have been covered if the generic equivalent were dispensed. Members will be subject to the difference between 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 & 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 the member copayment will normally be less than the otherwise applicable copayment.

Compound Drugs

PEEHIP does not cover ingredients in a compound that are currently excluded from coverage in non-compound prescriptions, such as 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. 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 inside or outside of 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 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. Members can reference the *Summary Plan Description* at www.rsa-al.gov/peehip/publications/ for detailed information about the Step Therapy program.



VIVA Health Plan (HMO)

(Active Members and Non-Medicare-Eligible Retirees)

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 on the next page 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 over 75 hospitals and over 7,000 physicians statewide. A brief explanation of benefits is below. Refer to the [Comparison of Benefits](#) chart to compare the two hospital medical plan options. **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 \$500 per person; \$1,500 maximum per family.
- Medical and prescription calendar year out-of-pocket combined maximum is **\$7,350 per member and \$14,700 per family coverage for the 2019 and 2020 calendar years.**
- 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
- \$25 copay for Primary Care Physician visit
- \$40 copay for Specialty Care; no referral required.
- \$40 copay for Chiropractic Care with a maximum of 25 visits per calendar year
- \$45 copay for Teladoc® consultation
- Preventive services are covered at 100% with no copay.

Dental Benefits *(Administered by Delta Dental)*

- 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).
- If the dentist is not part of the Delta Dental PPO network, the dentist may be able to bill you the difference between their fees and the Delta Dental PPO fee.

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
 - \$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 injectables, bio-technical, biological, and specialty drugs

*Mail order pharmacy is available.



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 do not 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 **65** counties; visit www.whyviva.com to find providers.

- Autauga, Baldwin, Barbour, Bibb, Blount, Bullock, Butler, Calhoun, Chambers, Cherokee, Chilton, **Choctaw**, Clarke, Clay, Cleburne, Coffee, Colbert, Conecuh, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas, DeKalb, Elmore, Etowah, Fayette, Franklin, Geneva, **Greene**, Hale, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marengo, Marion, Mobile, Monroe, Montgomery, Morgan, Perry, Pickens, Pike, Randolph, Russell, St. Clair, Shelby, **Sumter**, Talladega, Tallapoosa, Tuscaloosa, Walker, Washington, Wilcox, and Winston.

PEEHIP Supplemental Medical Plan

(Active Members and Non-Medicare-Eligible Retirees)

The PEEHIP Supplemental Medical Plan is administered by BCBS of Alabama.

PEEHIP offers a Supplemental Medical Plan to its members designed to supplement other eligible primary medical and prescription coverage by paying for the out-of-pocket amounts charged by the other plan. To allow even greater flexibility to our members who are enrolled in the PEEHIP Hospital Medical Plan, those members can switch to the Supplemental Medical Plan prospectively at any point during the plan year.

General Information

- There is no monthly premium charge for an individual or family plan if not enrolled in any other PEEHIP coverage.
- 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.
- Spouses who are independently eligible for PEEHIP who are covered by the PEEHIP Supplemental Medical Plan and Optional Coverage Plan will not be charged a premium.

Plan Specifics

- 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 High Deductible Health Plans (HDHP) are not eligible for the PEEHIP Supplemental Medical Plan. The IRS defines the minimum deductibles for HDHPs for calendar year 2019 as \$1,350 or more for individual and \$2,700 or more for family and for calendar year 2020 as \$1,400 or more for individual and \$2,800 or more for family. You must provide a copy of your primary plan document for verification of the deductibles.**
- To be eligible for reimbursement under the PEEHIP Supplemental Medical Plan, the primary insurance plan must have either 1) applied the eligible charges to the deductible, or 2) made primary payment for the services rendered.
- 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 member 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 \$7,900 for individual coverage and \$15,800 for family coverage for calendar year 2019; and \$8,150 for individual coverage and \$16,300 for family coverage for calendar year 2020.**
- Only active employees and non-Medicare-eligible retirees and dependent(s) are eligible to enroll in this plan.
- Members who are enrolled in the PEEHIP Hospital Medical Plan (Group #14000), VIVA Health Plan (offered through PEEHIP), Marketplace (Exchange) Plans, State Employees Insurance Board (SEIB), Local Government 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). Upon becoming Medicare-eligible, you and your covered dependents will be cancelled from this plan. Retired members who become eligible for Medicare will be eligible to enroll in the PEEHIP Group Medicare Advantage (PPO) Plan or the Optional Coverage Plans.



Optional Coverage Plans

(Active and Retired Members)

Southland Benefit Solutions administers the Optional Coverage Plans offered through PEEHIP.

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.

Important Information

- Optional Coverage Plan enrollment must be retained for the entire plan year (October 1 – September 30). New members employed during the Open Enrollment period cannot enroll in the Optional Coverage Plans on their date of hire or first of the month following their date of hire and cancel the plans effective October 1 of that same year.
- Members enrolled in family Optional Coverage Plans cannot change to individual Optional Coverage Plans outside of the Open Enrollment period unless all dependents become ineligible due to age, death, or divorce.
- 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, he or she can purchase one or more Optional Coverage Plan(s) (see [Premium Rates](#) for details). There is no premium cost for a retiree who is enrolled in two Optional Coverage Plans and is not enrolled in one of the PEEHIP hospital medical plans. **If a retiree enrolls in all four Optional Coverage Plans, they will pay the premium costs for two of the four plans.**

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



Additional Savings Programs

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

- VisionChoice® – VisionChoice® is an eye care savings plan designed to save members money! Members receive huge discounts on everything from eye exams to high index lenses. VisionChoice® works with participating providers to give members considerably lower prices. Members save up to 69% off retail eye wear, plus scratch resistant and UV coating are included on every lens at no extra cost.

All benefits are received at the time of purchase so there are no annoying claim forms to fill out. Start taking advantage of these discounts on your next vision need. There are no plan limitations, waiting periods, or deductibles to meet. To find a provider near you, call VisionChoice® at 800.476.3010 or visit www.southlandvision.com.

- Amplifon Hearing Health care – Southland Benefit Solutions has teamed up with Amplifon Hearing Health care to ensure healthy hearing for a lifetime. Get the care you and your family deserve for hearing healthcare services. The Amplifon Benefit Program covers you and your extended family. On top of the 40% members save on hearing test and diagnostic services, Amplifon also guarantees the lowest price on over 2,300 hearing aids. They have partnered with the nation's leading brands, including Miracle Ear and Phonak.

There are 40+ clinic locations in Alabama to provide you and your family best-in-class hearing solutions. To get started with this completely **free program**, call Amplifon at 888.669.2177 to find a provider near you. An Amplifon Care Advocate will explain the process and help you schedule an appointment. Amplifon will handle dealing with the provider to ensure that you will get your discount. For more information, visit www.amplifonusa.com/sbs.

Comparison of Benefits

Effective October 1, 2019 – September 30, 2020

(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 PEEHIP website for a complete list of benefits, limitations, and exclusions.

	PEEHIP Hospital Medical Plan Preferred Providers (Administered by BCBS)	VIVA Health Plan* (In approved areas only) (Active & 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 allowed amount with no deductible or copayment. For a listing of specific immunizations and preventive services, see www.alabamablue.com/preventiveservices .	\$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	\$25 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-rays and other diagnostics 90% coverage per test at hospital based labs
Teladoc®	\$0 copayment per consultation	\$45 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 also responsible for the physician copayment and lab fees. If 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 \$500 per individual; \$1,500 maximum per family.



	PEEHIP Hospital Medical Plan Preferred Providers (Administered by BCBS)	VIVA Health Plan* (In approved areas only) (Active & 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. 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 \$500 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 \$50 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 Blue Choice Behavioral Network providers, see www.alabamablue.com . Members can continue to use 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 per visit
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)	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 brand name is chosen, copayment will be the brand name copayment plus the cost differential between the brand and generic drugs. 90-day supply at retail pharmacy - 3x copay

	PEEHIP Hospital Medical Plan Preferred Providers (Administered by BCBS)	VIVA Health Plan* (In approved areas only) (Active & Non-Medicare Members Only)
<p>Prescription Drugs (cont.)</p>	<p>Pharmacists must dispense a generic equivalent medication when one is available unless the physician indicates in longhand writing on the prescription, indicates by mark or signature in the appropriate place on the prescription, or indicates in an electronic prescription, the following: “medically necessary,” “dispense as written,” or “do not substitute.” The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent, contain the same active ingredient or ingredients, and shall be of the same dosage, form, and strength.</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 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: Members 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>Refills on Retail and Specialty drugs (30-day supply) are allowed only after 75% of previous prescription has been used (example: 23 days into a 30-day supply). Refills are allowed for maintenance drugs (90-day supply) only after 75% of previous prescription has been used (example: 67 days into a 90-day supply). For Opioid and Benzodiazepine prescriptions, refills are allowed only after 90% of previous prescription has been used (example: 27 days into a 30-day supply).</p> <p>PEEHIP does not allow mail order for Retail drugs.</p> <p>Contraceptives are covered. \$0 copay - Generic; applicable copay for brand name.</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 \$7,350 per member and \$14,700 for family for the 2019 and 2020 calendar years.</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 Plan Preferred Providers (Administered by BCBS)	VIVA Health Plan* (In approved areas only) (Active & Non-Medicare Members Only)
Prescription Drugs (cont.)	<p>Certain prescription drugs and medications are excluded from PEEHIP coverage. To verify the formulary and coverage status of a medication, see https://mp.medimpact.com/ala.</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>Until 1/1/2020, Medicare-eligible retired members and Medicare-eligible covered dependents will be provided prescription drug coverage through the PEEHIP UnitedHealthcare® Group Medicare Advantage (PPO) Plan. For more information, see www.uhcretiree.com/peehip.</p> <p>Effective 1/1/2020, Medicare-eligible retired members and Medicare-eligible covered dependents will be provided prescription drug coverage through Humana®. Visit https://our.humana.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 BCBS 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

	PEEHIP Hospital Medical Plan Preferred Providers (Administered by BCBS)	VIVA Health Plan* (In approved areas only) (Active & Non-Medicare Members Only)
Dental	Not Covered	<p>(Administered by Delta Dental)</p> <p>Plan allows you to seek treatment from any licensed dentist. Dentists will be reimbursed based on Delta Dental's PPO fees. If dentist is not part of the Delta Dental PPO network, dentist may be able to bill you the difference between their fees and the PPO fee.</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 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>
Infertility Services	<p>Infertility services - 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>Medications for infertility treatment - 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>Infertility services - 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).</p> <p>Treatment for infertility is not a covered service.</p>



	PEEHIP Hospital Medical Plan Preferred Providers (Administered by BCBS)	VIVA Health Plan* (In approved areas only) (Active & Non-Medicare Members Only)								
Applied Behavioral Analysis (ABA) Therapy for Autism Spectrum Disorders	<p>Covered for children 0-18 years at 100% of allowed amount, subject to a \$15 copay per visit and the following annual maximum benefits:</p> <table border="1"> <thead> <tr> <th>Age</th> <th>Annual Maximum</th> </tr> </thead> <tbody> <tr> <td>0 to 9</td> <td>\$40,000</td> </tr> <tr> <td>10 to 13</td> <td>\$30,000</td> </tr> <tr> <td>14 to 18</td> <td>\$20,000</td> </tr> </tbody> </table> <p>May be balance billed from out-of-network providers for difference between the provider's charge and allowed amount.</p> <p><u>Preauthorization</u> is required prior to rendering ABA therapy to determine medical necessity. <u>Preauthorization</u> is required every six months thereafter to determine medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied.</p>	Age	Annual Maximum	0 to 9	\$40,000	10 to 13	\$30,000	14 to 18	\$20,000	<p>Covered at 80% of the allowed amount subject to the calendar year deductible</p>
Age	Annual Maximum									
0 to 9	\$40,000									
10 to 13	\$30,000									
14 to 18	\$20,000									
Annual Out-Of-Pocket Maximums for In-Network Services	<p>Covered members will pay no more than: \$7,900 for individual and \$15,800 for family coverage for calendar year 2019, and \$8,150 for individual and \$16,300 for family coverage for calendar year 2020.</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: \$7,350 per member and \$14,700 for family for 2019 and 2020 calendar years.</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.**

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

Teleconsultation Benefits

(Active and Retired Members)

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

	Hospital Medical Plans (Active and non-Medicare eligible retirees)		Medicare Advantage Plans (Medicare-eligible retirees)	
	BCBS (PPO)	VIVA Health (HMO)	UHC (PPO)*	Humana® (PPO)*
Benefit	Teladoc®		Virtual Visits (administered by Amwell® & Doctors on Demand®)	Virtual Visits (administered by MDLive®)
Availability	Nationwide 24/7/365; phone, web, and mobile app			
Video/Telephonic	Video and telephonic consults available		Video consults available via computer/smartphone/tablet; telephonic consults available	
Needed for Sign Up	Member ID card along with basic identifying information			
Cost	Medical: \$0 Behavioral Health: N/A	Medical: \$45 Behavioral Health: N/A	Medical: \$0 Behavioral Health: \$18	Medical: \$0 Mental/Behavioral Health: \$18
Website	www.teladoc.com/alabama	www.teladoc.com	www.uhcretiree.com/peehip	www.mdlive.com/humanamedicare
Phone	855.477.4549	800.TELADOC (800.835.2632)	877.298.2341 Customer Service gives step-by-step instructions to access Virtual Visits via web or mobile app	888.673.1992
Apps	Teladoc®, Doctors on Demand®, Amwell®n & MDLive® apps available on App Store or Google Play			
Doctor Types	PCP, pediatricians, family medicine		PCP, pediatricians, family medicine, behavioral health	PCP, pediatricians, family medicine, mental/behavioral health
Common Conditions Treated	cold, flu, allergies, bronchitis, UTI, respiratory infection, sinus, and more		cold, flu, allergies, bronchitis, UTI, respiratory infection, sinus, behavioral health, and more	

**Effective 1/1/2020, the administrator of PEEHIP's Group Medicare Advantage (PPO) Plan will change to Humana® for Medicare-eligible retired members and Medicare-eligible dependents covered on a retiree contract.*



Coordination of Benefits (COB)

(Other Insurance Coverage)

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

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

How to Update Other Insurance Coverage

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

Dental and Vision Plans

If 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. Refer to the [PEEHIP Summary Plan Description](#) section for more information on the COB rules.

Non-Duplication of Benefits

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

Wellness Programs

(Active Members and Non-Medicare-Eligible Retirees)

Choose Well, Live Well

Effective October 1, 2019, the PEEHIP Wellness program will be administered by Sharecare®, an industry leader in providing personalized health and wellness engagement activities and education to people to help them improve their health. Additionally, BCBS of Alabama will provide condition management services for members as part of the new wellness program. BCBS also brings with them their partners, Naturally Slim and Pack Health, to serve members who can most benefit from their programs. Wellness screenings will continue to be provided by ADPH.

This program offers **free** services for members and their covered spouses. In accordance with healthcare reform law, there is no required health standard which must be met.

Sharecare® is a company headquartered in Atlanta, GA, and cofounded by Jeff Arnold (founder of WebMD) and Dr. Oz. The Sharecare® concept is an all-in-one-place approach where members have access to a personalized platform that delivers specific content, education, tools, and resources matched to the specific health needs and preferences of the member.

Sharecare®, in combination with BCBS, will offer new personalized health improvement content and programs to members creating new opportunities for members to make small and easy decisions on a daily basis to improve their health. Sharecare® will encourage members to complete these activities through fun and engaging points - earning opportunities and challenges. These new additional activities will not be a requirement to earn the \$50 wellness premium waiver. Small decisions toward better health add up to real results and healthier habits. Healthier habits add up to a healthier PEEHIP.

The new wellness program will open up a path for members that provides a tailor-made opportunity to achieve better health, whether that means simply maintaining good health going forward, or reversing the progression toward diseases like diabetes. PEEHIP, Sharecare®, and BCBS are committed to creating a positive and rewarding culture of health in the state of Alabama.

Members Required to Participate

The following members enrolled in the PEEHIP Hospital Medical Plan Group administered by BCBS 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.

- 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 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

If you are unable to participate in any of the health-related activities or other wellness program requirements, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or alternative standard by contacting PEEHIP at 877.517.0020.



Incentive for Participating: \$50 Monthly Waiver of 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 and spouses who complete all required activities after the annual August 31 deadline may earn a wellness premium waiver prospectively. The waiver will be applied on the first day of the second month after the member and/or spouse successfully completes all required activities.

The wellness premium applies separately to covered members and their covered spouses. Covered members and their covered spouses can each earn the wellness premium waiver of \$50 for a potential combined wellness premium waiver of \$100 each month. The wellness premium is applied to the monthly PEEHIP premium beginning each October 1 for members and spouses 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, 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 or her wellness program requirements.

Newly enrolled PEEHIP members have the same wellness screening requirement as existing PEEHIP members, and health coaching may also be applicable to them if they receive a health coaching invitation letter from Sharecare®. Sharecare® will send health coaching invitation letters once per year in October. The Sharecare® member portal and app made just for PEEHIP members will show 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.

Required Activities to Earn the \$50 Monthly Wellness Premium Waiver

If you are required to participate in *Choose Well, Live Well*, you must complete a wellness screening, which is the minimum wellness activity required, by August 31 each year in order to qualify for the \$50 monthly wellness premium waiver. Participation in up to four Health Coaching activities is also required only if you and/or your covered spouse are identified as a candidate for these programs and receive an invitation letter from Sharecare®. See the [Health Coaching](#) section below for more information.

Members Who Do Not Complete by the Deadline

Members who do not complete all of their required activities by the August 31 deadline each year will be charged the \$50 monthly wellness premium beginning October 1 following the deadline. Members can still complete their required activities after the deadline for a prospective waiver through the end of the plan year in which they have been charged the wellness premium.

For example, if a member misses the August 31 deadline, they will begin paying the \$50 monthly wellness premium beginning in October. If later in the plan year the member completes the activities that were due by August 31, that member will earn a waiver of the \$50 monthly wellness premium beginning on the first day of the 2nd month after they complete, and that waiver will continue through the end of the plan year.

ActiveHealth was the previous administrator of PEEHIP's wellness program, but effective October 1, 2019, the program will be administered by Sharecare®. Any members who miss the current 2019 plan year deadline of August 31, 2019, will still be able to complete their activities and earn a prospective waiver by calling Sharecare® or logging into their Sharecare® mobile app or website.

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.alabamapublichealth.gov/worksitewellness 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 biometric values including:

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

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 Choose Well, Live Well 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/peehip/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 Coaching

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

Each year, BCBS will evaluate the membership data to determine which members could most benefit from one of these highly personalized coaching opportunities. In October, invitations for one of those coaching opportunities will be mailed by Sharecare® to identified members. In the invitation letter from Sharecare® that identified members will receive each October, the specific coaching program(s) available to that member will be included along with any available alternatives to health coaching that can complete the coaching requirement to earn the \$50 monthly wellness premium waiver.



Identified members will also receive information about their coaching programs directly from either BCBS, Sharecare®, Naturally Slim, or Pack Health, depending upon which program for which they are identified. These coaching opportunities offer high-touch personalized education and support for members with chronic conditions or at risk for chronic conditions, so access to these programs is limited exclusively to those members who can benefit from participation.

Sharecare® Coaching

PEEHIP's *Choose Well, Live Well* healthy lifestyle coaching program is provided by Sharecare®. Through convenient phone-based sessions, Sharecare® Wellness Coaching helps you find opportunities to improve your well-being every day. Your Sharecare® Wellness Coach will guide you through healthy behavior changes by building on your strengths. All calls are scheduled at your convenience and on your time line.

With help from your Sharecare® Wellness Coach you will:

- Better understand and reduce your health risks
- Receive encouragement to make long-term lifestyle changes
- Get answers to your health questions
- Find support to gain more control over your health
- Take small steps to improve your health
- Have access to personalized educational materials tailored for you

Naturally Slim and Pack Health Coaching

PEEHIP's *Choose Well, Live Well* coaching programs aimed toward disease prevention such as diabetes prevention are provided by Pack Health and Naturally Slim.

Pack Health is a digital health coaching company that helps people manage their **weight and prediabetes**. Pack Health is here to help you improve your health with weekly lessons, coaching calls, and personalized text and email follow-up including: reminders and encouragement, informational videos, resource recommendations, discounts, personalized action plans, and care coordination services. You'll work one-on-one with a Health Advisor, online and over the phone, to overcome barriers and achieve your personal health goals. Sign up today for high-touch, tailored support and start crushing your goals!

Naturally Slim is a common-sense, online weight loss program based on Eatology™, the study of when, why and how we eat. Unlike diets, which rely on your will power and 'eat this, not that' advice, Naturally Slim teaches you simple, repeatable skills to help you lose weight and keep it off in the real world, without giving up the foods you love. Naturally Slim is not about a body type, it's about adopting a set of behavioral skills that people who don't struggle with their weight use intuitively, to help you improve your overall health and quality of life.

BCBS Coaching

PEEHIP's *Choose Well, Live Well* condition management programs are provided by BCBS of Alabama. Condition management is a service for members diagnosed with chronic conditions including diabetes, asthma, chronic obstructive pulmonary disorder (COPD), coronary artery disease, and congestive heart failure. The program uses the latest clinical guidelines, member educational materials, and self-management support strategies to educate, coach and empower members and their caregivers. The team of clinicians include Registered Dietitians, Health Coaches, Certified Diabetic Educators, and Nurses that are available to assist you with reaching your best health. Get connected with a personal clinician to work with you one on one to help manage these long term conditions.

Gaps in Care

BCBS continuously analyzes healthcare information to look for opportunities to recommend certain tests, medications, or treatments based upon the established best practice medical guidelines. These are called gaps in care. BCBS will notify members as well as their providers of any gaps in care that need to be considered in order to encourage the best healthcare for that member. All of these messages encourage members to first speak with their healthcare provider about the recommendation.

Choose Well, Live Well Digital Platform by Sharecare®

Beginning October 1, 2019, visit your PEEHIP Sharecare® website at sharecare.com/peehip to register and take advantage of tools designed to help you reach your health goals. These include a Personal Health Record, a comprehensive health and wellness engagement solution providing a personalized experience to help you manage your health and achieve your health goals.

The key components of the program include:

- **The RealAge® Test:** A clinically validated health risk assessment that determines your age based upon your health and lifestyle as opposed to just your age based on birthdate.
- **Daily Trackers (Green Days):** Engagement data to track key RealAge® Test health indicators. Earning Green Days improves your RealAge® meaning improving your health.
- **Digital Health Programs:** Personalized recommendations, suggested content, targeted insights, and customized messages unique to the individual member.
- **Content Library:** Articles, questions and answers, videos, health topics, and much more.
- **AskMD:** Evidence-based and customizable symptom checker tool. Enter your symptoms and learn what might be causing them. Then get guidance you can trust and steps to take right away.
- **Personal Health Profile:** The health profile is where you will see all of the elements of your health such as the results of your RealAge® Test, Biometric Screening, Claims, and more.

Once you are registered for the Choose Well, Live Well program on Sharecare®, you will be able to track your activities and progress using the Sharecare® app for either Apple IOS or Android.

If you have already used the Sharecare® app or website in the past, simply visit sharecare.com/peehip to convert your previous account to your PEEHIP Sharecare® account.

Track the Completion Status of Your Required Wellness Activities

Your status toward earning your \$50 monthly wellness premium waiver will be available on the Rewards tab within the Sharecare® website and app. All required activities are shown under the Achieve tab in the Rewards section. Activities will be marked upon completion. If you would like additional confirmation of your wellness premium waiver status, you can view your status on the MOS web page at <https://mso.rsa-al.gov>.

Tobacco Cessation Programs

ADPH offers a free tobacco cessation program with live and online counseling to PEEHIP members. For more information about the Alabama Tobacco Quitline, visit www.quitnowalabama.com or call toll free 1.800.QUIT.NOW (800.784.8669).



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 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 spouses if there is a tobacco status change during the year, when members make changes to their coverage, and at the time of the wellness screening. Members can certify their non-tobacco use either online through MOS at <https://mso.rsa-al.gov> or by submitting a completed NEW ENROLLMENT AND STATUS CHANGE form.

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

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 and return it to the PEEHIP office by October 31. This form must be completed and sent to PEEHIP with a post-marked date of no later than October 31. This form can be downloaded from our website at www.rsa-al.gov/peehip/forms/. Upon receipt of this form, PEEHIP will notate that you are in pending status for a tobacco cessation program.

If you complete the cessation program before the end of the plan year, you must 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 postmarked date prior to the end of the plan year. If PEEHIP receives all of the required documentation by the time periods previously specified, you will be eligible to receive reimbursement of the tobacco premiums 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, 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, 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 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 Program Manager toll free at 877. 517.0020.

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

Baby Yourself® Program

Baby Yourself® is a maternity program, administered by BCBS of Alabama, for expectant mothers. This program is part of your PEEHIP Hospital Medical Plan and is available at no cost to you. PEEHIP strongly encourages all expectant mothers covered under the 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 BCBS 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** 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 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.



Premium Rates

(Active, Leave of Absence, and COBRA Members)

October 1, 2019 – September 30, 2020

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

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

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

Active Member

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

Member on LOA/COBRA

Individual	\$ 499
Family	\$1,258

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

Tobacco Premium and Wellness Premium

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

Refer to the [Wellness Programs](#) section to learn how you and/or your spouse can receive the non-tobacco user discount and wellness premium waiver.

Optional Coverage Plan Premiums

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

PEEHIP Supplemental Medical Plan

Active Member

Individual or Family	\$ 0
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Member on LOA/COBRA

Individual or Family	\$ 160
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Premium Assistance Program

(Active and Retired Members)

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

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

The discount does not apply to the tobacco premium or wellness premium for those who are subject to these premiums. The discount does not apply to members on Leave of Absence, COBRA, or a surviving dependent contract.

How to Apply for Premium Assistance

- Estimate eligibility for the discount using the household income table below and on the PREMIUM ASSISTANCE APPLICATION located online at www.rsa-al.gov/peehip/forms/
- If eligible, fill out steps 1-4 of the PREMIUM ASSISTANCE APPLICATION and send it to PEEHIP with all required information as specified in step 2.
- You will need to not only complete the PREMIUM ASSISTANCE APPLICATION, but you also need to provide your current year Federal Tax Return Transcript. To receive your transcript, call 800.908.9946 or visit <https://www.irs.gov/individuals/get-transcript>. You should receive your transcript within 7-10 business days.

Reminders:

- Only one application can be submitted per plan year regardless of income change.
- You must reapply every year during Open Enrollment or your discount will expire on the upcoming October 1.
- Any PREMIUM ASSISTANCE APPLICATION postmarked after the Open Enrollment period (July 1 – August 31) will be effective for the first day of the second month after the receipt and approval of the application.

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

Discounts for Family Size and Household Income

Family Size	50% Discount for Incomes	40% Discount for Incomes	30% Discount for Incomes	20% Discount for Incomes	10% Discount for Incomes
1 member	0 - \$12,490	\$12,491 - \$18,735	\$18,736 - \$24,980	\$24,981 - \$31,225	\$31,226 - \$37,470
2 members	0 - \$16,910	\$16,911 - \$25,365	\$25,366 - \$33,820	\$33,821 - \$42,275	\$42,276 - \$50,730
3 members	0 - \$21,330	\$21,331 - \$31,995	\$31,996 - \$42,660	\$42,661 - \$53,325	\$53,326 - \$63,990
4 members	0 - \$25,750	\$25,751 - \$38,625	\$38,626 - \$51,500	\$51,501 - \$64,375	\$64,376 - \$77,250
5 members	0 - \$30,170	\$30,171 - \$45,255	\$45,256 - \$60,340	\$60,341 - \$75,425	\$75,426 - \$90,510
6 members	0 - \$34,590	\$34,591 - \$51,885	\$51,886 - \$69,180	\$69,181 - \$86,475	\$86,476 - \$103,770
7 members	0 - \$39,010	\$39,011 - \$58,515	\$58,516 - \$78,020	\$78,021 - \$97,525	\$97,526 - \$117,030
8 members	0 - \$43,430	\$43,431 - \$65,145	\$65,146 - \$86,860	\$86,861 - \$108,575	\$108,576 - \$130,290



Free Tax Help

- For free tax preparation help, visit <https://www.irs.gov/individuals/free-tax-return-preparation-for-you-by-volunteers>.
- For free tax preparation software, visit <https://www.irs.gov/uac/free-file-do-your-federal-taxes-for-free>.

How to Reapply

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

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

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

Premium Assistance Law

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

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

Any reduction in an employee's or retiree's contribution pursuant to this section shall not be considered income of the employee or retiree for purposes of determining Medicaid eligibility for such employee or retiree.

Flexible Spending Accounts (FSA)

(Active Members Only)

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

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

1. **Premium Conversion Plan** requires all active members to pay premiums for PEEHIP using pre-tax dollars. This plan is strictly a function of the payroll system in which the member does not have to pay federal and state of Alabama income taxes on their health insurance premium.
2. **Dependent Care Reimbursement Account (DCRA)** allows active members to set aside up to a maximum of \$5,000 in pre-tax contributions each year to pay for dependent day care expenses so the member (and spouse, if married) can work outside of the home or attend school full time. If the member and spouse file separate tax returns, the maximum contribution amount for each is \$2,500. The minimum annual election to participate in this plan is \$120.
3. **Healthcare Flexible Spending Account (Health FSA)** allows active members to set aside up to a maximum of **\$2,700** of pre-tax contributions each year to pay for eligible healthcare expenses incurred by them and their dependents. The minimum annual election to participate in this plan is \$120.

Listed below are some of the eligible expenses that can be paid from your FSA for you and your dependents as defined by IRS Section 152:

DCRA:

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

Health FSA:

- Physician office copayments
- Prescription drug copayments
- Lab fees
- Dental copayments
- Orthodontia
- Deductibles
- Vision care including Lasik and Prelex surgery
- Hearing care
- OTC medications (only with a prescription)
- Chiropractors
- Medical equipment, such as blood pressure/glucose monitors, and CPAP devices

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

Flex Enrollment and Cancellation



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

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

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

Elected Amount and Reimbursement

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

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

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

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

Timely Filing Period Deadline/Funds Roll-Over

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

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

In accordance with IRS Notice 2013-71, PEEHIP allows members up to \$500 of unused funds remaining in a Health FSA after the timely filing period to be carried over and used for eligible Health FSA expenses in the following plan year. The carry over funds do not affect the annual maximum contribution amount. The Carryover Provision will apply to all plan participants that are still in active status at the beginning of the following plan year. Any funds remaining in the Health FSA, after the timely filing period has ended, in excess of \$500 will be forfeited. Members will have until the end of the new plan year to use the carry over funds on qualifying medical expenses. If a member terminates employment before the end of the plan year, carryover funds will be lost. Carryover funds may not be available for use until 30 days after the timely filing period has ended.

Retired Members

Retired members are not eligible to participate in the FSA 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/peehip/flex-account/.



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

Leave of Absence (LOA)

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

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

PEEHIP must receive an 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 LOA can add the remaining Optional Coverage Plans when he or she returns to work and becomes eligible for a full employer contribution. 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 ESS Portal and enter the hire status as the date the LOA 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 an employee is required to be at work.
- Employees on FMLA do accrue extra months of coverage while on leave under FMLA; the 3-1 Rule does apply while an employee is on FMLA. If extra months of coverage are earned for the summer months, the months should be applied to the end of the 12 weeks that were granted under FMLA.
- An employee cannot earn extra months of coverage under FMLA if he or she is retiring or not returning to work unless the reason for not returning to work is a serious health condition or circumstance beyond the control of the employee.
- The school system will collect premiums while the employee is on leave under FMLA and should collect premiums for any extra months earned under the 3-1 Rule.
- Employers must enter the FMLA status and beginning date in the ESS Portal when an employee is granted FMLA.
- Employers must enter the new status and FMLA ending date in the ESS Portal when the FMLA benefit ends.

COBRA

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

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

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

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

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

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

COBRA Compliance and PEEHIP Notification

The sanctions imposed under the auspices of COBRA can be quite severe, making a determination of compliance greatly important. It is the employer's responsibility to notify PEEHIP within a maximum of 30 days of an employee's termination, death or reduction in hours. The employer must notify the PEEHIP office by entering a termination date in the ESS Portal before the next payroll cycle. Employers must key the termination date in the ESS Portal for each employee who loses insurance coverage due to termination, resignation of employment, reduction in hours, or for an employee who does not earn the employer contribution, even if the employee does not want to continue the coverage.

Employers are subject to a penalty of \$100 per day for every day that they are past the 30-day notification deadline. It is the employee's or dependent's responsibility to notify PEEHIP within a maximum of 60 days when the **dependent** needs continuation coverage under COBRA.

Termination for Gross Misconduct

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

COBRA Eligibility

Under COBRA, the employee, ex-spouse, or dependent family member has the responsibility to inform PEEHIP within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan and must obtain a CONTINUATION OF COVERAGE application form. 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, 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. If you are entitled to Medicare before you become a qualified beneficiary, you may elect COBRA continuation coverage; your Medicare coverage will be primary and your COBRA continuation coverage will be secondary. You must have both Medicare Parts A and B to have full coverage, and you will be enrolled in the PEEHIP Group Medicare Advantage (PPO) Plan that includes prescription drug coverage.

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

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

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

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

An eligible member does not have to show that he or she is insurable to choose continuation of coverage. 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.

Employees who terminate and have a break in coverage and/or continue coverage through COBRA have 30 days from the date they return to work to enroll in coverage effective their date of hire (date returned to work) or first of the month following the date they return to work. Otherwise, they can enroll during Open Enrollment for an October 1 effective date of coverage. To enroll, PEEHIP must receive an online enrollment request or a completed NEW ENROLLMENT AND STATUS CHANGE form.

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 for a PEEHIP participating employer and wishes to enroll in new coverage, the member must complete a new enrollment request within 30 days from their hire date. The member may not drop existing coverage until the Open Enrollment period.

COBRA Extension for Covered Members Who Have Become Disabled

In certain circumstances, COBRA can be extended for covered members who become disabled. If a covered member becomes disabled under Title 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.

For the disability extension of COBRA coverage to apply, you must give the PEEHIP office timely notice of the Social Security Administration's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. The member or another person on his or her behalf must also notify PEEHIP within 30 days of any revocation of Social Security disability benefits.

Provision for Medicare-Eligible Active Members

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

As a result of these changes, PEEHIP does not provide an active member or 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, and home health services.) This means that the plan will pay the covered claims and those of the active employee's Medicare-eligible spouse first, up to the limits contained in the plan, and Medicare may pay all or a portion of the unpaid balance of the claims, if any, subject to Medicare limitations. If the active employee's spouse is not eligible for Medicare and has no other coverage, the PEEHIP plan will be the sole source of payment for the spouse's claims. Since PEEHIP also covers items and services not covered by Medicare, PEEHIP will be the sole source of payment of medical claims for these services.

Because of the cost of Medicare Part B, an active employee 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 both Medicare Part A and Part B so that the Medicare Part A and Part B coverage is effective no later than the date of retirement of the policyholder.**

The Social Security Administration handles Medicare enrollments. If 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 both Medicare Part A and Part B, you will not be eligible for the PEEHIP Group Medicare Advantage (PPO) Plan and you will not have hospital medical or prescription drug coverage with PEEHIP.**

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 hospital medical 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.



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

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

Other Medicare Rules

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. **If you are retired, you must be enrolled in both Medicare Part A and Part B to be eligible for the PEEHIP Group Medicare Advantage (PPO) Plan. If you do not have Medicare Part A and Part B, you will not have hospital medical or prescription drug coverage with PEEHIP.**

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 become primary.

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.

Health Insurance Policies for Retired Members

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

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 TRS Board of Control no less than 30 days or more than 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 continuation of or cancellation from PEEHIP coverage. 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 Plans until the Open Enrollment period.

Retired members are eligible for two of the Optional Coverage Plans without a payroll deduction if not enrolled in any other PEEHIP coverage. The member must indicate which Optional Coverage Plans 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 individual coverage, he or she can only enroll in individual 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 individual 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 is enrolled in the PEEHIP Hospital Medical Plan and one or more Optional Coverage Plans, he or she cannot drop the Optional Coverage Plans until the Open Enrollment period. **Also, a member cannot add Optional Coverage Plans on the date of retirement.** Retired members are eligible for two of the Optional Coverage Plans without a payroll deduction if not enrolled in any other PEEHIP coverage.

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 the applicable premium for the Optional Coverage Plans. Mr. Smith cannot add the PEEHIP Hospital Medical Plan nor is he allowed to drop only one Optional Coverage Plan until the Open Enrollment period.
- Example 2: Mrs. Scott retired from the University of Alabama (a non-participating system) on January 1. Mrs. Scott was enrolled in the BCBS health insurance plan with the University of Alabama. Therefore, Mrs. Scott can enroll in the PEEHIP Hospital Medical Plan on January 1. If Mrs. Scott was enrolled in the family BCBS plan with the University of Alabama, Mrs. Scott could add her dependents. However, if Mrs. Scott only had the individual BCBS plan, Mrs. Scott could not enroll her family in the PEEHIP Hospital Medical Plan until the Open Enrollment period or if there is another IRS qualifying life event.
- Example 3: When Mrs. Sellers was age 55, she terminated her employment with Auburn University with 11 years of service. When she turned age 60, she began drawing a retirement check and became eligible for the PEEHIP Hospital Medical Plan. Mrs. Sellers is eligible to enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Medical Plan effective the date of her retirement or she could wait until the Open Enrollment period. Mrs. Sellers must wait until the Open Enrollment period to enroll in any of the Optional Coverage Plans.

A Medicare-Eligible Retiree and Medicare-Eligible Dependent

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

It is extremely important for the Medicare-eligible member and/or dependent to have Medicare Part A and Part B to assure coverage with PEEHIP. **In addition, the member should notify Medicare of his or her retirement date and request Medicare to change their records to reflect that Medicare should be the primary payer on the member's date of retirement. Until January 1, 2020, Medicare-eligible members and Medicare-eligible dependents who are covered on a retiree contract will be automatically enrolled in the PEEHIP UnitedHealthcare® Group Medicare Advantage (PPO) Plan. Effective January 1, 2020, the administrator of the PEEHIP Group Medicare Advantage (PPO) Plan will change to Humana®. The plan is fully insured by Humana® and members are 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 both Part A and Part B of Medicare to have coverage with the PEEHIP Humana® Group Medicare Advantage (PPO) Plan. For more information, please contact Humana® by calling 800.747.0008.**

What if You Want Medical Coverage Only

If you have TRICARE or a different Medicare Part D Group 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® until 12/31/2019, and Humana® as of 1/1/2020**, that only includes hospital medical coverage.

**Creditable prescription drug coverage means that it is at least as good as what Medicare Part D offers. If 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® for coverage through 12/31/2019, and from Humana® for coverage beginning 1/1/2020**, to use for your hospital medical services. 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 UnitedHealthcare® prescription drug coverage and enroll in the PEEHIP UnitedHealthcare® Group Medicare Advantage (PPO) Plan with hospital 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 PEEHIP Humana® Group Medicare Advantage (PPO) Plan that already includes prescription drug coverage and then enroll in an individual Medicare Part D prescription drug plan, Medicare will automatically disenroll you from PEEHIP Humana® Group Medicare Advantage (PPO) Plan and you will lose your hospital medical and prescription drug coverage.

Non-Medicare-Eligible Dependents

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

Insurance Coverage Periods and Employer Contributions

Retiring members are eligible to receive the extra coverage months under the 3-1 Rule. For 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 will continue to provide the appropriate employer contribution earned under the 3-1 Rule. **However, the member must have both Medicare Part A and Medicare Part B effective the date of retirement.** The PEEHIP office assumes that the employer will not pay the September contribution for the June 1 retirees.

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

Retiree Other Employer Group Health Insurance Coverage

Legislation requires certain members who retired after September 30, 2005, to take other employer health insurance. 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 individual 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 if they are not Medicare eligible. Failure by a retiree to enroll in the other employer's group health plan under the terms of the Act will result in the termination of coverage in PEEHIP. Retired members who retired on or after October 1, 2005, and are ineligible for the PEEHIP coverage can be covered as a dependent on their spouse's PEEHIP plan.

- Example: 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. Medicare eligible members and dependents should not enroll in a separate Medicare Part D program if they are enrolled in the PEEHIP Group Medicare Advantage (PPO) Plan.

Until January 1, 2020, Medicare-eligible members and Medicare-eligible dependents who are covered on a retiree contract will be automatically enrolled in the PEEHIP UnitedHealthcare® Group Medicare Advantage (PPO) Plan. Effective January 1, 2020, the administrator of the Medicare Advantage Plan will change to Humana®. The plan is fully insured and members are 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 PEEHIP Humana® Group Medicare Advantage (PPO) Plan.

Some other advantages regarding the **PEEHIP Humana® 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. For more information, please contact **Humana®** by calling **800.747.0008**.

Plan Costs	In-Network	Out-of-Network
Annual medical deductible	Your plan has an annual combined in-network and out-of-network medical deductible of \$185 each plan year	

Medical Benefits	In-Network	Out-of-Network
Doctor’s office visit	Primary Care Physician copay: \$13 Specialist copay: \$18	Same as in-network
Inpatient hospital care	\$200 copay per day: day 1 \$25 copay per day: days 2-5 \$0 copay per day after that	Same as in-network
Lab Services	\$0 copay	Same as in-network
Outpatient X-rays	\$0 copay	Same as in-network
Ambulance	\$0 copay	Same as in-network
Emergency room	\$35 copay (worldwide)	Same as in-network
Telehealth/Virtual Visits	\$0 copay Speak to specific doctors using your computer or mobile device. Find participating doctors online at www.uhcretiree.com/peehip until 1/1/2020 and https://our.humana.com/PEEHIP effective 1/1/2020.	Same as in-network

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



Retiree Premium Rates

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

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

The monthly premiums for members who retired **prior to October 1, 2005**, or members who retired **on or after October 1, 2005, and before January 1, 2012, with 25 years of service** are listed in the chart below and show a retiree's out-of-pocket cost after subtracting the retiree insurance contribution.

Type of Contract	*Retiree Monthly Out-of-Pocket Premium	Premium if One Covered Dependent is ME Spouse	Premium if One Covered Dependent is NME Spouse
Individual/NME Retired Member	\$166	N/A	N/A
Family/NME Retired Member with more than 1 Dependent or Only Dependent NME	\$421	\$451	\$521
Family/NME Retired Member with Only 1 Dependent who is their Spouse	N/A	\$305	\$496
Family/NME Retired Member & Only 1 Nonspousal ME Dependent	\$280	N/A	N/A
Individual/ME Retired Member	\$ 25	N/A	N/A
Family/ME Retired Member with more than 1 Dependent or Only Dependent NME	\$280	\$310	\$380
Family/ME Retired Member with Only 1 Dependent who is their Spouse	N/A	\$164	\$355
Family/ME Retired Member & Only 1 Nonspousal ME Dependent	\$139	N/A	N/A

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

***This rate applies to the PEEHIP Hospital Medical Plan 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. A retiree premium calculator is available for your review on our website at www.rsa-al.gov/about-rsa/calculators/.

- **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 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 24 months from the member's date of retirement if the member qualifies for Social Security Disability benefits during the 24 months following the member's date of retirement and proof of the Social Security Disability benefit is provided to PEEHIP.
- **Members who retired on disability on or after January 1, 2012**, are subject to the age and subsidy component prior to becoming Medicare eligible. However, they are not affected by the sliding scale premiums **for 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 24 months from the member's date of retirement if the member qualifies for Social Security Disability benefits during the 24 months following the member's date of retirement and proof of the Social Security Disability benefit 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 and will terminate at the end of the 24 month period if Social Security Disability benefits have not been awarded. 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. The premium reduction can be reinstated prospectively if documentation is provided to PEEHIP showing that Social Security Disability benefits were awarded after the 24 month period.
- Members who retired on service and later became disabled are not eligible for this premium reduction.
- **Members who retired on or after January 1, 2012**, are subject to the sliding scale premiums which are based on age at retirement, years of service, and the cost of the insurance program. Refer to the [Retiree Sliding Scale Legislation](#) section for more information.

Optional Coverage Plan Premium

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



Retiree Sliding Scale Legislation

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

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 healthcare (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 healthcare (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 entitlement 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-eligible retiree subsidy. For Fiscal Year 2020, the

subsidy component is **\$179.14**. Upon Medicare entitlement, the subsidy will be removed.

The total of the additional service premium, age premium, and subsidy premium resulting from the new law was 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.
- Surviving children of the deceased member are only eligible to continue PEEHIP coverage until they reach the limiting age.* Once they reach the limiting age, they would need to contact PEEHIP for an application to continue coverage through COBRA.

****If the child is incapacitated, the child is allowed to keep the coverage as long as premiums are paid by the due date each month.***

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

Premiums Effective October 1, 2019 - September 30, 2020

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

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

Individual/Non-Medicare-eligible (NME) Survivor	\$ 845
Family/NME Survivor & more than 1 Dependent or Only Dependent NME	\$1,117
Family/NME Survivor & Only Dependent Medicare-eligible (ME)	\$1,021
Individual/ME Survivor	\$ 355
Family/ME Survivor & more than 1 Dependent or Only Dependent NME	\$ 724
Family/Medicare-eligible Survivor & Only Dependent ME	\$ 609
Supplemental Medical Plan (Individual or Family)	\$ 160
Optional (Each Plan) - Cancer, Indemnity, Vision, and Individual Dental	\$ 38
Optional - Family Dental Premium	\$ 50
Tobacco Premium for Survivor Enrolling in Hospital Medical	\$ 50
Wellness Premium/NME Survivor	\$ 50

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

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

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The Public Education Employees' Health Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

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

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

Effective Date of Notice: September 23, 2013.

How the Plan Uses and Discloses Health Information

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

Uses and Disclosures Related to Payment, Healthcare Operations, and Treatment

The Plan and its business associates may use your health information without your permission to carry out payment or healthcare operations. The Plan may also disclose health information to the Plan Sponsor, PEEHIP, for purposes related to payment or healthcare operations.

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

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

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



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

Other Uses and Disclosures that do not Require Your Written Authorization

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

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

Additional Disclosures to Others Without Your Written Authorization

The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your healthcare or payment for that care. For example, the Plan may confirm whether 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, healthcare operations and treatment. The Plan will consider, but may not agree to, such requests.

Alternative Communication

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

Copy of Health Information

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

Amend Health Information

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

Right to Access Electronic Records

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

List of Certain Disclosures

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

Right to a Copy of Privacy Notice

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

Complaints

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

The Plan’s Responsibilities

The Plan is required by 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 (OBGYN) Care Notice

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

Choice of Primary Care Physician Notice

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

Women’s Health and Cancer Rights Act Notice

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

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



This coverage will be provided in a manner determined in consultation with the patient and the patient's attending physician, and is subject to any applicable annual deductibles, coinsurance and/or copayment provisions. Call BCBS of Alabama at 800.327.3994 for more information.

Newborns' and Mothers' Health Protection Act of 1996

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

Want to sit
down with a
counselor?



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

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

201 South Union Street
Montgomery, Alabama



PEEHIP

Mail Public Education Employees' Health Insurance Plan

P.O. Box 302150

Montgomery, AL 36130-2150

Website www.rsa-al.gov