PEEHIP

Public Education Employees' Health Insurance Plan

Effective October 1, 2023

Administered by

Blue Cross and Blue Shield of Alabama

Table of Contents

OVERVIEW OF THE PLAN

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

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

If you have any questions, please call our Customer Service at 800-327-3994.

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

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

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

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

Public Education Employees' Health Insurance Plan (PEEHIP)

Group 14000

BlueCard® PPO

Effective October 1, 2023-
September 30, 2024

Public Education Employees' Health Insurance Plan (PEEHIP)
BlueCard® PPO

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.		
SUMMARY OF COST SHARING PROVISIONS		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible for Major Medical Services	$300 individual; $900 family maximum	
Calendar Year Out-of-Pocket Maximums	**Major Medical Maximums:** $400 individual annual major medical out-of-pocket maximum (no family maximum) plus the $300 calendar year deductible. In-network Other Covered Services are the only expenses applicable to the calendar year major medical out-of-pocket maximum (includes Participating Chiropractor Services, Physical Therapy, DME, Occupational Hand Therapy, Speech Therapy, Allergy Testing and Treatment, Infertility Services, Preferred Home Health and Hospice, and Ambulance services). **Overall Maximums:** $9,100 individual; $18,200 family contract calendar year overall out-of-pocket maximum for 2023 and $9,450 individual; $18,900 family contract calendar year overall out-of-pocket maximum for 2024 All deductibles, copays and coinsurance for in-network services apply to the calendar year overall out-of-pocket maximum, including prescription drugs. After you reach your individual Calendar Year Out-of-Pocket Maximum (even if you are covered under family coverage), applicable expenses for you will be covered at 100% of the allowed amount for the remainder of the calendar year.	
INPATIENT FACILITY AND PHYSICIAN BENEFITS		
Precertification is required for inpatient admissions (except medical emergency services, maternity and as required by Federal Law); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-354-7412 for precertification.		
Inpatient Hospital* (including maternity) **Note:** Maternity benefits are not available to dependent children of any age.	Covered at 100% of the allowed amount for semi-private room and board; intensive care units, general nursing services and usual hospital ancillaries after a $200 per admission deductible and a $25 per day copay for days 2-5 *Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®. More information is available at https://www.bcbs.com/blue-distinction-center/facility	Covered at 80% of the allowed amount for semi-private room and board; intensive care units, general nursing services and usual hospital ancillaries after a $200 per admission deductible and a $25 per day copay for days 2-5 **Note:** In Alabama, in-patient benefits available only for medical emergency services and accidental injury
OUTPATIENT FACILITY BENEFITS		
Precertification is required for some outpatient hospital benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Certain medications require enrollment in the HealthSmartRx program. For questions, please call 1-833-798-6733. Additional information and the applicable drug list is available at AlabamaBlue.com/Providers/HealthSmartRx. **Please see your benefit booklet. If precertification is not obtained, no benefits are available.** Select procedures that require precertification include but are not limited to implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, surgery for obstructive sleep apnea, reduction mammoplasty, rhinoplasty and surgery for varicose veins.		
Outpatient Surgery* (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount after $150 facility copay *Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®. More information is available at https://www.bcbs.com/blue-distinction-center/facility	Covered at 80% of the allowed amount subject to calendar year deductible **In Alabama,** out-of-network facilities, not covered
Outpatient Surgery & Anesthesia Physician Visits	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Medical Emergency) (In-Area/Out-of-Area) Facility Charge	Covered at 100% of the allowed amount after $150 facility copay for true medical emergencies. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 100% of the allowed amount after $150 facility copay for true medical emergencies. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible.
Emergency Room (Accidental Injury) (In-Area/Out-of-Area) Facility Charge **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **(Medical Emergency)** above.	Covered at 100% of the allowed amount after $150 facility copay	Covered at 100% of the allowed amount after $150 facility copay
Outpatient Diagnostic Lab & Pathology Genetic laboratory testing requires precertification. For precertification, call 1-800-248-2342. Certain testing may require precertification to be payable under the plan.	Covered at 100% of the allowed amount after $5 copay per test	Covered at 80% of the allowed amount subject to the calendar year deductible; **In Alabama,** out-of-network facilities not covered
Chemotherapy, Dialysis, IV Therapy & Radiation Therapy Radiation therapy management services requires precertification. For precertification, call 1-866-803-8002. If precertification is not obtained, no benefits will be payable under the plan for the services.	Covered at 100% of the allowed amount after $25 facility copay	Covered at 80% of the allowed amount subject to the calendar year deductible **In Alabama,** out-of-network facilities, not covered
Outpatient Diagnostic X-ray	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible **In Alabama,** out-of-network facilities, not covered
Advanced Imaging (i.e., MRA, MRI, PET, CT and CTA) **Precertification required-**If precertification is not obtained, no benefits will be payable under the plan for the services. For precertification, call 1-866-803-8002.	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible **In Alabama,** out-of-network facilities, not covered
PHYSICIAN BENEFITS		
Precertification is required for some physician benefits and provider-administered drugs; visit AlabamaBlue.com/Provider Administered Precertification Drug List. Certain medications require enrollment in the HealthSmartRx program. For questions, please call 1-833-798-6733. Additional information and the applicable drug list is available at Alabamablue.com/Providers/HealthSmartRx. Please see your benefit booklet. If precertification is not obtained, no benefits are available. Select procedures that require precertification include but are not limited to implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, surgery for obstructive sleep apnea, reduction mammoplasty, rhinoplasty and surgery for varicose veins.		
Inpatient Physician Visits and Consultations*	Covered at 100% of the allowed amount; no copay or deductible *Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®. More information is available at https://www.bcbs.com/blue-distinction-center/facility	Covered at 80% of the allowed amount subject to calendar year deductible
Office Visits and In-Person Consultations-Primary Care Physician (Includes Urgent Care, Internal Medicine, Family Practice, General Practice, Physician Assistant, Clinic, Gynecology, Obstetrics, Certified Nurse Practitioner, Midwives, and Pediatrician)	Covered at 100% of the allowed amount after a $30 office visit copay	Covered at 80% of the allowed amount subject to the calendar year deductible
Office Visits and In-Person Consultations-Specialist	Covered at 100% of the allowed amount after a $35 office visit copay	Covered at 80% of the allowed amount subject to the calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Telephone and Online Video Physician Consultations Program A service, through Teladoc™ to diagnose, treat and prescribe medication (when necessary) for certain medical issues. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4549	Covered at 100% of the allowed amount; no copay or deductible	Group 14000 members have access to Teladoc® nationwide. Teleconsultation providers other than Teladoc® are not covered
Emergency Room (Physician)	Covered at 100% of the allowed amount after $35 physician copay	Covered at 100% of the allowed amount after $35 physician copay
Outpatient Surgery & Anesthesia	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
Diagnostic Lab & Pathology Genetic laboratory testing requires precertification. For precertification, call 1-800-248-2342. Certain testing may require precertification to be payable under the plan.	Covered at 100% of the allowed amount after a $5 copay per test	Covered at 80% of the allowed amount subject to the calendar year deductible
Chemotherapy, Dialysis, IV Therapy, Radiation Therapy & X-ray Radiation therapy management services requires precertification. For precertification, call 1-866-803-8002. If precertification is not obtained, no benefits will be payable under the plan for the services.	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
Advanced Imaging (i.e., MRA, MRI, PET, CT and CTA) **Precertification required-**If precertification is not obtained, no benefits will be payable under the plan for the services. For precertification, call 1-866-803-8002 (toll free).	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
Maternity Care	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/ Preventive Services** for listing of immunizations and preventive services or call our Customer Service Department for a printed copy.	Covered at 100% of the allowed amount; no copay or deductible. In addition to the standard the following are covered: • Urinalysis (once by age 5 and once between ages 12 through 17) • CBC (once each calendar year) • Cholesterol Screening (once per calendar year for members age 18 and older) • Glucose Screening (once per calendar year for member age 18 and older)	Not Covered
MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE BENEFITS		
Inpatient Facility Services	Covered at 100% of the allowed amount subject to a $200 per admission deductible and a $25 per day copay for days 2-5. Precertification required.	Covered at 100% of the allowed amount subject to a $200 per admission copayment and a $25 per day copay for days 2-5. Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital in Alabama. Precertification is required.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Inpatient Physician Services	Covered at 100% of the allowed amount subject to a $0 copay. Mental Health – No inpatient day limit on coverage availability during a covered admission. Precertification required by admitting facility.	Covered at 80% of the allowed amount, Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to an in-network hospital in AL. Precertification required by admitting facility.
Outpatient Facility Services Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)	Covered at 100% of the allowed amount subject to $150 copay per treatment episode. Precertification required.	Covered at 100% of the allowed amount subject to $the calendar year deductible. Precertification required.
Outpatient Physician Services at PEEHIP Certified Community Mental Health Centers	Covered at 100% of the allowed amount subject to a $10 copay per visit. Limited to 20 visits per member each plan year. Maximum visits are combined for mental and substance abuse.	Not applicable. All PEEHIP Certified Community Mental Health Centers are in-network.
Outpatient Physician Services for BlueCard PPO and Blue Choice Behavioral Network Providers	Covered at 100% of the allowed amount, subject to a $15 copay per visit. For a list of in-network providers, see **AlabamaBlue.com**.	Covered at 80% of the allowed amount, subject to the calendar year deductible;
Residential Treatment Facilities **Required precertification and approval through case management New Direction Behavioral Health (NDBH)**	Covered at 100% of the allowed amount subject to a $200 per admission deductible and a $25 copay for days 2-5	80% of the allowed amount subject to a $200 per admission deductible and a $25 copay for days 2-5.

PRESCRIPTION DRUG BENEFITS
(PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH EXPRESS SCRIPTS)

Prior Authorization, Step Therapy and/or Quantity Limits may apply for some drugs.			
	Up to a 30-day supply	**31-60 day supply**	**61-90 day supply**
Tier 1 – Generic Drugs	**$6**	**$12**	**$12**
Tier 2 – Preferred Brand Drugs	**$40**	**$80**	**$120**
Tier 3 – Non-preferred Brand Drugs	**$60**	**$120**	**$180**
Specialty Drugs	**20% coinsurance per prescription, with a minimum of $100 copay and maximum of $150 copay**	**Days supplies greater than 30 are not allowed for specialty drugs**	**Days supplies greater than 30 are not allowed for specialty drugs**

Generic Law: 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.

Maintenance Drugs: To obtain a supply greater than 30 days, the drug must be on PEEHIP's Maintenance Drug List and must be prescribed for up to a 90-day supply. The first fill of a maintenance drug will be up to a 30-day supply. Subsequent fills can be obtained up to a 90--day supply.

Dispense as Written (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.

Diabetic Supplies: Certain diabetic supplies are covered only through the pharmacy drug plan. Some examples include needles and syringes for insulin, glucometers and lancets.

Certain prescription drugs are excluded from PEEHIP coverage. Mail order for Retail drugs is excluded. To verify the drug formulary coverage status of a medication, please visit the Express Scripts website at express-scripts.com.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Non-participating pharmacies (both in-state and out-of-state): Members must pay the full amount of the prescription drug and then file the claim to Express Scripts to be reimbursed at the participating pharmacy rate less the applicable copay. All PEEHIP clinical utilization management programs will apply. Out-of-pocket costs will be higher if you use a non-participating pharmacy.		
Contraceptives: Generic contraceptive drugs are covered at a zero copay. Brand contraceptives are covered at the applicable brand copay.		
Flu vaccines: Eligible flu vaccines are covered at a zero copay when administered by a participating pharmacy.		
Shingrex vaccine: Covered at zero copay when administered by a participating pharmacy for those aged 50 and older.		
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 Express Scripts and their partner SaveOnSP will offer copay assistance programs for certain specialty drugs so that the member copayment will normally be less than the otherwise applicable copayment.		
Infertility Drugs: Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP member contract. Members will pay 100% of the cost of the medications after the $2,500 lifetime maximum is reached.		

BENEFITS FOR OTHER COVERED SERVICES

Precertification is required for some other covered services and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Allergy Testing & Treatment	Covered at 80% of the allowed amount subject to the calendar year deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
Ambulance Service	Covered at 80% of the allowed amount subject to the calendar year deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
Participating Chiropractic Services	Covered at 80% of the allowed amount; no copay or deductible **Note:** In Alabama, more than 18 visits in a calendar year rendered by a Participating Chiropractor require precertification.	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 12 visits in a calendar year.
Durable Medical Equipment (DME) Precertification is required for certain durable medical equipment (i.e., motorized/power wheelchairs). Medically necessary insulin pumps and cartridges are covered. Medically necessary diabetic supplies (syringes, needles for insulin, glucometers and lancets) are covered under the medical plan benefit when Medicare is primary.	Covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Physical Therapy Physical therapy will require precertification after 15 visits to determine medical necessity for continued therapy. Visits will accumulate regardless of provider. Call 1-800-248-2342	Covered at 80% of the allowed amount subject to the calendar year deductible. Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.	Covered at 80% of the allowed amount subject to the calendar year deductible. Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.
Occupational Therapy Occupational Therapy will require precertification. Call 1-800-248-2342	Covered at 80% of the allowed amount subject to the calendar year deductible. Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.	Covered at 80% of the allowed amount subject to the calendar year deductible. Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.
Speech Therapy	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 30 sessions per person per calendar year combined in and out-of-network. Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 30 sessions per person per calendar year combined in and out-of-network. Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Applied Behavioral Analysis (ABA) Therapy for children aged 0-18 diagnosed with an Autism Spectrum Disorders	Covered at 100% of the allowed amount subject to a $15 copay per visit. *Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied.	Covered at 80% of the allowed amount subject to the calendar year deductible. *Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied.
Preferred Home Health and Hospice	Covered at 100% of the allowed amount; no copay or deductible. Precertification required for services rendered outside of Alabama. Call 1-800-248-2342	Covered at 80% of the allowed amount subject to the calendar year deductible. Precertification required for services rendered outside of Alabama. Call 1-800-248-2342 **In Alabama,** out-of-network services, not covered
Home Infusion Services Some Home Infusion medications require enrollment in the HealthSmartRx program. For questions, please call 1-833-798-6733. Additional information and the applicable drug list is available at AlabamaBlue.com/Providers/HealthSmartRx.	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 80% of the allowed amount subject to the calendar year deductible. **In Alabama,** out-of-network services, not covered
Infertility Testing and Treatment Limited to a lifetime maximum of 8 artificial insemination attempts (whether successful or not). Benefits are not provided for IVF (in-vitro fertilization), ART or GIFT (gamete intrafallopian transfer).	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 80% of the allowed amount subject to the calendar year deductible.

HEALTH MANAGEMENT BENEFITS	
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231**.**
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease and other specialized conditions. For more information, call 1-888-841-5741.
Baby Yourself®	A maternity program highly recommended for all pregnancies; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.** This group will waive the in-network and out-of-network inpatient hospital $200 per admission deductible for maternity admissions for the delivery of a baby for members participating in Baby Yourself. The member must enroll in the program in the first trimester and complete the program. The $25 per day copay will still apply for days 2-5, if applicable. Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact PEEHIP at 1-877-517-0020 and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website **(AlabamaBlue.com)** or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s).*
- *Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area, the average charge for care in the area, or as required by applicable Federal Law.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*

Please note: Providers/Specialists may be listed in a PPO directory or on the provider finder website (**www.bcbs.com**), but not covered as PPO benefits by this group health plan (i.e., DME, Ambulance, Allergists). Please check your benefit matrix or benefit booklet to determine coverage. This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract.

Check your benefit booklet for more detailed coverage information.

PEEHIP members who use non-participating hospitals, providers or outpatient facilities will incur additional out-of-pocket costs.

To maximize your benefits, always use network providers.

Teladoc® Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

If you have any questions concerning your PEEHIP hospital / medical benefits or a claim, call 1-800-327-3994.

To certify emergency or maternity admission, call 1-800-354-7412.

To certify home health and hospice services, call 1-800-821-7231.

To take advantage of the Baby Yourself® program, call 1-800-222-4379.

Visit our website at **AlabamaBlue.com/peehip**

For questions concerning prescription drugs, call Express Scripts at 1-800-363-9389 or visit **express-scripts.com**.

Group 14000
Revised 11/21/2022

Using *my*BlueCross to Get More Information

By being a member of the plan, you get exclusive access to ***my*BlueCross** - an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at www.AlabamaBlue.com/register. With ***my*BlueCross**, you have 24-hour access to personalized healthcare information, PLUS easy-to-use online tools that can help you save time and efficiently manage your healthcare:

- Download and print your benefit booklet or Summary of Benefits and Coverage.
- Request replacement or additional ID cards.
- View all your claim reports in one convenient place.
- Find a doctor.
- Track your health progress.
- Get fitness, nutrition, and wellness tips.

Blue Care Health Advocate

By being a member of the plan, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research, and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you, and much more. To find out more or to contact your BlueCare Health Advocate, call our Customer Service Department at the number on the back of your ID card.

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PEEHIP and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a standard Medicare drug plan or keep your PEEHIP Medicare Advantage Prescription Drug Plan (MAPDP) coverage.

The PEEHIP Employer Group Medicare Advantage Plan with Prescription Drug Plan Coverage (MAPDP) is administered by United Healthcare for Medicare retirees and Medicare covered dependents. All PEEHIP covered Medicare eligible retirees and Medicare covered dependents will be automatically enrolled in PEEHIP's MAPDP coverage unless they are enrolled in another MAPDP plan or Medicare Part D plan, or they choose to opt-out. You can opt-out of the hospital medical and prescription drug coverage completely, or you can opt-out of just the prescription drug coverage if you have other creditable prescription drug coverage. If you opt-out of the prescription drug coverage offered through this plan, you will have no prescription coverage through PEEHIP. If you opt-out of this plan completely, you will have no hospital medical and prescription drug coverage through PEEHIP.
If you are considering joining a standard Medicare Part D drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. However, if you choose to enroll in a standard Medicare Part D drug plan, another Medicare Advantage Plan, or Medicare Supplemental Plan, you will lose the PEEHIP hospital medical and prescription drug coverage. **You cannot be enrolled in more than one Medicare plan at the same time.** If you switch to another Medicare plan, your coverage in the old plan is automatically canceled as soon as the new coverage becomes effective.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a standard Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All standard Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. PEEHIP has determined that the prescription drug coverage offered by PEEHIP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. You can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a standard Medicare drug plan because your existing PEEHIP coverage is Creditable Coverage.

When Can You Join a Medicare Drug Plan?

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

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

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

If you do decide to join a standard Medicare drug plan or another Medicare Advantage Plan or a Medicare Supplemental Plan and drop your PEEHIP Employer Group Medicare Advantage plan, your current PEEHIP coverage will terminate on the date that you enroll in the other Medicare Part D, Medicare Advantage or Medicare Supplemental Plan. Please be aware that you and your covered dependents will lose the PEEHIP coverage, and you will not be able to get this coverage back until you drop the other Medicare plan. **You cannot be enrolled in PEEHIP's Employer Group Medicare Advantage Plan and another Medicare Plan at the same time.** If you switch to another Medicare plan, your coverage in the PEEHIP Employer Group Medicare Advantage Plan is automatically canceled as soon as the new coverage becomes effective.

If you enroll in any other Medicare Plan, you and your dependents will no longer be eligible for your current PEEHIP health benefits.

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

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

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

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

Contact the PEEHIP office at 877-517-0020 for further information. NOTE: You will receive this notice each year in the PEEHIP Advisor newsletter, and you may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

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

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICAR (800-633-4227). TTY users should call 877-486-2048.

An exception may apply to certain "low-income" individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and Part D (two separate steps). For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 800-772-1213 (TTY 800-325-0778).

Keep this important Creditable Coverage notice. If you decide to join one of the standard Medicare Advantage or Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Access to Obstetrical and Gynecological (ObGyn) Care Notice

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

Choice of Primary Care Physician Notice

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

Women's Health and Cancer Rights Act Notice

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

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

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

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

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

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

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

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage or proof of health coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan.

For more information regarding this notice, please contact PEEHIP.

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Public Education Employees' Health Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

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

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

How the Plan Uses and Discloses Health Information

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

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

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity, appropriateness of care, utilization review,

and pre-authorizations). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

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

The Plan will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. Only information relating to the task being performed will 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 Not Requiring Written Authorization

The Plan may disclose health information to persons and entities that provide services to the Plan and that 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, or
- is for limited marketing activities.

The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether 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 at 877-517-0020.

Uses and Disclosures Requiring 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.

Restrict Uses and Disclosures

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

Alternative Communication

The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plan to send health information to a different address than that of the member. 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.

Coverage is provided under this plan pursuant to applicable laws and is limited to those services, supplies and/or drugs that may be legally performed, prescribed or dispensed by a licensed health care provider, supplier or pharmacy.

Definitions

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

Receipt of Medical Care

Even if the Plan does not cover benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

After-hours care is generally provided by your physician who may have a variety of ways of addressing your needs. You should call your physician for instructions on how to receive medical care after the physician's normal business hours, on weekends and holidays, or to receive non-emergency care for a condition that is not life threatening but requires medical attention.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room.

Primary Care Physicians

Although you are not required to have a primary care physician, it is a good idea to establish a relationship with one. Having a primary care physician has many benefits, including:

- Seeing a physician who knows you and understands your medical history,
- Having someone you can rely on as a key resource for your healthcare questions, or

- Help when you need to coordinate care with specialists and other providers.

Primary care physicians specialize in family medicine, internal medicine, or pediatrics. Find a physician in your area by visiting AlabamaBlue.com/FindADoctor.

Specialists

If you need to see a specialist or behavioral health provider, you can contact their office directly to make an appointment. If you choose to see a specialist or behavioral health provider in our BlueCard PPO or Blue Choice Behavioral Health networks, you will have in-network benefits for services covered under the plan. If you choose to see an out-of-network specialist or behavioral health provider, your benefits could be lower.

Beginning of Coverage

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

Limitations and Exclusions

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

Medical Necessity and Precertification

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

In some cases, the plan requires that you or your treating physician pre-certify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered.

Precertification (also sometimes referred to as prior authorization) is required for certain procedures, tests and provider-administered drugs. You can find a list of the provider-administered drugs that require precertification at AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. This list will be updated monthly.:

Outpatient Hospital Benefits, Physician Benefits, Other Covered Services

Precertification is required for the following outpatient hospital benefits, physician benefits and other covered services. You can find more information about the specific services that require precertification at AlabamaBlue.com/Precert. This list will be updated no more than twice a calendar year. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services.

The general categories or descriptions of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the filing of this booklet include:

- Certain advanced imaging (such as, for example, MRA, MRI, CT, CTA and PET); For precertification, call 1-866-803-8002 (toll free).
- Intensive outpatient services and partial hospitalization; For precertification, call 1-800-548-9859 (toll free).
- Certain select procedures (such as, for example, implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, and surgery for obstructive sleep apnea); For precertification, call 1-800-248-2342 (toll free).

- Certain reconstructive procedures (such as, for example, reduction mammoplasty; rhinoplasty, and surgery for varicose veins); For precertification, call 1-800-248-2342 (toll free).

- Certain durable medical equipment (such as, for example, motorized/power wheelchair); For precertification, call 1-800-248-2342 (toll free).

- Home health and hospice when services are rendered outside the state of Alabama; For precertification, call 1-800-821-7231 (toll free).

- Certain radiation therapy management services (such as, for example, proton beam therapy, cyberknife and stereotactic radiosurgery); For precertification, call 1-866-803-8002 (toll free).

- Certain genetic laboratory testing (such as, for example, breast cancer (BRCA) testing and genetic carrier screening); ~~and~~ For precertification, call 1-866-803-8002 (toll free).

- ABA therapy; For precertification, call 1-877-563-9347 (toll free).

If precertification is not obtained, no benefits will be payable under the plan for the services.

Provider-Administered Drugs

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, or physician's office. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

For precertification, call the Customer Service Department number at 800-327-3994.

If precertification is not obtained, no benefits will be payable under the plan for provider-administered drugs.

In-Network Benefits

One way the plan tries to manage healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider.

If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. As one example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the plan. Additionally, out-of-network providers have not contracted with us or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts exceeding the allowed amounts under the plan.

In-network providers are hospitals, physicians, pharmacies, and other healthcare providers or suppliers that contract with us or any Blue Cross and/or Blue Shield plans (directly or indirectly through, for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced price.

Examples of the plan's Alabama in-network providers are:

- BlueCard PPO
- Participating Hospitals
- Preferred Outpatient Facilities
- Participating Ambulatory Surgical Centers
- Participating Ground Ambulance
- Participating Licensed Registered Dietitian Network
- Participating Renal Dialysis Providers
- Preferred Medical Doctors (PMD)
- Blue Choice Behavioral Health Providers
- Preferred Medical Laboratories
- Blue Achievement – Knees and Hips Network
- Participating Air Medical Transport
- Preferred Home Health Network

Preferred Home Infusion Network To locate Alabama in-network providers, go to AlabamaBlue.com/FindADoctor.

1. In the search box, you can select the category you would like to search under (doctor, hospital, dentist, pharmacy, etc.) or keep on All Categories to search all. Type in the provider's name to search or leave blank to see all results.
2. In the "Network or Plan" section, use the dropdown menu to select a specific provider network (as noted above).

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit AlabamaBlue.com/FindADoctor and log into your *my*BlueCross. Search for a specific provider by typing their name in the Search Term box or click Search to see all in-network providers for your plan. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician.

When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. On your behalf, PPO providers will file claims with the local Blue Cross and/or Blue Shield plan where services are rendered. The local Blue Cross and/or Blue Shield plan will then forward the claims to us for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the plan or is not covered under the contract between the provider and Blue Cross and Blue Shield of Alabama or the local Blue Cross and/or Blue Shield plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the plan, such as Other Covered Services.

If a network provider is terminated ***without*** cause from our network while you are a continuing care patient, you may request to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates under the plan. After the provider's contract is terminated, the provider cannot bill you for amounts in excess of the in-network allowed amounts under the plan. For this purpose of requesting this continuity of care, a continuing care patient is defined as an individual who:

- Is or was determined to be terminally ill and is receiving treatment for such illness;
- Is undergoing a course of treatment for a serious and complex condition;
- Is pregnant and undergoing a course of treatment for the pregnancy;
- Is undergoing a course of institutional or inpatient care; or
- Is scheduled to undergo non-elective surgery, including receipt of post-operative care, with respect to such a surgery.

If you have successfully transitioned to another in-network provider, if you have met or exceeded benefit limitations of the

plan, or if care is not medically necessary, you will no longer be eligible for this continuity of care. If we deny your request for continuity of care, you may file an appeal following the procedures described in the Claims and Appeals section of this booklet.

Continuity of Care

If you qualify as a continuing care patient, and your healthcare provider or facility is no longer in your network due the termination of a contractual relationship, you may request to continue treatment with such provider or facility until your treatment is complete or for 90 days from notification, whichever is shorter, at in-network cost-sharing rates under the plan. A continuing care patient is defined as an individual who:

• Is or was determined to be terminally ill and is receiving treatment for such illness;

• Is undergoing a course of treatment for a serious and complex condition;

• Is pregnant and undergoing a course of treatment for the pregnancy;

• Is undergoing a course of institutional or inpatient care;

• Is scheduled to undergo non-elective surgery, including receipt of post-operative care, with respect to such a surgery; or

Under these circumstances, the provider or facility cannot bill you for amounts in excess of the in-network allowed amounts under the plan. Continuity of care does not apply if your provider or facility was involuntarily terminated from your network for failure to meet applicable quality standards or for fraud.

If you have successfully transitioned to another in-network provider, if you have met or exceeded benefit limitations of the plan, or if care is not medically necessary, you will no longer be eligible for this continuity of care. If we deny your request for continuity of care, you may file an appeal following the procedures described in the Claims and Appeals section of this booklet.

Outpatient Hospital Benefits, Physician Benefits, Major Medical Benefits

Precertification is required for certain outpatient hospital benefits, physician benefits and other covered services. The general categories or descriptions of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the filing of this booklet are set forth below. Examples are for illustrative purposes only.

The general categories or descriptions of outpatient hospital benefits, physician benefits, and major medical benefits that require precertification at the time of the filing of this booklet include:

- Certain advanced imaging procedures (such as MRA, MRI, CT, CTA, and PET;)
- Intensive outpatient services and partial hospitalization. For precertification, call 1-800-248-2343 (toll free).
- Certain select procedures (such as implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, gastric restrictive procedures (if covered by your plan), surgery for obstructive sleep apnea, and wireless capsule endoscopy.
- Certain reconstructive procedures (such as blepharoplasty, brow lift or ptosis repair, breast reconstruction, rhinoplasty, and surgery for varicose veins); and
- Certain durable medical equipment. For precertification, call 1-800-248- 2342 (toll free).
- Home health and hospice when services are rendered outside the state of Alabama. For precertification, call 1-800-821-7231 (toll free).
- Certain radiation therapy management services (such as proton beam therapy, cyberknife, and stereotactic radiosurgery); and
- ABA therapy. For precertification, call 1-866-803-8002 (toll free).
- Certain Genetic laboratory testing (such as breast cancer (BRCA) testing and genetic carrier screening). For precertification, call 1-866-803-8002 (toll free).

If precertification is not obtained, no benefits will be payable under the plan for the services.

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

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer health plan will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

Claims and Appeals

When you receive services from an in-network provider, your provider will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with us for reimbursement under the terms of the plan. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review. Thereafter, you may have the right to an independent external review. The provisions of the plan dealing with claims or appeals are found later in this booklet.

Changes in the Plan

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

Your Rights

As a member of the plan, you have the right to:

- Receive information about us, our services, in-network providers, and your rights and responsibilities,
- Be treated with respect and recognition of your dignity and your right to privacy,
- Participate with providers in making decisions about your healthcare,
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the plan provides, and
- Make recommendations regarding our member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service Department at 800-327-3994.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.
"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:
You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:
• Cover emergency services without requiring you to get approval for services in advance (prior authorization).
• Cover emergency services by out-of-network providers.
• Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
• Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint. Or, you can submit a complaint online at **https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing**.
Visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.
Visit **https://www.aldoi.gov** for more information about your rights under Alabama law.

Your Responsibilities

As a member of the plan, you have the responsibility to:

- Supply information (to the extent possible) that we need for payment of your care and your providers need to provide care,
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan, and
    - Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Termination of Coverage

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

ELIGIBILITY AND ENROLLMENT

Insurance Eligibility for Active and Retired Non-Medicare-Eligible Employees

Full-time employees, permanent part-time employees, and retired non-Medicare-eligible (NME) employees are eligible for coverage with PEEHIP.

Full-Time Employees

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

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

Permanent Part-Time Employees

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

A part-time employee also includes any person who is not included in the definition of employee in Section 16-25A-1, but who is employed on a permanent part-time basis by any board, agency, organization, or association which participates in the 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 not a substitute or a transient employee. A permanent part-time employee is eligible for PEEHIP if they agree to payroll deduction for a pro rata portion of the premium cost for a full-time employee. The portion is based on the percentage of time the permanent part-time worker is employed.

Ineligible Employees

The following employees are not eligible to participate in PEEHIP:

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

Retired NME Employees

Retired employees are defined as follows:

Any person receiving a monthly benefit from the TRS who at the time of their retirement was employed by a public institution of education within the State of Alabama which provided instruction at any combination of grades K through 14, exclusively, under the auspices of the State Board of Education or pursuant to Section 16-25A-11.

Any person receiving a monthly benefit from TRS who at the time of their employment was employed by a state-supported postsecondary institution and any person receiving a monthly benefit from the Employees' Retirement System of Alabama (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. Appropriate documentation is required by PEEHIP before a dependent can be enrolled. Refer to the **Dependent Eligibility Verification** section for details.

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 they are currently and legally married. Excludes a divorced spouse and a common law spouse.

Children

PEEHIP offers dependent coverage to children up to age 26. Coverage cancels the first of the month following the date the child turns age 26. PEEHIP is not required and will not provide coverage for a child of a child receiving dependent coverage. Maternity benefits and delivery charges are not covered for children of any age regardless of marital status.

In accordance with the federal health care reform legislation, the following children are eligible for PEEHIP coverage:

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

     Two exceptions:

     - New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment
     - Existing member requests hospital medical coverage of the incapacitated child over the age of 26 within 45 days of the qualifying life event of loss of eligibility and coverage 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 they reach the limiting age of 26 as an incapacitated child. For example, approved permanently incapacitated children can continue the PEEHIP plans they are on at the time they age out, but they are not eligible to be covered on other PEEHIP plans once they reach the limiting age of 26. If the child is approved as incapacitated child and allowed to stay on the PEEHIP Hospital Medical Plan, the child cannot change plans and be covered on other PEEHIP plans, such as VIVA Health Plan or the Optional Coverage Plans if they have already reached the limiting age of 26.

Ineligible Dependents

- An ex-spouse, regardless of what the divorce decree may state
- Ex-stepchildren, regardless of what the divorce decree may state

- Children aged 26 and older
- Disabled children over 26 who were never enrolled or whose coverage was previously canceled
- A child of a dependent child cannot both be covered on the same policy
- A spouse of a dependent
- Grandchildren or other children related to the member by blood or marriage for which the member does not have legal guardianship or legal custody who are not foster children or adopted children and temporarily disabled dependent children who have aged out.
- Grandparents
- Parents
- A fiancé(e) or non-married significant other

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

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. 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.

COBRA for Dependents

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

When can I enroll or make changes in coverage?

Open Enrollment

Open Enrollment is the once-a-year opportunity for active and retired employees to enroll in or change plans and/or add or drop eligible dependents from coverage.

Each June, PEEHIP mails all eligible active and retired members an Open Enrollment one-page notice to their home address. The notice provides information about the Open Enrollment deadlines, how to enroll or make changes online through Member Online Services (MOS) and indicates the coverage(s) in which the member is currently enrolled, including the current tobacco status on file with PEEHIP. In addition, Open Enrollment information is available on the PEEHIP Open Enrollment web page by July 1 every year. Active and retired members can view and/or download a copy of the Open Enrollment information from the PEEHIP Open Enrollment web page at www.rsa-al.gov/peehip/open-enrollment.

Members can make their insurance changes through Member Online Services (MOS) at www.rsa-al.gov. For those members who do not have internet access and cannot download the information, a PEEHIP Member Handbook which contains the Open Enrollment information can be mailed if the member contacts RSA Member Services at 877-517-0020.

The annual Open Enrollment period begins July 1 and ends by the following deadlines. All Open Enrollment changes are effective October 1.

Open Enrollment deadlines:

- August 31: Paper form deadline. Paper forms postmarked after August 31 will not be accepted.
- September 10: Online MOS deadline. After midnight on September 10, the Open Enrollment link will be closed, and online Open Enrollment changes through MOS will not be accepted.

- September 30: The **Flexible Spending Account** for active employees online or paper deadline.
- Changes in coverage or tobacco status cannot be made from a phone call.

Open Enrollment changes will not be accepted after these deadlines.

Other Open Enrollment Information

- Members do not need to re-enroll in coverage if they want to continue their current coverage. Their current coverage will remain in effect and premium deductions will continue if they do not add/change/cancel coverage during Open Enrollment.
- New coverage elections are placed on claim hold until the initial premium is received. The initial premium can be paid via MOS at the time of enrollment. ID cards should be received before October 1.
  Payroll deductions for the changes made during Open Enrollment (effective October 1) for active and NME retired members will be reflected in the September paycheck or retirement benefit check. PEEHIP premiums for health insurance and optional plans are deducted in the month prior to the month of coverage. All members covered by PEEHIP insurance should review their paycheck or retirement check deductions each month to ensure the proper amount has been deducted for their PEEHIP premiums.
- Flexible Spending Accounts (FSA) require a new enrollment each year. Only active members are eligible to enroll in FSA accounts. Members enrolling in an FSA (effective October 1) will have their first contribution withheld from their October paycheck. FSA contributions are deducted in the current month and are based on twelve-month deduction cycles.
- The Premium Assistance discount program requires a new enrollment application each year. The member must submit a paper application to PEEHIP to apply for this discount. The paper application can be uploaded to PEEHIP via MOS.

New Employees

New employees who wish to enroll in PEEHIP coverage must do so within 30 days of their hire date. Enrollment must be completed through Member Online Services (MOS). They have the option to begin their coverage on their date of hire or the first day of the month following their date of hire. New employees hired during Open Enrollment (July 1 – August 31) have the added option to begin their coverage October 1.

If enrollment is not completed within the deadline, the new employee is permitted to enroll in individual hospital medical coverage and must complete a paper enrollment form. The coverage effective date will be the date the completed form is received by PEEHIP. The employee can enroll in family hospital medical and/or Optional Coverage Plans (dental, vision, cancer, and indemnity) during the next Open Enrollment period.

Premium payments for hospital medical and Optional Coverage Plans are payroll deducted in the month prior to the month of coverage. Flexible Spending Account contributions are payroll deducted in the current month. New employees who have enrolled in PEEHIP coverage effective their date of hire or the first of the month following their date of hire and have not begun receiving a paycheck must make payment directly to PEEHIP for their initial premiums. Payment can be made through MOS. Subsequent premiums will be payroll deducted through your employer.

Transfers

Employees who transfer from one system to another system and who do not have a break in coverage are considered current employees and are not considered new employees for insurance enrollment purposes. Transferring employees are required to continue existing PEEHIP coverage and cannot make insurance changes until the Open Enrollment period (July 1 – August 31) for an October 1 effective date.

Dependent Eligibility Verification

Enrollment Documentation Required by PEEHIP

Every member who enrolls a dependent on their PEEHIP coverage(s) is required to certify to PEEHIP their dependent's eligibility. Certification requires submission of appropriate documents to verify dependent eligibility. All dependents must have a valid Social Security Number (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, but it must be accompanied with these required immigration documents. Documents must be mailed, emailed (encrypted) to PEEHIP, or uploaded in MOS.

Enrollments cannot be processed without the appropriate documentation. PEEHIP is not bound by a court order to insure dependents who do not meet PEEHIP guidelines.

To avoid missing enrollment deadlines, submit your enrollment request with copies of the dependent eligibility documents you have on hand, and timely submit the remaining documentation once you obtain it.

Do not send original documents to PEEHIP.

Spouse - A person to whom you are currently and legally married. Required documents:

- Social Security card, **and**
- Marriage Certificate filed with probate court, **and**, if married more than six months, one of the following:
    - mortgage statement, home equity loan, or lease agreement
    - utility bill (water, electric, gas, cellular, etc.)
    - credit card or account statement
    - Property Tax documents
    - automobile registration

Black out account numbers, income, or statement balances prior to sending documents to PEEHIP. Under no circumstances does PEEHIP solicit this type of information from members.

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

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

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

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

- 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:

- 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)

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

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

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

I**ncapacitated Child** - An unmarried incapacitated child 26 years of age or older who:

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

Two Exceptions:

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

If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once they reach the limiting age of 26 as an incapacitated child. If the child cancels coverage after reaching the limiting ages of 26, they cannot re-enroll. All 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 stepchild.
- 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

Resources to Obtain Documents

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

Dependent Eligibility Audit

PEEHIP has limited funds to cover the high cost of claims and coverage of its eligible members and their dependents who are enrolled in PEEHIP coverages. PEEHIP must use its limited funds appropriately and this entails monitoring compliance with eligibility policies to prevent fraud, waste, and abuse. Therefore, PEEHIP continues to ensure compliance with its dependent eligibility policies by performing audits and monitoring compliance. If you are covering an

ineligible dependent, you must notify PEEHIP and disenroll the dependent immediately. If you know of someone who is covering an ineligible dependent, please notify PEEHIP by phone 877-517-0020, fax 877-517-0021, email peehipinfo@rsa-al.gov or mail PEEHIP, P.O. Box 302150, Montgomery, AL 36130-2150. Covering ineligible dependents unnecessarily raises costs for all eligible PEEHIP members. Help PEEHIP prevent fraud, waste, and abuse through compliance with its dependent eligibility policies.

Health Insurance Portability and Accountability Act (HIPAA)

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

Pre-Existing Conditions

Beginning October 1, 2014, and pursuant to the federal healthcare reform laws, all members, and dependents regardless of age that are added to PEEHIP coverage on or after October 1, 2014, will not have waiting periods applied on pre-existing conditions.

Credit Must Be Given for Creditable Coverage

When medical coverage is canceled on a PEEHIP member or dependent, Blue Cross and Blue Shield of Alabama or VIVA Health Plan will mail a proof or Certificate of Creditable Coverage to the member's address on file.

HIPAA Special Enrollment Outside of Open Enrollment for (Active and Retired Members)

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

Special Enrollment Opportunities

What is Special Enrollment?

Special enrollment allows 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 health coverage and upon certain qualifying life events (QLE). For both types, the member must request enrollment within 45 days of the life event triggering the special enrollment.

1. Under the first, members and dependents who decline coverage due to having other health coverage have special enrollment rights when they experience a **loss of eligibility for other health coverage**. For instance, a member turns down enrollment in PEEHIP health coverage for themselves and their dependents because they have coverage through their spouse's plan. Coverage under the spouse's plan ceases. The member can then request enrollment in PEEHIP's health plan for themselves and their dependents. Proof of loss of eligibility must be provided for each person for which enrollment in PEEHIP coverage is requested. This special enrollment pertains to enrolling in a PEEHIP hospital medical plan. It does not create a special enrollment opportunity to enroll in the Optional Coverage Plans even if these were part of the coverage that was lost.

2. Under the second, members are permitted to enroll a **newly acquired dependent** because of marriage, birth, adoption, placement for adoption, or legal custody. This special enrollment pertains to adding the new dependent(s) to any PEEHIP coverage in which the member is enrolled at the time they acquired the new dependent. **Tag-Along Rule:** When a newly acquired dependent becomes eligible for special enrollment, all eligible dependents can be added to the PEEHIP coverages at that time.

A special enrollment right also arises for 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 spouse'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 their 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 their 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 a member requests special enrollment, how long will they wait until coverage begins?

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

How does a member request special enrollment?

To request special enrollment, members must either enroll through MOS for applicable QLEs, or complete and mail a NEW ENROLLMENT AND STATUS CHANGE form to PEEHIP.

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

When requesting special enrollment of a **newly acquired dependent** due to marriage, birth, adoption, placement for adoption, or legal custody of a child, PEEHIP requires documentation of proof of the new dependent. The enrollment can be submitted online through MOS.

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

When Special Enrollment Rights Do NOT Apply

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

- As a result of the individual's failure to pay premiums
- For cause, such as making a fraudulent claim
- If the 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 is considered a QLE. The following are examples of life events that would allow an active employee to cancel their PEEHIP hospital medical coverage outside of Open Enrollment. The cancellation request must be sent to PEEHIP within 45 days of the life event. Appropriate documentation must also be provided to PEEHIP to verify the event.

- Going on Family Medical Leave Act (FMLA) or Leave of Absence (LOA)
- Commencement of spouse or dependent employment
- Marriage, if enrolling in the new spouse's qualified health plan
- Divorce
    - Ex-spouses and ex-stepchildren are not eligible dependents even if a member continues to pay for family coverage for other eligible dependents and regardless of what the divorce decree states. The ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of divorce. The member will be responsible for an ex-spouse's and ex-stepchildren's claims when they are not removed from coverage. An ex- spouse and ex-stepchildren are eligible for COBRA if the request to enroll in COBRA is made within 60 days of the cancellation of coverage. Refer to the **COBRA** section for details.
- Medicare/Medicaid entitlement
- Spouse's employer has a different Open Enrollment period than PEEHIP
    - Members can remove their spouse from their PEEHIP Hospital Medical 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 if 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 cancelation of the last remaining dependent. Policies are only canceled effective on the first day of the month.

Retired Employees

Retirees **do not** pay PEEHIP premiums with pre-tax dollars. A retiree can cancel their PEEHIP hospital medical coverage at any time during the plan year on a prospective basis. A signed NEW ENROLLMENT AND STATUS CHANGE form must be sent to PEEHIP to cancel coverage. The coverage will be canceled the first day of the month following receipt of the

NEW ENROLLMENT AND STATUS CHANGE form. Optional Coverage Plans can only be canceled during Open Enrollment.

Updating Information

Name and Social Security Number Changes

PEEHIP receives a member's name from information reported by the employer to PEEHIP or TRS. Members provide their eligible dependent's name(s) through the insurance enrollment process available online through Member Online Services (MOS) or on PEEHIP paper enrollment forms.

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

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

Address Changes

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

Alternatively, members can change their address by completing and mailing to PEEHIP an ADDRESS CHANGE NOTIFICATION form which can be downloaded from the RSA website. Lastly, PEEHIP will accept a letter that includes the old address, new address, insured's name, Social Security number, and signature.

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

National Medical Child Support Orders

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

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

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

Relationship to Medicare and Provision for Medicare-Eligible Members

Members must notify PEEHIP when they or any of their covered dependents become eligible for Medicare.

Active Members

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

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

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

Because of the cost of Medicare Part B, an active employee aged 65 or older may decide to defer enrolling for Part B until they reach retirement, at which point Medicare will become the primary payer and the retired member must enroll in Medicare Part B effective the date of retirement. However, a member and their Medicare-eligible spouse can enroll in Medicare Part B only during certain times allowed by Medicare. **Medicare-eligible members must contact their local Social Security office at least two months prior to retiring to enroll in both Medicare Part A and Part B so that the Medicare Part A and Part B coverage is effective no later than the date of retirement of the policyholder.**

The Social Security Administration handles Medicare enrollments. Members should contact the Social Security Administration at 800-772-1213 with questions regarding enrollment in Medicare Part B. A Medicare-eligible retired member and/or spouse must have both Medicare Part A and Part B to be eligible for coverage with PEEHIP's Medicare Advantage (PPO) Plan. **If they do not have Medicare Part A and Part B effective your date of retirement, they will not be eligible for the PEEHIP Group Medicare Advantage (PPO) Plan, and they will not have hospital medical or prescription drug coverage with PEEHIP.**

- **If I work after age Certain select procedures (such as implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, gastric restrictive procedures (if covered by your plan), surgery for obstructive sleep apnea, and wireless capsule endoscopy.**

65 or become eligible for Medicare, am I still covered?

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

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

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

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

Other Medicare Rules

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

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

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

Medicare-Eligible Retired Members

Retired members are not affected by the TEFRA amendment to the Age Discrimination in Employment Act; therefore, upon retirement and Medicare eligibility, the member's coverage under PEEHIP will complement their Medicare coverage. Medicare eligible members and dependents must be enrolled in Medicare Part A and Part B effective the date of retirement. Members and dependents will be enrolled in PEEHIP's Group Medicare Advantage Plan that includes prescription drug 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 spouse must have both Medicare Part A and Part B to have coverage with PEEHIP.

Medicare-eligible members and Medicare-eligible dependents should not enroll in a separate Medicare Part D program if they are enrolled in the PEEHIP Group Medicare Advantage (PPO) Plan. All retired Medicare-eligible members and Medicare-eligible dependents on retired contracts are enrolled in the Group Medicare Advantage plan offered by PEEHIP unless they choose not to participate by Opting Out.

Leave of Absence

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

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

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

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

COBRA Coverage

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

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

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

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

An individual may have other options available to them when they lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, they may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, they may qualify for a 30-day special enrollment period for another group health plan for which 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 the Open Enrollment to enroll in Marketplace coverage. An individual who enrolls in Marketplace coverage relinquishes their COBRA rights.**

COBRA Compliance and PEEHIP Notification

The sanctions imposed under the auspices of COBRA can be quite severe making a determination of compliance greatly important. It is the employer's responsibility to notify PEEHIP within a maximum of 30 days of an employee's termination, death, or reduction in hours. The employer must notify the PEEHIP office by entering a termination date in the Employer Self Service (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 resignation, termination 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.

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

Termination for Gross Misconduct

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

Eligibility

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

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

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

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

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

Continuation of Coverage

If the eligible member chooses continuation of coverage, PEEHIP is required to give the member coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members and is the same coverage they had prior to the qualifying event. If 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 Part 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 ineligible for reasons such as aging out or divorce be afforded an opportunity to maintain coverage for 36 months.

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

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

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

- The member or dependent becomes entitled to Medicare after COBRA benefits begin.
- The member becomes divorced from a covered member and subsequently remarries and is covered under the new spouse's group health plan, which does not contain any exclusions or limitations with respect to pre-existing conditions.

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

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

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, they have the right to continuation of coverage if group health coverage under the Plan is lost for any of the following reasons:

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

Members on COBRA Who Return to Work

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

Can COBRA coverage be extended for covered members who have become disabled?

In certain circumstances, COBRA can be extended for covered members who become disabled. If a covered member becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act

during the first 60 days after the employee's termination of employment or reduction in hours, the 18-month period may be extended to 29 months or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period. For this disability extension to apply, members must notify the PEEHIP office of Social Security's determination within 30 days of any revocation of Social Security disability benefits.

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

For spouses and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. The 36-month period will run from the original date of the termination of employment or reduction in hours.

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

Extensions of COBRA for Second Qualifying Events

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

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

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

Notice Procedures

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

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

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the plan and for your notice of a second qualifying event, you must mail or hand-deliver your notice to the PEEHIP office. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree.

Medicare and COBRA Coverage

You should consider whether it is beneficial to purchase COBRA coverage. After you terminate employment, your COBRA coverage will be PEEHIP's Group Medicare Advantage Plan. To be eligible for PEEHIP's Group Medicare Advantage Plan, you must be enrolled in Medicare Parts A and B effective no later than the first day of the month after your termination date.

If you think you will need COBRA after your termination of employment, you must enroll in Medicare Parts A and B so that it is effective on or before the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your termination of employment, or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months from the date of your termination of employment. If you do not enroll in Medicare on or before the date on which you make your election to buy COBRA coverage, you will not be eligible for COBRA through PEEHIP's Group Medicare Advantage Plan and your coverage with PEEHIP will end the last day of the month after your termination date Your covered dependents will have the opportunity to continue their own COBRA coverage.

If you do not want COBRA for yourself, your covered family members will still have the option to buy COBRA when you terminate employment. However, if your covered family members become enrolled in Medicare after electing COBRA, their COBRA coverage will end. See the Early Termination of COBRA section of this booklet for more information about this.

Early Termination of COBRA

Your COBRA coverage will terminate early if any of the following events occurs:

- The group no longer provides group health coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA coverage, you become covered under another group health plan;
- After electing COBRA coverage, you become enrolled in Medicare; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan. For example, if you submit fraudulent claims, your coverage will terminate.

If your group stops providing healthcare through Blue Cross, you will cease to receive any benefits through us for all claims incurred after the effective date of termination of our contract with the group. This is true even if we have been billing your COBRA premiums prior to the date of termination. It is the responsibility of your group, not Blue Cross, to notify you of this termination. You must contact your group directly to determine what arrangements, if any, your group has made for the continuation of your COBRA benefits.

If you have any further questions about COBRA or if you change marital status, or you or your spouse or child changes address, please contact PEEHIP at 877-517-0020. Additional information about COBRA can also be found at the website of the Employee Benefits Security Administration of the United States Department of Labor.

WELLNESS PROGRAM

Members Required to Participate

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

Wellness Premium Waiver

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

- An ADPH work site wellness clinic or county health department
- A BCBS in-network participating pharmacy
- A primary care physician or healthcare provider – *must complete a* HEALTHCARE PROVIDER SCREENING FORM

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

Newly Enrolled PEEHIP Members

Newly enrolled PEEHIP members and covered spouses have the same August 31 due date as the existing PEEHIP members unless their new effective date of coverage occurs between June 2 and September 30. If their effective date of coverage falls within this 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. No PEEHIP member will ever have less than 3 months to complete the wellness screening.

Screenings Completed After the Deadline

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

If you are unable to obtain a wellness screening due to pregnancy, disability, or other infirmity, you may be entitled to a reasonable accommodation or an alternative standard to receive the wellness premium waiver. Contact PEEHIP at 877-517-0020 for additional details.

View Your Wellness Completion Status

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

Wellness Screenings

Wellness screenings will measure biometric values including:

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

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

Work Site Screenings offered by ADPH

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

Pharmacy Biometric Screenings

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

Healthcare Provider Screenings

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

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

Health Coaching

PEEHIP's health coaching offerings include coaching provided by BCBS, Pack Health, and Wondr Health The range of coaching provided includes content and education aimed to help create healthier lifestyles, prevent disease, or help manage existing conditions. Members will be sent an invitation to enroll at the start of each program. Space is limited in these programs. Member and covered spouses are encouraged to sign up quickly to secure their spot. Participation in health coaching is strictly voluntary and is not required to earn the monthly wellness premium waiver. Dependent children, including adult dependent children, are not eligible to participate in health coaching.

Blue Cross Blue Shield, Pack Health, and Wondr Health

BCBS Disease Management programs focus on chronic health conditions that are sometimes debilitating but can be managed through early intervention, awareness of appropriate treatment, and lifestyle changes. Disease Management is a service for members diagnosed with chronic conditions including diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease, and heart failure. The program uses the latest clinical guidelines, educational materials, and self-management support strategies to educate, coach, and empower members and caregivers. Contact BCBS directly at 888-841-5741 any time to enroll and get connected with a personal clinician to work with members one-on-one to help manage these long-term conditions.

Pack Health is a disease management program that is available for members with chronic illness. This program offers support and education through a dedicated health advisor to help members improve their health behaviors and make healthy lifestyle changes. This program is only available for members with Blue Cross and Blue Shield of Alabama coverage.

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

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

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. These messages encourage members to first speak with their healthcare provider about the recommendation. Members are not required to close any gaps in coverage to earn the wellness premium waiver.

Non-Tobacco User Discount

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

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

Tobacco Cessation Programs

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

Commitment to Participate in Tobacco Cessation Program

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

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

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

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

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

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

Baby Yourself® Program

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

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

PEEHIP will waive the $200 copayment for the delivery of their baby for members who enroll during the first trimester and complete the program. The $25 per day copayment for days 2 through 5 will apply (maximum of $100 copayment). Members who think they might be unable to meet a standard for a reward under this wellness program might qualify for an opportunity to earn the same reward by different means. PEEHIP will work with the member (and, if they prefer, their physician) to find a wellness program with the same reward that is right for them in light of their health status by calling PEEHIP at 877-517-0020. The goal of Baby Yourself® is to have healthy mothers and babies at delivery. Members who are pregnant, please enroll today in Baby Yourself® by calling 800-222-4379 or registering online at www.alabamablue.com/babyyourself.

COST SHARING

Effective 10/01/2023 – 9/30/2024

Calendar Year Deductible for Major Medical Services	$300 per person each calendar year; $900 aggregate family maximum
Calendar Year Major Medical Out-of- Pocket Maximum (In-network Other Covered Services are the only expenses applicable to the calendar year major medical out-of-pocket maximum)	$400 per person (applicable to Other Covered Services) plus the $300 calendar year deductible
Calendar Year Overall Out-of-Pocket Maximum (All In-Network deductibles, copayments, and coinsurance, including prescription drugs, for In-Network services apply to the overall out-of-pocket maximum)	$9,100 individual; $18,200 per family contract for calendar year 2023 $9,450 individual; $18,900 per family contract for calendar year 2024 After you reach your individual calendar year out-of-pocket maximum (even if you are covered under family coverage), applicable In-network expenses for you will be covered at 100% of the allowed amount for the remainder of the calendar year
Lifetime Dollar Maximum on Essential Health Benefits	Unlimited

Calendar Year Deductible

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

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

- The individual calendar year deductible must be satisfied on a per member per calendar year basis, subject to the family calendar year deductible.
- The family calendar year deductible is an aggregate dollar amount. This means that all amounts applied toward the individual calendar year deductible will count toward the family calendar year amount. Once the family calendar year deductible is met, no further family members must satisfy the individual calendar year deductible.
- Only one individual calendar year deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- In all cases, the deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

In certain circumstances as and when required by Federal law, the cost-sharing amounts (deductibles, copayments and coinsurance) that you are required to pay for out-of-network services will apply to the in-network calendar year deductible. Those services include:

- Medical or Accident emergency
- Air Ambulance
- Certain Non-emergency services performed by out-of-network providers at certain in-network facilities

Calendar Year Out-of-Pocket Maximum

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

There may be many expenses you are required to pay under the plan that do not count towards the calendar year out-of-

pocket maximum, and that you must continue to pay even after you have met the calendar year out-of-pocket maximum. The following are some examples:

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

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

In certain circumstances as and when required by Federal law, the cost-sharing amounts (deductibles, copayments and coinsurance) that you are required to pay for out-of-network services will apply to the in-network calendar year out-of-pocket maximum. Those services include:

• Medical or Accident emergency

• Air Ambulance

• Certain non-emergency services performed by out-of-network providers at certain in-network facilities

Other Cost Sharing Provisions

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

- **Per admission deductibles:** These apply upon admission to a hospital. Only one per admission deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- **Copayments:** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor's office.
- **Coinsurance:** Coinsurance is the amount that you must pay as a percent of the allowed amount.
- **Amounts more than the allowed amount:** As a rule, the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with us or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts more than the allowed amount.

As one example, certain out-of-network facility claims may include very expensive ancillary charges such as implantable devices for which no extra reimbursement is available as these charges are not separately considered under the plan. This means you could be responsible for these charges if you use an out-of-network provider.

Out-of-Area Services

Blue Cross and Blue Shield of Alabama has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program and may include negotiated National Account arrangements available between Blue Cross and Blue Shield of Alabama and other Blue Cross and Blue Shield Licensees.

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

participating healthcare providers. Blue Cross and Blue Shield of Alabama payment practices in both instances are described below.

A. BlueCard® Program

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

Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Alabama.

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

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

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

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

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

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

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

1. Member Liability Calculation

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

2. Exceptions

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

In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

HEALTH BENEFITS

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

Inpatient Hospital Benefits

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

For emergency hospital admissions, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

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

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

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

Generally, if preadmission certification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, the benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on the retrospective review by the plan.

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

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

Inpatient hospital benefits consist of the following if provided during a hospital stay:

- Bed and board and general nursing care in a semiprivate room;
- Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them;
- Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
- Administration of anesthetics by hospital employees and all necessary equipment and supplies: casts, splints, surgical dressings, treatment, and dressing trays;
- Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and X-rays;
- Physical therapy, hydrotherapy, radiation therapy, chemotherapy, oxygen, and equipment to administer it;
- All drugs and medicines used by you if administered in the hospital;
- Regular nursery care and diaper service for a newborn baby while its mother has coverage;
- Blood transfusions administered by a hospital employee.

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

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

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

Inpatient Rehabilitation Benefits

These inpatient hospital benefits consist of:

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

The patient's condition must require:

- A rehabilitation trained physician available 24 hours a day;
- A rehabilitation trained nurse present 24 hours a day;
- Four hours of therapy provided by a licensed therapist a day;

- Continued progress toward goals requiring you to remain in the hospital. Your record must show conferences with your physician, therapists, and nurses at least weekly about your progress, any problems and their solutions, and review of the goals set for you.

Inpatient care for rehabilitation is excluded:

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

Occupational therapy services when the following conditions are met:

- The services must be medically necessary and performed by a licensed occupational therapist.
- Call Customer Service at 1-800-327-3994 to determine what specific diagnostic codes and procedures are covered.

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

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

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

Outpatient Hospital Benefits

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Outpatient surgery* (including ambulatory surgical centers)	100% of the allowed amount, subject to a $150 facility copayment Benefits are **only** available for any surgery for morbid obesity **or** related bariatric procedures at a Bariatric Blue Distinction Center located within Alabama.	80% of the allowed amount, subject to the calendar year deductible Bariatric surgery is not covered in out-of-network facilities. In Alabama, out-of-network facilities, not covered
Emergency Room Facility Charge (Medical Emergency)	100% of the allowed amount subject to a $150 facility copayment if a true medical emergency. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowance subject to the calendar year deductible.	
Emergency Room Facility Charge (Accidental Injury)	100% of the allowed amount subject to a $150 facility copayment **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **Emergency Room (Medical Emergency)** above.	

Outpatient diagnostic lab, and pathology Genetic laboratory testing requires precertification. For precertification, call 1-800-248-2342. Certain testing may require precertification to be payable under the plan.	100% of the allowed amount, no deductible; subject to a $5 copayment per test	80% of the allowed amount, subject to the calendar year deductible In Alabama, out-of-network facilities, not covered

Outpatient diagnostic X-ray	100% of the allowed amount, no deductible or copayment	80% of the allowed amount, subject to the calendar year deductible In Alabama, out-of-network facilities, not covered
Outpatient dialysis, IV therapy, chemotherapy, and radiation therapy (not administered in the emergency room) Radiation therapy management services requires precertification. For precertification, call 1-866-803-8002. If precertification is not obtained, no benefits for these services will be payable under the plan.	100% of the allowed amount, no deductible; subject to a $25 facility copayment	80% of the allowed amount, subject to the calendar year deductible In Alabama, out-of-network facilities, not covered
Sleep studies on children ages 18 and under	100% of the allowed amount, subject to a $10 facility copayment	80% of the allowed amount, subject to the calendar year deductible
Sleep studies on members ages 19 and above	100% of the allowed amount, subject to a $150 facility copayment	80% of the allowed amount, subject to the calendar year deductible
Sleep studies performed in a free-standing sleep clinic	100% of the allowed amount, subject to a $10 facility copayment	80% of the allowed amount, subject to the calendar year deductible
Outpatient hospital services or supplies not listed above	80% of the allowed amount, subject to the calendar year deductible	

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

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

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

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Office visits and in-person consultations (Primary Care Physician) A primary physician includes Urgent Care, Internal Medicine, Family Practice, General Practice, Physician Assistant, Clinic, Gynecology, Obstetrics, Certified Nurse Practitioner, Midwives and Pediatrician. All other providers are considered specialists.	100% of the allowed amount, subject to a $30 visit copayment	80% of the allowed amount, subject to the calendar year deductible
Office visits and in-person consultations (Specialist)	100% of the allowed amount, subject to a $35 visit copayment	80% of the allowed amount, subject to the calendar year deductible

Telephone and online video consultations program To enroll in the telephone and online video consultations program, go to www.Teladoc.com/Alabama or call 1-855-477-4549. Telephone and online video consultations to diagnose, treat and prescribe medication (when necessary) for certain medical issues. Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations are offered 7 days a week, 7 a.m. to 9 p.m. (where available).	100% of the allowed amount, subject to the calendar year deductible	Not covered
Emergency room (physician)	100% of the allowed amount, subject to a $35 visit copayment	
Surgery, second surgical opinion, and anesthesia for a covered service	100% of the allowed amount, no deductible or copayment	80% of the allowed amount, subject to the calendar year deductible

Maternity care	100% of the allowed amount, no deductible or copayment	80% of the allowed amount, subject to the calendar year deductible
Inpatient visits and consultations including specialty provider	100% of the allowed amount, no deductible or copayment *Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®	80% of the allowed amount, subject to the calendar year deductible
Diagnostic lab and pathology Genetic laboratory testing requires precertification. For precertification, call 1-800-248-2342. Certain testing may require precertification to be payable.	100% of the allowed amount, no deductible; $5 copayment per test	80% of the allowed amount, subject to the calendar year deductible
Chemotherapy, dialysis, IV therapy, and radiation therapy, and x-ray Radiation therapy management services requires precertification. For precertification, call 1-866-803-8002. If precertification is not obtained, no benefits will be payable under the plan for these services.	100% of the allowed amount, no deductible or copayment	80% of the allowed amount, subject to the calendar year deductible
Chemotherapy and radiation therapy	100% of the allowed amount, no deductible or copayment	80% of the allowed amount, subject to the calendar year deductible
Allergy testing and treatment	80% of the allowed amount, subject to the calendar year deductible	

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

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, and heart catheterization.
- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.
- Telephone and online video consultations program, covered at 100% of the allowed amount, not subject to the

calendar year deductible. To enroll in the telephone and online video consultations program, go to www.Teladoc.com/Alabama or call 1-855-477-4549. Telephone and online video consultations to diagnose, treat and prescribe medication (when necessary) for certain medical issues are available through Teladoc. Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations (where available) are offered7 days a week, 7 a.m. to 9 p.m.

Physician Preventive Benefits

Under the Affordable Care Act, non-grandfathered plans are required to provide in-network coverage for all the following without cost-sharing:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force:
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee to Immunization Practices of the Centers for Disease Control and Prevention;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and,
4. With respect to women, preventive care and screenings as provided in the binding, comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, including (but not limited to) all Food and Drug Administration (FDA)-approved contraceptive methods for women, sterilization procedures, and patient education and counseling for all women (including dependent daughters) with reproductive capacity.

Attention: In some cases, routine immunizations and routine preventive services may be billed separately from your office visit or other facility visit. In that case, the applicable office visit or outpatient facility cost sharing amounts under your physician benefits or outpatient hospital benefits may apply. In any case, applicable office visit or facility visit cost sharing amounts may still apply when the primary purpose for your visit is not routine preventive services and/or routine immunizations.

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

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

Provider-Administered Drug Benefits

Precertification (also sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find a list of provider-administered drugs that require precertification at AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. This list will be updated monthly.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office, or home healthcare setting. Provider- administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy. You can find additional information at Provider-Administered Specialty Pharmacy Drug List (exploremyplan.com)

Provider-administered drugs also include gene therapy and cellular immunotherapy. Gene therapy is generally a therapy designed to introduce genetic material into cells to compensate for abnormal genes or to make a beneficial protein.
Cellular immunotherapy is generally the artificial stimulation of the immune system to treat cancer, such as cytokines, cancer vaccines oncolytic virus therapy, T-cell therapy, and some monoclonal antibodies.

For precertification, call the Customer Service Department number on the back of your ID card.

If precertification is not obtained, no benefits will be payable under the plan for the provider-administered drug.

Provider-administered drug coverage is subject to Drug Coverage Guidelines and medical necessity policies found in the pharmacy section of our website. A drug may not be covered under the plan because, for example, there are safety and/or efficacy concerns. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. The guidelines in some instances also require the drug to be administered by a provider and/or facility approved by the drug manufacturer. Certain medications require enrollment in the HealthSmartRx program. For questions, please call 1-833-798-6733. Additional information and the applicable drug list is available at Alabamablue.com/Providers/HealthSmartRx.

New to market FDA-approved drugs, devices, diagnostics, therapies, and medical treatments are considered non-covered until they have been reviewed and approved by the claims administrator and deemed eligible for coverage.

Mental Health and Substance Abuse Benefits

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

- Inpatient care for mental health disorders and substance abuse;
- Outpatient visits, including outpatient visits with Blue Card PPO provider and Blue Choice Network providers;
- Individual, group and family therapy or counseling;
- Psychological and laboratory testing.

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Substance Abuse		
Inpatient Facility Services	100% of the allowed amount, subject to a $200 per admission deductible and a $25 copay for days 2-5 (copays and inpatient hospital deductible can be less than but not greater than medical) Precertification required.	100% of the allowance subject to a $200 per admission deductible and a $25 copay for days 2-5 Precertification is required
Inpatient Physician Services	100% of the allowed amount, $0 copay	80% of the allowed amount, subject to the calendar year deductible Precertification is required.
Outpatient Facility Services – Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)	100% of the allowed amount subject to $150 copay per treatment episode. Precertification required.	
Outpatient Physician Services at PEEHIP Certified Community Mental Health Centers	100% of the allowed amount, subject to a $10 copay per visit for up to 20 outpatient visits per plan year (10/1-9/30) at approved mental health facilities. Maximum visits are combined for mental and substance abuse.	Not applicable. All PEEHIP Certified Community Mental Health Centers are in-network.

Outpatient Physician Services with Blue Choice Behavioral Network Providers	100% of the allowed amount, subject to a $15 copay per visit For a list of in-network BlueCard PPO and Blue Choice Behavioral Networkproviders,see AlabamaBlue.com.	80% of the allowed amount, subject to the calendar year deductible
Residential Treatment Facilities Required precertification and approval through case management New Directions Behavioral Health (NDBH) at 1-855-339-8558.	100% of the allowance subject to a $200 per admission deductible and a $25 copay for days 2-5	100% of the allowance subject to a $200 per admission deductible and a $25 copay for days 2-5

Outpatient PPO Benefits		
Applied Behavioral Analysis (ABA) Therapy (for children aged 0-18 diagnosed with an Autism Spectrum Disorder) Annual dollar maximums are combined for both in and out-of-network	100% of the allowed amount subject to a $15 copayment per visit and the following maximum benefits: Benefits are provided for the screening, diagnosis, and treatment of expanded autism spectrum disorders for members birth through 18 when prescribed by the treating physician **or** psychologist in accordance with a treatment plan and may include: Behavioral health treatment (including applied behavior analysis provided by a board-certified behavior analyst, psychiatrist, **or** psychologist), Pharmacy care, Psychiatric/psychological care. **Precertification** is required prior to rendering ABA therapy to determine the medical necessity. **Precertification** is also required every six months to determine medical necessity for continued therapy. If **precertification** is **not** obtained, **no** benefits are available. For a complete listing of covered services and **Precertification** requirements, please call 1-877-563-9347.	
Intake and Evaluation	Included in the combined 20-visit maximum per member each plan year	$10 copayment per day

Individual and Family Therapy	Limited to 2 units per procedure per member each day (billed in 30-minute units)	$10 per procedure
Crisis Intervention	Limited to 4 units per member each day (billed in 15-minute units)	$10 per day

Psychometric Testing and Diagnostic Testing by Psychologist	Limited to 5 hours per member each plan year (billed in one-hour units)	$20 per day
Psychometric Testing and Diagnostic Testing by Technician	Limited to 5 hours per member each plan year (billed in one-hour units)	$20 per day
Psychometric Testing and Diagnostic Testing by Computer	Limited to 1 hour per member each plan year (billed in one-hour units)	$20 per day
Group Therapy	Limited to 2 hours per member each day (billed in 30-minute units)	$5 per hour
Physician Assessment	Limited to 4 units per member each day (billed in 15-minute units)	$10 per day
Substance Abuse Intensive Outpatient Program	Limited to 40 visits per member each plan year	No copayment
Partial Hospitalization	Limited to 90 visits per member each plan year	$20 per day
Adult and Child Mental Illness Intensive Day Treatment	Limited to 50 visits per member each plan year	$10 per day
Adult Rehabilitation Day Program	Limited to 35 visits per member each plan year	$5 per day
Hospital Screening/After Hours	Limited to $150 per day	No copayment
Medication Monitoring	Limited to 2 units per member per day (billed in 15-minute units)	No copayment
Medication Administration	Limited to $14 per day	No copayment

Outpatient Non-PPO	10 visits per plan year, subject to the calendar year deductible	50% copayment

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

The following services and supplies are not covered:

- Diagnosis or treatment of mental retardation;
- Rehabilitation of a temporary or permanent disability or for hearing or vision impairment;
- Treatment for chronic pain or solely for obesity;
- Services related to nicotine addiction;
- Sex therapy programs or treatment for sex offenders;
- Services or supplies furnished by a Residential Treatment Facility, except through Behavioral Health Case Management;

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

* **Partial or Day Hospitalization**
** **Intensive Outpatient Program**

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

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

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

Other Covered Services

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Accident-related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury	80% of the allowed amount, subject to the calendar year deductible	
Ambulance services	80% of the allowed amount, subject to the calendar year deductible	

Medically necessary infertility services which include artificial insemination and related services, including physician services, laboratory services, X-Ray services, ultrasound services and medications administered in the physician's office. Limited to a lifetime maximum of 8 artificial insemination attempts (whether successful or not). Benefits are not provided for ART, IVF and GIFT.	100% of the allowed amount, no copay or deductible Office visit copayments, laboratory services, x-ray services, ultrasound services and medications administered in the physician's office will be subject to the applicable copayments outlined in each respective section of this Summary Plan Description. Precertification required for services rendered outside of Alabama. Call 1-800-248-2342.	80% of the allowed amount, subject to the calendar year deductible Office visit copayments, laboratory services, x-ray services, ultrasound services and medications administered in the physician's office will be subject to the applicable copayments outlined in each respective section of this Summary Plan Description. Precertification required for services rendered outside of Alabama. **In Alabama**, out-of-network facilities, not covered.
Chiropractic: Professional services of a licensed chiropractor practicing within the scope of his license	80% of the allowed amount, no deductible Note: In Alabama, more than 18 visits in a calendar year rendered by a participating chiropractor require precertification	80% of the allowed amount, subject to the calendar year deductible Member responsible for any difference between the charge and the allowed amount Limited to 12 visits in a calendar year
Dialysis services at a renal dialysis facility	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible
Durable medical equipment (DME) Precertification is required for certain DME (i.e. motorized/power wheelchairs). Medically necessary insulin pumps and cartridges are covered. Medically necessary diabetic supplies (syringes, needles for insulin, glucometers, and lancets) are covered under the medical plan benefit when Medicare is primary.	80% of the allowed amount, subject to the calendar year deductible (for DME the allowed amount will generally be the smaller of the rental or purchase price)	80% of the allowed amount, subject to the calendar year deductible (for DME the allowed amount will generally be the smaller of the rental or purchase price) Member responsible for any difference between the charge and the allowed amount
Eyeglasses or contact lenses: One pair will be covered if medically necessary to replace the human lens function because of eye surgery or eye injury or defect	80% of the allowed amount, subject to the calendar year deductible	
Home health and hospice care within the state of Alabama	100% of the allowed amount, no copay or deductible	Not covered
Home health and hospice care outside the state of Alabama	100% of the allowed amount, no deductible; **precertification is required – call 1-800-821-7231**	80% of the allowed amount, subject to the calendar year deductible; **precertification is required – call 1-800-821-7231**
Home Infusion inside the state of Alabama	100% of the allowed amount, no deductible; precertification is required – call 1-800-821-7231	Not covered
Home Infusion outside the state of Alabama	100% of the allowed amount, no deductible; precertification is required – call 1-800-821-7231	80% of the allowed amount, subject to the calendar year deductible; precertification is required – call 1-800-821-7231

Occupational therapy services	80% of the allowed amount, subject to the calendar year deductible Precertification is required. For precertification, call 1-800-248-2342. Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.

Physical therapy After 15 visits, **precertification** is required to determine medical necessity for continued therapy. Visits will be cumulative regardless of provider. For precertification, call 1-800-248-2342.	80% of the allowed amount, subject to the calendar year deductible Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.	80% of the allowed amount, subject to the calendar year deductible Member responsible for difference between the charge and the allowed amount Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.
Speech therapy	80% of the allowed amount, subject to the calendar year deductible Limited to 30 sessions per person per calendar year combined in and out-of-network. Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan.	
TMJ	80% of the allowed amount, subject to the calendar year deductible Surgical care must be pre-certified at least three weeks prior to surgery	

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

Benefits are provided for Hemophilia Management through the Magellan Rx/Hemophilia Management Program. Providers are required to obtain Prior Authorization on behalf of the member. Providers should contact 401-344-1021 with general questions. Providers should fax Prior Authorization requests to 1-866-606-6021. Providers should fax prescriptions for hemophilia factor replacement products to Option Care Specialty Pharmacy at 205-982-8408.

ADDITIONAL BENEFIT INFORMATION

Individual Case Management Benefits

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

Prescription Drug Benefits Administered by Express Scripts

For questions concerning prescription drugs, call Express Scripts at 800-363-9389 www.express-scripts.com.

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 Express Scripts will offer copay assistance programs for certain specialty drugs so that the member copayment will normally be less than the otherwise applicable copayment.

Infertility Drugs: Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP member contract. Members will pay 100% of the cost of the medications after the $2,500 lifetime maximum is reached.

Additional PEEHIP Changes - Compounds

PEEHIP does not cover ingredients in a compound that are currently excluded from coverage in non-compound prescriptions, such as over-the-counter (OTC) medications. This exclusion applies to PEEHIP's non-Medicare (commercial) plan and the Medicare Part D plan.

Drug Utilization Management

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

Excluded Drugs:

Certain prescription drugs and medications are excluded from PEEHIP coverage as explained in the Prescription Drug Exclusion Section of the handbook. To verify the formulary and coverage status of a medication, please visit the Express Scripts website at-www.express-scripts.com.

Prescription Drug Benefits

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

1. To be eligible for benefits, drugs must be medically necessary, legend drugs prescribed by a physician and dispensed by a pharmacy. Legend drugs are medicines which must by law be labeled, “Caution: Federal Law prohibits dispensing without a prescription. In some cases, drugs may also require prior authorization. Your participating Pharmacist will advise if this is a requirement.

2. The first fill of a maintenance drug can be dispensed for up to a 30-day supply. Refilled maintenance drugs can be dispensed in a 90-day supply when the prescription is written for a 90- day supply and the drug is on the approved PEEHIP maintenance list. Refills are allowed on maintenance medication only after 75% of the prescription has been used. Also, there cannot be more than a 130-day lapse from the time that the maintenance drug prescription has been purchased and filed through the PEEHIP prescription plan. Approved maintenance list drugs may be purchased up to a 90-day supply with two copays when the drug is prescribed by the physician as a maintenance drug. You can determine if a drug is on the maintenance list by going to the PEEHIP website or calling your Participating Pharmacy. For a drug to be considered for the Maintenance List, it must meet all the following criteria as determined by an expert panel of physicians and pharmacists:

    - Drug has a low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic response over a course of prolonged therapy;
    - Drug’s most common use is to treat a chronic disease state;
    - Drug is administered continuously rather than intermittently;
    - Excluded are dosage forms that are not practical for large dispensing quantities (such as liquids) and drugs known for life-threatening toxicity when taken as an intentional overdose;
    - New drugs that are classified as non-formulary are not eligible to be added to the PEEHIP maintenance list.

3. All claims must be received within 365 days after medications are filled for the claim to be considered for payment.

4. Manual claim forms can be obtained from the PEEHIP website.

5. A Participating Pharmacy must dispense a generic medication when one is available. Please read Section 16-25A-18 (Act#2002-266) in the Code of Alabama 1975 for additional information.

6. **Non-Medicare eligible retirees** and **Active** members requiring insulin and/or diabetic supplies:

    Diabetic supplies such as insulin, test strips, lancets, and syringes are covered under PEEHIP prescription plan. The pharmacist must file insulin first and after filing insulin file syringes. Syringes are covered with no copay. Insulin and syringes must be filed by the pharmacist on the same day, otherwise each has a separate copay. The pharmacist must file test strips first and then the lancets, Lancets are covered with no copay. Test strips and lancets must be filed by the pharmacist on the same day, otherwise each has a separate copay.

    - Glucose monitors always have a separate copay. Glucose monitors are limited to one per person each contract year.
    - Insulin pump and supplies are covered under Blue Cross Major Medical benefits and not under the pharmacy program.
    - The copay that applies depends on whether the monitor or supplies are generic, Preferred Brand or Non-Preferred Brand.
    - Blood glucose test strips, lancets and glucose monitors are the only diabetic supplies available through the Prescription Drug program.
    - Benefits for insulin, needles and syringes, blood glucose test strips, lancets and glucose monitors are only provided under the Prescription Drug benefits.

7. **Medicare eligible retirees** requiring insulin and/or diabetic supplies:
    - Needles and syringes do not have a copay.
    - Blood glucose test strips, lancets and glucose monitors are covered under the Medicare Part B benefit. for Medicare eligible retirees.
    - Medicare Part B covered medications are excluded from coverage under the PEEHIP prescription drug benefit.
    - Medicare Part B covers certain drugs and supplies that include but are not limited to those within the following categories: diabetes supplies (such as blood glucose test strips, lancets, and blood glucose monitors); oral anti-cancer medications; respiratory medications; and immunosuppressants. Retirees who are Medicare-eligible must receive Medicare Part B drugs and diabetic supplies under Medicare Part B.

What is a Preferred Drug?

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

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

Making a Choice

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

Step Therapy Program

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

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

- Provide safe and effective treatments for your good health;

- Make prescriptions more affordable;
- Enable PEEHIP to continue to provide affordable prescription coverage while controlling rising costs.

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

How does Step Therapy work?

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

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

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

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

If you have medical reasons that prevent you from trying a first-step drug, your physician can contact Express Scripts to request a prior authorization by calling 800-211-1456. For other questions about the Step Therapy program, contact Express Scripts Customer Service toll free at 800-363-9389.

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

Prescription Drug Exclusions and Limitations

The following items are not eligible for coverage:

- Appetite Suppressants
- Desoxyn/Dexedrine-for Weight Control Purposes
- Agents used to suppress appetite and control fat absorption (e.g. Xenical, Meridia)
- Experimental Drugs
- Over-the-Counter Drugs (OTC is not covered even if prescribed by a physician unless mandated by the Affordable Care Act)
- Rx version of an OTC medication
- OTC equivalents (Items available over the counter without a prescription even when prescribed by a physician (vitamins and food supplements)
- Medical Foods
- Progesterone Suppositories-for PMS
- Replacement for Lost or Destroyed Drugs
- Topical Minoxidil

- Yocon
- Photo-aged skin products
- Hair growth agents
- Injectable cosmetics (e.g. Botox) and other drugs for cosmetic purposes
- Depigmentation products used for skin conditions requiring a bleaching agent
- Serums, toxoids, and some vaccines
- Legend homeopathic drugs
- Nicotine Gum and lozenge and some smoking cessation agents, unless mandated by the Affordable Care Act
- Transcutaneous nicotine patches which are now OTC drugs
- Medications used to treat erectile dysfunction. Examples include, but are not limited to Viagra, Cialis, Levitra, and Yohimbine
- Prescription drugs and medicines are considered under "Prescription Drug Benefits" and are not eligible for coverage under Major Medical.
- Arestin
- Prescription drugs and medications excluded by the PEEHIP plan. Also, to verify the formulary and coverage status of a drug, please visit the Express Scripts website at www.express-scripts.com.
- Compound medications that contain bulk chemicals powders. The following items have limited coverage:
- Certain drugs have quantity level limits for a 30-day supply. Your pharmacist will advise if this is a requirement.
- Certain drugs have step therapy requirements to try a first line agent before a second line agent will be covered.
- Certain drugs require prior authorization. Your pharmacist will advise if this is a requirement.
- Drug benefits for medically necessary fertility drugs are covered at a 50% copay for any infertility drug up to a lifetime maximum of $2,500 cost to the PEEHIP plan.

Act 2002-266 Generic Equivalent Drug

As a condition of participation in PEEHIP, a pharmacist shall dispense a generic equivalent medication to fill a prescription for a patient covered by PEEHIP when one is available unless the physician indicates on the prescription "medically necessary" or "dispense as written" or "do not substitute". The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent and contain the same active ingredient or ingredients and shall be of the same dosage, form, and strength.

Health Management Benefits

HEALTHMANAGEMENT BENEFITS	
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury
Chronic Condition Management: provided by BCBSAL for subscribers and covered spouses; also provided by BCBSAL for covered children and members not required to participate in the PEEHIP Wellness Program	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease

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

ADDITIONAL BENEFIT INFORMATION

Infertility Services

Benefits for Medically Necessary infertility services are provided as follows:Artificial insemination and related services, including physician services, laboratory services, X-Ray services, and ultrasound services.

- Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum cost of $2,500 for PEEHIP per member contract. Members will pay 100% of the medications after the $2,500 lifetime maximum is reached.

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

Exclusions:

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

Colorectal Cancer Screening

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

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

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

Mastectomy and Mammograms

Women's Health and Cancer Rights Act Information:

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema.

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

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

- If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic X-rays.
- If you are at high risk of developing breast cancer or have a family history of breast cancer - within the meaning of our medical guidelines - and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic X-rays.
- In all other cases the claim will be subject to the provisions and limitations described elsewhere in this booklet, including the section called Physician Preventive Benefits

Organ and Bone Marrow Transplants

The organs for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney; and (6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve a facility for transplant services it is limited to the specific types of transplants stated. Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma.

Transplant benefits for cadaveric donor organ costs are limited to search, removal, storage, and transporting the organ and removal team.

Transplant benefits for living donor expenses are limited to:

- Solid organs: testing for related and unrelated donors as pre-approved by us;
- Bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrow registry;
- Pre-diagnostic testing expenses of the actual donor for the approved transplant;
- Hospital and surgical expenses for removal of the donor organ, and all such services provided to the donor during the admission;
- Transportation of the donated organ;
- Post-operative hospital, medical, laboratory and other services for the donor related to the organ transplant limited to up to 90 days of follow-up care after date of donation.

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copays, coinsurance, and other plan limitations. If the member's coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

There are no transplant benefits for: (1) any investigational/experimental artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) donor costs if the recipient is not covered by this plan; (7) recipient or donor lodging, food, or transportation costs, unless otherwise specifically stated in the plan; (8) a condition or disease for which a transplant is considered investigational; (9) transplants (excluding kidney) performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

Tissue, cell, and any other transplants not listed above are not included in this organ and bone marrow transplant benefit but may be covered under other applicable provisions of the plan when determined to be medically necessary and not investigational. These transplants include but are not limited to heart valves, tendon, ligaments, meniscus, cornea, cartilage, skin, bone, veins, etc.

COORDINATION OF BENEFITS (COB)

COB is a provision designed to help manage the cost of healthcare by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary. A primary plan is one whose benefits for a person's healthcare coverage must be determined first without taking the existence of any other plan into consideration. A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of Benefit Determination

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

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

Employee/Dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the group, Medicare secondary payer rules may require Blue Cross to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee and is also covered by Medicare. In this case, the order of benefit determination will be as follows:

1. the plan covering the patient as a dependent;
2. Medicare; and
3. the plan covering the patient as an inactive or retired employee.

Dependent Child – Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married),

1. The plan of the parent whose birthday falls earlier in the year will be primary.
2. If the parents have the same birthday, the plan covering the patient longer is primary.

Dependent Child – Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary. If the court-ordered parent has no health care coverage for the dependent child, benefits will be determined in the following order:
    a. The plan of the spouse of the court-ordered parent;
    b. The plan of the non-court-ordered parent; and,
    c. The plan of the spouse of the non-court-ordered parent.

    If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of "Dependent Child - Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

    If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.
2. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
    a. The plan of the custodial parent;
    b. The plan covering the custodial parent's spouse;
    c. The plan covering the non-custodial parent; and,
    d. The plan covering the non-custodial parent's spouse.
3. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the "birthday rule" as if those individuals were parents of the child.

Active Employee or Retired or Laid-Off Employee:

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. For example, if a PEEHIP member has a retired PEEHIP contract and the spouse of that PEEHIP member is actively employed as has an active non-PEEHIP plan, the non-PEEHIP active contract is primary and the PEEHIP retiree contract is secondary.

2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a retired employee is covered under their own plan as a retiree and is also covered as a dependent under an active spouse’s plan, the retiree plan will be primary, and the spouse’s active plan will be secondary. In some cases, depending upon the size of the plan, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the member is covered as an inactive or retired employee, is also covered as a dependent of an active employee and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the member as a dependent; second, Medicare; and third, the plan covering the member as an inactive or retired employee.

COBRA or State Continuation Coverage:

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer’s plan (the “COBRA plan”) and is also covered as a dependent under an active spouse’s plan, the COBRA plan will be primary, and the spouse’s active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under their former spouse’s plan (the “COBRA plan”) and is also covered as a dependent under a new spouse’s plan, the COBRA plan will be primary and the new spouse’s plan will be secondary.

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

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

Determination of Amount of Payment

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.

2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination

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

COB Terms

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

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

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

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

Custodial Parent: The term "custodial parent" means:

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

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

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

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

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

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

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

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

under those rules the plan determines its benefits first.

Secondary Plan: The term “secondary plan” means a plan that is not a primary plan.

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Blue Cross may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Blue Cross will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Blue Cross is more than they should have paid under this COB provision, Blue Cross may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Special Rules for Coordination with Medicare

Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare’s coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group.

For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare’s coverage if you fail to enroll in Medicare when eligible.

SUBROGATION

Right of Subrogation

If PEEHIP pays or provide any benefits for you under this plan, PEEHIP is subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits PEEHIP has paid or provided. That means that PEEHIP may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, PEEHIP has a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which PEEHIP has paid plan benefits. This means that you promise to repay PEEHIP from any money you recover the amount PEEHIP has paid or provided in plan benefits. It also means that if you recover money because of a claim or a lawsuit, whether by settlement or otherwise, you must repay PEEHIP. And, if you are paid by any person or company besides PEEHIP, including the person who injured you, that person’s insurer, or your own insurer, you must repay PEEHIP. In these and all other cases, you must repay PEEHIP.

PEEHIP has the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all your claim for damages and you are not made whole for your loss. This means that you promise to repay PEEHIP first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay PEEHIP first even if another person or company has paid for part of your loss. And it means that you promise to repay PEEHIP first even if the person who recovers the money is a minor. In these and all other cases, PEEHIP still has the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

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

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

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

HEALTH BENEFIT EXCLUSIONS

The Plan **will not** provide services for exclusions set forth in this booklet including but not limited to the following:

A

Services or expenses for elective **abortions**.

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

Anesthesia services or supplies or both by local infiltration, unless otherwise dictated by Plan policies.

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

C

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

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

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

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

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

Services or expenses for cosmetic surgery. **Cosmetic surgery** is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma, or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

- You must contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic.
- You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic.
- You must show us history and physical exams, visual field measures, and photographs before and after surgery.

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

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

D

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

Services for or related to a **dependent pregnancy**, including the six-week period after delivery. A dependent pregnancy means the pregnancy of any dependent other than the contract holder's wife. This exclusion does not apply to adult female preventive services and immunizations as determined in accordance with the requirements of the Patient Protection and Affordable Care Act.

Drugs - certain prescription drugs and medications are excluded from PEEHIP coverage as explained in the Prescription Drug Exclusion Section of the handbook. Also, many of the excluded drugs can be found in the PEEHIP newsletters located at the PEEHIP website. To verify the formulary and coverage status of a drug, please visit the Express Scripts website at www.express-scripts.com.

E

Services, care, or treatment you receive after the **ending date of your coverage.** This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.

Eyeglasses or contact lenses or related examinations or fittings, except under the limited circumstances set forth in the section of this booklet called Other Covered Services.

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

F

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

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

G

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

H

Hearing aids or examinations or fittings for them.

I

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

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

L

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

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

M

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

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

N

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

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

O

Except as may be otherwise expressly covered in this booklet, services, or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines of Blue Cross. Benefits will only be provided for one surgical procedure for obesity (morbid) per member under this plan. Benefits will be provided for a subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) only if medically necessary and in compliance with the guidelines of Blue Cross. However, no benefits will be provided for subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) (including revisions or adjustments to a covered surgical procedure or conversion to another covered bariatric procedure and weight gain or failure to lose weight) if the complications arise from non-compliance with medical recommendations regarding patient activity and lifestyle following the procedure. This exclusion for subsequent surgery for complications that arise from non-compliance with medical recommendations applies even if the subsequent surgery would otherwise be medically necessary and

would otherwise be in compliance with the guidelines of Blue Cross. (This exclusion does not apply to cardiac or pulmonary rehabilitation, diabetes self-management programs or Plan approved programs for pediatric obesity.)

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

P

Private duty nursing.

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

R

Services or expenses for **recreational** or educational therapy (except for plan-approved ABA Therapy, diabetic self-management programs, pulmonary rehabilitation programs, or Phase 1 or 2 cardiac rehabilitation).

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

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

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

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

Routine well childcare and routine immunizations except for the services described in Physician Preventive Benefits.

S

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

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

Sleep studies performed outside of a healthcare facility, such as home sleep studies, whether supervised or attended.

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

T

Services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. For example, braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw or because of injury of natural teeth. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under Other Covered Services.

Services provided through **teleconsultation**.

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

dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.

Except as may be otherwise expressly covered in this booklet, dietary instructions.

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

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

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

W

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

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

CLAIMS AND APPEALS

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

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

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

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

Post-Service Claims

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

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

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

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

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

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

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from Blue Cross before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies to obtain coverage under the plan.

Pre-service claims pertain only to the medical necessity of a service or supply. If Blue Cross grants a pre-service claim, Blue Cross is not telling you that the service or supply is, or will be, covered; Blue Cross is only telling you that the service or supply meets their medical necessity guidelines.

To file a pre-service claim, you or your provider must call the Health Management Department at 205-988-2245 or 1-800-248-2342 (toll-free). You must tell Blue Cross your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person Blue Cross can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to Blue Cross at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to Blue Cross during their regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to Blue Cross within 48 hours of the admission and Blue Cross certify the admission as both medically necessary and as an emergency admission. You are not required to pre-certify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD). If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you. For home healthcare and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to pre-certify treatment.

If you attempt to file a pre-service claim but fail to follow their procedures for doing so, Blue Cross will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Blue Cross's notification may be oral, unless you ask for it in writing. Blue Cross will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of Blue Cross's company that is customarily responsible for handling benefit matters, and (2), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent Pre-Service Claims: Blue Cross will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells Blue Cross that your claim is urgent, Blue Cross will treat it as such.

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

of the 48-hour period Blue Cross gave you for furnishing information to Blue Cross.

Non-Urgent Pre-Service Claims: If your claim is not urgent, Blue Cross will notify you of their decision within 15 days. If Blue Cross needs more information, Blue Cross will let you know before the 15-day period expires. Blue Cross will tell you what further information they need. You will then have 90 days to provide this information to Blue Cross. To expedite their receipt of the information, Blue Cross may request it directly from your provider. If Blue Cross does this, Blue Cross will send you a copy of their request. However, you will remain responsible for seeing that Blue Cross gets the information on time. We will notify you of their decision within 15 days after we receive the requested information. If Blue Cross does not receive the information, your claim will be considered denied at the expiration of the 90-day period they gave you for furnishing the information to Blue Cross.

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

Concurrent Care Determinations

Determinations by Us to Limit or Reduce Previously Approved Care: If we have previously approved a hospital stay

or course of treatment to be provided over a period of time or number of treatments, and Blue Cross later decides to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care, or treatments are no longer approved. You must follow any reasonable rules Blue Cross establishes for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by You to Extend Previously Approved Care: If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to Blue Cross or through your treating physician or a hospital representative. The phone numbers to call to request an extension of care are as follows:

- For inpatient hospital care, call 205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network physical therapy or occupational therapy (if covered by your plan) call 205-220-7202.
- For care from an in-network chiropractor (if covered by your plan) call 205-220-7202.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, Blue Cross will give you their decision within 24 hours of when your request is submitted. If your request is not made before this hour time frame, and your request is urgent, Blue Cross will give you their determination within 72 hours. If your request is not urgent, Blue Cross will treat it as a new claim for benefits and will make a determination on your claim within the pre-service or post-service time frames discussed above.

Your Right to Information

You have the right, upon request, to receive copies of any documents that Blue Cross relied on in reaching their decision and any documents that were submitted, considered, or generated by Blue Cross while reaching their decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that Blue Cross may have relied upon in reaching their decision. If their decision was based on a medical or scientific determination (such as medical necessity), you may also request that Blue Cross provide you with a statement explaining their application of those medical and scientific principles to you. If Blue Cross obtained advice from a healthcare professional (regardless of whether Blue Cross relied on that advice), you may request that Blue Cross give you the name of that person. Any request that you make for information under this paragraph must be in writing. Blue Cross will not charge you for any information that you request under this paragraph.

Appeals

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

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

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

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

How to Appeal Post-Service Adverse Benefit Determinations: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim Blue Cross recommends that you use a form that Blue Cross has developed for this purpose. The form will help you provide Blue Cross with the information that Blue Cross needs to consider your appeal. To get the form, you may call the customer service department. You may also go to www.AlabamaBlue.com.

Once there, you may request a copy of the form.

If you choose not to use their appeal form, you may send Blue Cross a letter. Your letter must contain at least the following information:

- The patient's name;
- The patient's contract number;
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available). (The best way to satisfy this requirement is to include a copy of your claims report with your appeal.); **and,**
- A statement that you are filing an appeal. You must send your appeal to the following address:

  Blue Cross and Blue Shield of Alabama
  Attention: Customer Service Department - Appeals
  P.O. Box 12185
  Birmingham, Alabama 35202-2185

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

How to Appeal Pre-Service Adverse Benefit Determinations: You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network physical therapy or occupational therapy (if covered by your plan) call 205-220-7202.
- For care from an in-network chiropractor (if covered by your plan) call 205-220-7202.

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

- For inpatient hospital care and admissions:

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

or

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

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

Your written appeal should provide Blue Cross with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

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

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

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

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

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

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

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

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

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

- Ask the Customer Service Department for further help;
- File a voluntary appeal (discussed below);
- File a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below); or

- File a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If Blue Cross has given you their appeal decision and you are still dissatisfied you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), Blue Cross will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. Blue Cross will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, Blue Cross will not impose any fees or costs on you as part of your voluntary appeal.

You may ask Blue Cross to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

External Reviews

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with Blue Cross for an independent, external review of their decision. You must request this external review within 4 months of the date of your receipt of their adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address: Blue Cross and Blue Shield of Alabama, Attention: Customer Service Department Appeals, P.O. Box 10744, Birmingham, AL 35202-0744.

If you request an external review, an independent organization will review Blue Cross's decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give Blue Cross copies of this additional information to give Blue Cross an opportunity to reconsider the denial. Both of us will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both of us.

Expedited External Reviews for Urgent Pre-Service Claims

If your pre-service claim meets the definition of urgent under law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling Blue Cross at 1-800-248-2342 (toll-free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll-free).

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

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

If your account is placed on claims hold, your claims will not be processed by Blue Cross until PEEHIP notifies Blue Cross that the account has been returned to active status. In the event your account is placed on claims hold, please contact PEEHIP at 877-517-0020 immediately so that PEEHIP may work with you to return your account to active status.

RESPECTING YOUR PRIVACY

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

Disclosures of Protected Health Information to the Plan Sponsor:

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

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

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

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

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

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

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

Security of Your Personal Health Information:

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

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

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

Our Use and Disclosure of Your Personal Health Information:

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

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

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

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

Notice

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

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

Correcting Payments

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

Responsibility for Providers

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

Misrepresentation

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

Governing Law

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

Termination of Benefits and Termination of the Plan

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

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

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

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

Changes in the Plan

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

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

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

No Assignment

As discussed in more detail in the Claims and Appeals section of this booklet, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network provider (as required by our contract with your in-network provider) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the

Provider – even if you have assigned payment of your claim to someone else. When we pay you or your provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

DEFINITIONS

ABA Therapy: ABA therapy is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.

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

In-Network Providers: Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered care. The negotiated price applies only to services that are covered under the plan and covered under the contract that has been signed with the in-network provider.

Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2), which subset of those providers will be considered BlueCard PPO providers, and (3), the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.

See Out-of-Area Services, earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Alabama.

Out-of-Network Providers: In accordance with Blue Cross and Blue Shield of Alabama's applicable provider payment policies in effect at the time the service is rendered, the allowed amount for care rendered by out-of-network providers may be based on the negotiated rate payable to in-network providers for the care in the area, may be based on the average charge for the care in the area, or may be based on a percentage of what Medicare would typically pay for the care in the area (or, if no Medicare rates are available, an approximation of what Medicare would pay for care using various sources) or in accordance with applicable Federal law . In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;
- The relative complexity of the service;
- The in-network allowance in Alabama for the same or a similar service;
- Applicable state healthcare factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

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

For out-of-network emergency services for medical emergencies or for air ambulance services, the allowed amount will be determined in accordance with the requirements of the applicable Federal law

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

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

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

BlueCard Program: An arrangement among Blue Cross and/or Blue Shield plans by which a member of one Blue Cross and/or Blue Shield plan receives benefits available through another Blue Cross and/or Blue Shield plan located in the area where services occur. The BlueCard program is explained in more detail in other sections of this booklet, such as In-Network Benefits and Out-of-Area Services.

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

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

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

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

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

Durable Medical Equipment (DME): Equipment we approve as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

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

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

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

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

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

Home Infusion Service Provider: A home infusion service provider is a state-licensed pharmacy that specializes in provision of infusion therapies to patients in their home or other alternate sites associated with the home infusion provider such as a home infusion suite.

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

Implantable Devices: An implantable device is a biocompatible mechanical device, biomedical material, or therapeutic agent that is implanted in whole or in part and serves to support or replace a biological structure, support and/or enhance the command and control of a biological process or provide a therapeutic effect. Examples include, but are not limited to, cochlear implants, neurostimulators, indwelling orthopedic devices, cultured tissues, tissue markers, radioactive seeds, and infusion pumps.

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

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

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

we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

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

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

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

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

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

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

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

Mental Health Disorders: These are mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. These disorders, illnesses, and conditions are considered mental health disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders regardless of how they a caused, based, or brought on. Mental health disorders include, but are not limited to, psychoses, neuroses, schizophrenic- affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are generally intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

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

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

Physician: Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

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

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

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

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

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

Pregnancy: The condition of and complications arising from a woman having a fertilized ovum, embryo, or fetus in her body - usually, but not always, in the uterus - and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Preventive or Routine: Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

Private Duty Nursing: A session of four or more hours during which continuous skilled nursing care is furnished to you alone.

Psychiatric Specialty Hospital: An institution that is classified as a psychiatric specialty facility by such relevant credentialing organizations as we or any Blue Cross and/or Blue Shield plan (or its affiliates) determines. A psychiatric specialty hospital does not include a substance abuse facility.

Substance Abuse: The uncontrollable or excessive abuse of addictive substances, such as (but not limited to) alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use.

Substance Abuse Facility: Any institution that is classified as a substance abuse facility by such relevant credentialing organizations as we or any Blue Cross and/or Blue Shield plan (or its affiliates) determine and that solely provides residential and/or outpatient substance abuse rehabilitation services.

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

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

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

NOTICE OF NONDISCRIMINATION

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

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

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

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

FOREIGN LANGUAGE ASSISTANCE

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ1-855-216-3144 (الهاتف النصي:

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાનઆપો:જો રાતીબોલતાહોય,તોભાષાસહાયતાસેવા,તમારામાટે ઉપલબ્ધછે.1-855-216-3144પરકૉલ તમે ગ જકર ો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

1-855-216-3144 (TTY: 711) पर क ॉल कर ।

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Laotian: ໂ ປ ດ ຊ າ ບ : ຖ ້ າ ທ ່ ານ ເ ວ ົ ້ າ ພ າ ສ າ ລ າ ວ , ກ ານ ບ ໍ ່ ກ ານ ຊ ່ ວ ຍ ເ ຫ ຼ ື ◌ ◌ ອ ດ ້ ານ ພ າ ສ າ , ໂ ດ ຍ ບ ໍ ່

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144
（TTY: 711）まで、お電話にてご連絡ください

PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN

PO Box 302150
Montgomery, AL 36130-2150

201 South Union Street
Montgomery, AL 36104

Phone: (334) 517-7000
1-877-517-0020

www.rsa-al.gov

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

450 Riverchase Parkway East
Birmingham, AL 35298

AlabamaBlue.com/peehip

Customer Service: 1-800-327-3994

Rapid Response Forms Order: 1-800-248-5123

Fraud Hotline: 1-800-824-4391

Baby Yourself: 1-800-222-4379

Preadmission Certification: 1-800-248-2342

Express Scripts 1-800-363-9389
https://www.express-scripts.com/

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