Local Government Health Benefit Plan

Local Government Plan

Effective January 1, 2013

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

INTRODUCTION

This summary of health care benefits of the Local Government Health Insurance Plan (LGHIP) is designed to help you understand your coverage. This booklet replaces any previously issued information. All terms, conditions and limitations are not covered here. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the State Employees Insurance Board (SEIB) and Blue Cross Blue Shield (BCBS) of Alabama or other third party administrators that the SEIB may contract with that it deems is necessary to carry out its statutory obligations. Copies of all contracts are kept on file at the SEIB office and are available for review.

The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the LGHIP and reserves the right to change the terms and conditions and/or end the LGHIP at any time and for any reason.

Local Government Health Insurance Program
Benefit Plan

Administered By:

State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: 334.263.8326
Toll-Free: 1.866.836.9137
Website: www.alseib.org

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ELIGIBILITY AND ENROLLMENT

Eligible Participants

1. Employee - an employee must be a permanent active full-time employee, who is not on layoff or leave of absence. An employee must be employed in a bona fide employer-employee relationship, working 30 hours (minimum) per week. You are not eligible for coverage if you are classified as an employee on a temporary, part-time, seasonal, intermittent, emergency, or contract basis, or if employment is known to be for a period of one year or less.

   Elected officers of a local government unit are also eligible while in office. Elected officers will be classified for insurance purposes as active employees upon proper notification to the SEIB and compliance with the LGHIP's enrollment rules.

2. Retiree – a retired employee may elect to continue coverage under a plan designated by the SEIB if:
   - Retiree has 25 years of creditable service, regardless of age, or
   - Retiree has ten years of service and:
     - is 60 years old or
     - is determined to be disabled by the Social Security Administration or the Retirement Systems of Alabama

   Individuals enrolling in the LGHIP after January 1, 2005 must:
   - Have been enrolled in the LGHP for 10 years prior to the date of retirement, or
   - If unit has been enrolled less than 10 years, the employee must have been enrolled continuously from the unit's inception date.

Any retired employee who does not meet the above requirements will be considered a termination.

Each government unit is responsible for determining whether eligible retirees may continue their LGHIP coverage and, if so, whether it may be maintained upon entitlement to Medicare. Once a governmental unit makes this determination it must be applied uniformly to all retirees.

An active employee, who retires from a local government unit that does not allow retirees to continue on the coverage, will be offered COBRA upon written notification of retirement from the local government unit. (See "Termination of Services".)

An active employee who retires from a local government unit that allows retirees to continue coverage has the option of electing retiree coverage or COBRA. If COBRA coverage is elected, the retiree will forfeit his or her right to elect retiree coverage at a later date.

Eligible retirees must enroll on the date they first become eligible for retiree health benefits. If coverage is declined, enrollment will not be allowed after the retirement date.

Eligible Dependent

The term "dependent" includes the following individuals subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes divorced or common-law spouse).

2. A child under age 26, only if the child is:
   a. your son or daughter
   b. a child legally adopted by you or your spouse (including any probationary period during which the child is required to live with you)

c. your stepchild
d. your grandchild, niece or nephew for whom the court has granted custody to you or your spouse.

(Exception: children age 19 and older who are eligible for coverage through their employer are not eligible for coverage under LGHIP.)

3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent upon the subscriber for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the SEIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the SEIB within 60 days from the date the child would otherwise cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who otherwise meets the eligibility requirements except for age:
1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment, or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   - the employee's spouse loses the other coverage because:
     a. spouse's employer ceases operations, or
     b. spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
     c. spouse's employer stopped contribution to coverage,
   - a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
   - Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The SEIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The SEIB reserves the right to periodically re-certify incapacitation.

Exclusion: You may not cover your wife, husband or other dependents if they are insured or if they are eligible to be insured as an active employee in the LGHIP.

Initial Group Enrollment

Eligible employees, elected officers, retirees and dependents who make application on or before the effective date of the Group Contract will be enrolled for coverage as of the effective date of the Group Contract. The 270-day waiting period for preexisting conditions shall be waived for employees, elected officers, retirees and dependents enrolled during the initial Group enrollment.

Initial Employee Enrollment

All full-time employees of the local government unit (and elected officials if covered by the government unit) must enroll in the LGHIP or submit a declination form with proof of other employer group health insurance coverage.

Family Coverage Enrollment

Family Coverage Enrollment

A participating employee, elected officer or retiree in the Program may apply for family coverage under the following circumstances:

- at initial enrollment (enrollment form LG01), or
- at annual open enrollment (dependent change form LG02B) or
- upon acquiring a new dependent (dependent change form LG02B), or
- if a dependent qualifies for dependent special enrollment (dependent change form LG02B).

Dependents

Appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) must be submitted to the SEIB. **Note**: to ensure that enrollment deadlines are met, change forms should be submitted to the SEIB even if all the required documentation is not available. If documentation is not received with an enrollment form or change form, the SEIB will send a notice to you to submit the documentation within 30 days. If documentation is not received by the SEIB within 60 days, the SEIB has the right to disallow the request to add dependent coverage.

Initial Enrollment/New Employees

New employees may elect to have dependent coverage begin on the date their coverage begins.

Acquiring New Dependent

A newly acquired dependent may be enrolled if the SEIB is notified within 60 days of acquiring the new dependent through marriage, birth, adoption, or custody of a grandchild, niece or nephew. The effective date of coverage will be the date of birth, adoption, or custody of a grandchild, niece or nephew. If the SEIB is notified of a new dependent after the 60 days, the eligible participant will need to reapply during the annual open enrollment.

Annual Open Enrollment

A participating employee, elected official or retiree may apply for family coverage during the month of November for a January 1 effective date.

Dependent Special Enrollment

If a dependent loses their other group coverage, they may apply for Dependent Special Open Enrollment. The effective date of coverage will be the date other group coverage ceased. See “Special Enrollment Period, Dependents.” The only dependents eligible are those that experienced a qualifying event.

Open Enrollment

Annual Open Enrollment will be held in November, for coverage to be effective January 1 of each year to allow active eligible employees not currently participating in the insurance program a chance to enroll.

Eligible participants may add dependents or family coverage. If an employee wishes to add dependents or family coverage during open enrollment, a dependent change form (Form LG02B) must be filled out.

Eligible participants are permitted to change insurance carriers/plans.

Special Enrollment Period

Employees

Under the Health Insurance Portability and Accountability Act, the LGHIP must offer a special enrollment period in addition to open enrollment for those employees who experience a qualifying event such as loss of their other employer group coverage or the addition of a dependent. However, since the LGHIP already requires that an employee enroll in the plan when they lose other employer group coverage, special enrollment will only apply to the following qualifying events not related to loss of coverage:

- the addition of a new dependent through birth, adoption or marriage or
- a substantial change in their other employer group coverage or
- a substantial change in the cost of their other employer group coverage.

To be eligible for special enrollment an employee must have a declination of coverage form with proof of other employer group coverage on file. Employees requesting special enrollment must notify the SEIB in writing within 30 days of a qualifying event. Notification should include:

1. Letter requesting participation in the special enrollment;
2. A completed enrollment form;
3. Thereafter, the following documentation must be submitted within 60 days of the qualifying event:
   a. proof of a qualifying event, listing the reason and date of loss for all individuals affected by loss of coverage (e.g. employment termination on company letterhead); and
   b. a Certificate of Creditable Coverage from the health insurer with the coverage information that includes coverage period and coverage end date.

All employees who lose their other employer group coverage, whether voluntarily or involuntarily must submit an enrollment form to the SEIB with coverage effective as of the date coverage is lost.

Dependents

To be eligible for dependent special enrollment an employee must submit a change form with proof of loss of other employer group coverage. Employees requesting dependent special enrollment must notify the SEIB within 30 days of a qualifying event. Notification should include:

1. A completed change form;
2. Proof of a qualifying event, listing the reason and date of loss; and
3. Thereafter, the following documentation must be submitted within 60 days of the qualifying event:
   a. proof of a qualifying event, listing the reason and date of loss for all individuals affected by loss of coverage (e.g. employment termination on company letterhead); and
   b. a Certificate of Creditable Coverage from the health insurer with the coverage information that includes coverage period and coverage end date.

The effective date of coverage will be the date other group coverage ceased.

Health Insurance Portability and Accountability Act (HIPAA)

If you are covered by another plan before becoming covered by SEIB, the time you were covered will be credited toward the 270-day waiting period for preexisting conditions, if:

1. There is no greater than a 63 day break in coverage, and
2. The last coverage was “creditable coverage,” .e.g., under an individual or group health plan including COBRA, Medicare, Medicaid, U.S. Military, CHAMPUS, Federal Employee Program, Indian Health Service, Peace Corps Service, a state risk pool or a public health service.

In order to waive all or a portion of the waiting period for preexisting conditions, you must submit a Certificate of Creditable Coverage when you enroll.

Waiting Period for Preexisting Medical Conditions

Each participant is subject to a waiting period of 270 consecutive days before benefits for “preexisting medical conditions” are available. The 270-day waiting period commences on the employee’s date of hire. Dependent’s 270-day waiting period commences on the dependent’s effective date. To be entitled to benefits under the contract, the entire 270-day waiting period must be served before the participant receives services or supplies or is admitted to the hospital for preexisting conditions. NOTE: The 270-day waiting period does not apply to pregnancy, newborns and recently adopted children.

A “preexisting medical condition” is any condition, no matter how caused, for which you received medical advice, diagnosis, care, or for which treatment was recommended or received during the six months before your coverage began.

The waiting period for preexisting medical conditions shall be waived for the following:

1. Employees, elected officers, retirees and dependents who enroll during the initial groups enrollment (hence, the group and employee's effective date are the same),
2. Certificate of Creditable Coverage verifying coverage without a 63-day break in service. This certificate must be obtained by the subscriber from the previous carrier. All or a portion of the 270-day waiting period may be waived.
3. Members under the age of 19.

You or your dependents may request a copy of a Certificate of Creditable Coverage from your previous carrier. The certificate will tell you the date on which coverage began and ended. In order to request a copy of a Certificate of Creditable Coverage, you or someone on your behalf must call or write your previous carrier no later than 24 months after the date on which your coverage ceases.

When Coverage Commences

Coverage commences as of the effective date of the employee's insurance contract.

Cancellation of Family Coverage

An employee may drop family coverage at any time. The earliest effective date of cancellation will be the first day of the month following receipt of written notification by the SEIB office. The SEIB requires proof of divorce (divorce decree) when dropping a former spouse due to divorce.

Transfers

Only new employees meeting the following criteria will be considered as transfers under the LGHIP:

1. New hire, previously covered by LGHIP or by the State Employees' Health Insurance Plan (SEHIP), and
2. New hire, terminated employment with another local government unit covered by LGHIP, or State employee covered by SEHIP, who became employed with a local government unit during the same calendar month of termination.

Notice

Notice of any enrollment changes is the responsibility of the employee (for example, additions or deletions of dependents or address changes).

Supernumeraries

Supernumeraries will be classified for insurance purposes as retired employees.

Declination of Coverage

Employees may decline coverage at any time. The earliest effective date of cancellation will be the first day of the month following receipt of **both the Declination of Coverage and acceptable proof of group coverage with another employer**. Acceptable proof is a current Certificate of Creditable Coverage or letter from employer/insurance carrier verifying current coverage.

Premium

The SEIB bills in advance for the following month's coverage. To be eligible for coverage members must comply with the LGHIP's enrollment and eligibility rules. Acceptance of premium payment does not guarantee coverage.

PROVISION FOR MEDICARE ELIGIBLES

Active Employees

The State Employees' Insurance Board provides active employees, over age 65, coverage under the LGHIP under the same conditions as any employee under age 65. Medicare is secondary to benefits payable under the LGHIP 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 who may pay all or a portion of the unpaid balance of the claim subject to Medicare limitations.

SEIB will not provide an active employee or his/her spouse with benefits that supplement Medicare. The employee has the right to elect coverage under the LGHIP on the same basis as any other employee.

The LGHIP 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 employee's Medicare-entitled 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 employee's spouse is not eligible for Medicare, the Plan will be the sole source of payment of the spouse's claims.

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

Retired Employees

Health benefits will be modified when you or your dependent becomes entitled to Medicare. Coverage under this plan will be reduced by those benefits payable under Medicare, Parts A and B. If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, the retiree must notify the SEIB to be eligible for the reduced premiums and to ensure that claims are paid properly.

The LGHIP remains primary for retirees until the retiree is entitled to Medicare. Upon Medicare entitlement the member's coverage under the LGHIP will complement his/her Medicare Parts A and B coverages. Medicare will be the primary payer and the LGHIP will be the secondary payer. **A Medicare retiree and/or Medicare dependent should have both Medicare Parts A and B to have adequate coverage with the LGHIP.**

Medicare Part B premiums are the retiree's responsibility. These premiums are deducted from the retiree's Social Security check.

Medicare Part D Prescription Drug Coverage

Effective January 1, 2013, the Local Government Health Insurance Plan's (LGHIP) prescription drug benefit for Medicare retirees and Medicare Dependents will change to the LGHIP Employer Group Waiver Plan (EGWP). The LGHIP EGWP is a Medicare Prescription Drug (Part D) plan that is in addition to your coverage under Medicare Part A or Part B. Plan documents, as well as an EGWP Blue Rx card, will be mailed to you shortly after SEIB receives a copy of your Medicare card and verifies that Medicare is your primary insurance plan.

It is your responsibility to inform LGHIP of any prescription drug coverage that you have or may get in the future. You can only be enrolled in one Medicare prescription drug plan at a time. You are not required to be enrolled in the LGHIP EGWP but if you want to opt out, you must complete an EGWP Opt-Out Form and return it to the SEIB. Opt-out forms are available on SEIB's website at www.alseib.org or by calling SEIB toll free at 1.866.836.9137.

If you opt out of this plan, **you will have no prescription drug coverage from the LGHIP**. You will, however, still have the LGHIP secondary Medicare Part A and B coverage if you opt-out of the LGHIP

EGWP. You can also decide to join a different Medicare Part D prescription drug plan. You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for help in learning how to enroll in another Medicare Part D prescription drug plan. (TTY users should call 1-877-486-2048.)

Keep in mind that if you leave the LGHIP plan and do not have or do not enroll in another prescription drug plan, you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

Medicare limits when you can make changes to your coverage. You may leave this plan only at certain times of the year or under certain special circumstances. Generally, there is an open enrollment period at the end of each year when you can change Medicare Part D prescription drug plans for coverage that will be effective January 1 of the following year. To request to leave the LGHIP EGWP, please submit the EGWP Opt-Out Form to:

State Employees' Insurance Board
PO Box 304900
Montgomery, AL 36130-4900.

Once you are a member of the LGHIP EGWP, you have the right to appeal plan decisions about payment of services if you disagree. Read EGWP plan documents to know the rules you must follow to receive coverage with this Medicare prescription drug plan.

TERMINATION OF COVERAGE

When Coverage Terminates

The member's coverage will terminate:

1. On the last day of the month in which the member's employment terminates.
2. When this plan is discontinued.
3. When premium payments cease.
4. In addition to the above, the coverage terminates for a dependent:
   a. on the last day of the month in which such person ceases to be an eligible dependent, or
   b. if the dependent becomes eligible to be insured as an employee in the Program.

In many cases you will have the option to choose continuation of group benefits as provided by the Public Health Service Act. (See COBRA Section.)

Family and Medical Leave Act

The State Employees' Insurance Board will adhere to the provisions of the Family and Medical Leave Act.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

Introduction

The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that the SEIB offer covered employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the LGHIP would otherwise end. COBRA coverage can be particularly important for several reasons:

1. It will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it.

2. It can prevent you from incurring a break in coverage (persons with 63-day breaks in creditable coverage may be required to satisfy preexisting condition exclusion periods if they obtain health coverage elsewhere).

3. It could allow you to qualify for coverage under the Alabama Health Insurance Program (AHIP). See the AHIP section for more information about this.

This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of this law. **You and your spouse should take the time to read this carefully.**

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the LGHIP when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed under the section entitled "Qualified Beneficiaries" below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the LGHIP is lost because of a qualifying event. Under the LGHIP, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage

Qualified Beneficiaries

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under the LGHIP on the day before the event that caused a loss of coverage such as termination of employment, or a divorce from, or death of, the covered employee. (An increase in the cost of retiree coverage relative to active employee coverage is also considered a loss of coverage for COBRA purposes.) In addition, a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the LGHIP because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the LGHIP because either one of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the LGHIP because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the LGHIP as a "dependent child."

Coverage Available

If you choose continuation coverage, the SEIB is required to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the LGHIP to similarly situated employees or family members.

When Your Employer Should Notify the SEIB

COBRA continuation coverage will be offered to qualified beneficiaries only after the SEIB has been notified that a qualifying event has occurred. Your employer is responsible for notifying the SEIB of the following qualifying events:

- End of employment,
- Reduction of hours of employment, or
- Death of an employee.

When You Should Notify the SEIB

The employee or a family member has the responsibility to inform the SEIB of the following qualifying events:

- A divorce,
- A legal separation, or
- A child losing dependent status.

Written notice must be given to the SEIB within 60 days of the date of the event or the date in which coverage would end under the LGHIP because of the event, whichever is later. All notices should be sent to the address listed under "SEIB Contact Information" at the end of this section.

Election Period

When the SEIB is notified that a qualifying event has happened, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. In addition, a covered employee may elect COBRA continuation coverage on behalf of his or her spouse and either covered parent may elect COBRA continuation coverage on behalf of their children.

You have 60 days from the date you would lose coverage because of a qualifying event, or the date notice of your election rights is sent to you, whichever is later, to inform the SEIB that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance will end.

Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage will last for up to a total of 36 months when one of the following qualifying events occurs:

- Death of the employee,
- Divorce or legal separation, or
- Dependent child loses eligibility as a "dependent child" under LGHIP.

COBRA continuation coverage will last for up to a total of 18 months when one of the following qualifying events occurs:

- End of employment or
- Reduction in the hours of employment.

There are only two ways to extend the 18-month COBRA continuation coverage period:

- **Disability** – if you or anyone in your family covered under LGHIP is determined by the Social Security Administration to be disabled and you notify the SEIB within 30 days of the determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage. The disability would have to have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. (You must provide a copy of the Social Security Administration determination to the SEIB at the address listed under "SEIB Contact Information" at the end of this section.)

- **Second Qualifying Event** – if your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage. You must notify the SEIB within 30 days of the second qualifying event. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage when one of the following qualifying events occurs:
  - Employee or former employee dies,
  - Becomes entitled to Medicare benefits (under Part A, Part B or both),
  - Employee or former employee gets divorced or legally separated or
  - If dependent child loses eligibility as a "dependent child" under LGHIP.

For the extension to apply, the above listed events must have caused the spouse or dependent child to lose coverage under the LGHIP had the first qualifying event not occurred.

Family and Medical Leave Act

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage. The period of your COBRA continuation coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

Premium Payment

If you qualify for Continuation Coverage, you will be required to pay the group's premium plus 2% administrative fee directly to the State Employees' Insurance Board. Members who are disabled under Title II or Title XVI of the Social Security Act when a qualifying event occurs, will be required to pay 150% of the group's premium for the 19th through the 29th month of coverage or the month that begins more than 30 days after the date is determined that you are no longer disabled under Title II or Title XVI of the Social Security Act, whichever comes first. (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.)Your coverage will be canceled if you fail to pay the entire amount in a timely manner.

Your initial premium payment must be received by the SEIB within forty-five (45) days from your date of election. All subsequent premiums are due on the first day of the month of coverage. There is a thirty-day (30) grace period.

Termination of Continuation Coverage

The law provides that your COBRA continuation coverage may be terminated for any of the following five reasons:

1. SEIB no longer provides group health coverage;
2. The premium for your continuation coverage is not paid on time;
3. You become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any preexisting condition you or your covered dependents may have;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your COBRA continuation coverage. There is a grace period of 30 days for payment of the regularly scheduled premium.

Note: If you are entitled to Medicare before you become a qualified beneficiary, you may elect COBRA continuation coverage; however, your Medicare coverage will be primary and your COBRA continuation coverage will be secondary. You must have Medicare Parts A and B in order to have full coverage

Keep the SEIB Informed of Address Changes

In order to protect your family's rights, you should keep the SEIB informed of any changes in the address of family members. You should also keep a copy for your records of any notices you send to the SEIB.

If You Have Any Questions

Questions concerning your COBRA continuation coverage rights may be addressed by calling the SEIB at 1.866.836.9137 or 334.263.8326 or by mail at the contact listed below. For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

SEIB Contact Information

All notices and requests for information should be sent to the following address:

State Employees' Insurance Board
LGHIP COBRA Section
P.O. Box 304900
Montgomery, AL 36130-4900

The Alabama Health Insurance Plan

If you exhaust your COBRA coverage you may qualify for coverage through the Alabama Health Insurance Plan (AHIP). For more information about AHIP, call the SEIB at 1.866.833.3375.

BENEFIT CONDITIONS

To qualify as plan benefits, medical services and supplies must meet the following:

- They must be furnished after your coverage becomes effective;
- Services or supplies for any preexisting condition must be furnished after the 270-day preexisting condition exclusion period;
- Blue Cross must determine before, during, or after services and supplies are furnished that they are medically necessary; (Note: all inpatient hospital stays and some outpatient procedures must be reviewed by Blue Cross. See Utilization Management section for details).
- PPO benefits must be furnished while you are covered by the LGHIP and the provider must be a PPO provider when the services are furnished to you;
- Separate and apart from the requirement in the previous paragraph, services and supplies must be furnished by a provider (whether Preferred Provider or not) who is recognized by Blue Cross as an approved provider for the type of service or supply being furnished. For example, Blue Cross reserves the right not to pay for some or all services or supplies furnished by certain persons who are not Medical Doctors (MD's), even if the services or supplies are within the scope of the provider's license. Call Blue Cross Customer Services if you have any question whether your provider is recognized by Blue Cross as an approved provider for the services or supplies you plan on receiving.
- Services and supplies must be furnished when the LGHIP and your coverage are both in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the LGHIP or your coverage ends.

DISEASE MANAGEMENT
1.800.551.2294

Disease Management is a program for members diagnosed with Diabetes, Coronary Artery Disease, or Chronic Obstructive Pulmonary Disease (COPD). This program is available to eligible members at no cost as a part of your benefits.

Blue Cross translates your doctor's treatment plan into daily actions to improve your health. They educate you in the disease process in hopes of avoiding relapses that can lead to hospital and emergency room visits.

First, Blue Cross identifies members who would benefit from the program by analyzing medical and pharmaceutical claims. Once identified, an invitation and welcome kit is mailed.

Working with you and your doctor, a health care professional specializing in your condition develops your personal health goals such as losing weight or lowering your blood pressure or blood sugar. You get support to help you reach your goals.

Everything about the program is confidential. Only you, your doctor and Blue Cross know you are in the program.

INPATIENT HOSPITAL BENEFITS

Preadmission Certification and Post Admission Review

To be eligible for inpatient hospital benefits, all inpatient hospital admissions and stays (except medical emergency must have Post-admission Review) must be reviewed, approved, and certified by BCBS as medically necessary before you are admitted to the hospital. SEIB contracts with BCBS for health management programs.

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefits. You are responsible for being aware of the limitations of your benefits, such as the 270-day waiting period for preexisting medical conditions.

To obtain preadmission certification:

- You or your provider must telephone BCBS at least seven days before the proposed elective hospital admission at 1.800.551.2294. **It is your responsibility to make sure this is done. Failure to comply may result in reduced benefits.**
- BCBS will determine whether the proposed inpatient hospital admission and stay are medically necessary and will send written notice of its determination to you, your hospital and your provider.
- If BCBS is notified of your pregnancy before the end of your second trimester and you participate in the Maternity Management program, known as "Baby Yourself," the $100 hospital deductible and daily copay will be waived. Additional information is provided in the Utilization Review Section, Maternity Management Program.

To be eligible for inpatient hospital benefits, all inpatient hospital admissions that you or your provider believes to be for medical emergency care must be post-admission reviewed and approved by BCBS.

To obtain post-admission review:

- You, your provider or a person acting for you must telephone BCBS at 1.800.551.2294 with details of the admission within 24 hours of the admission or by the next business day. It is your responsibility to make sure this is done. After your admission, you or your provider may be asked to supply written information regarding your condition and treatment plan. Failure to comply may result in reduced benefits.
- Your provider and the hospital must provide BCBS with all medical records about your admission upon request.
- BCBS will determine whether the inpatient hospital admission and stay were medically necessary and whether the admission was for a medical emergency.

If you or your provider disagrees with BCBS's decision, you may obtain a review of that decision. If you are denied inpatient hospital benefits for failure to request Preadmission Certification, and if you or your provider considers that you had a medical emergency condition that did not require precertification, you may obtain review of whether your condition was for a medical emergency. If you are denied inpatient hospital benefits for failure to request Post-admission Review or because BCBS disagrees that the admission was for a medical emergency, you may obtain review of whether your condition was for a medical emergency.

Subject to your rights of appeal, if you do not obtain preadmission certification or post-admission approval of an inpatient hospital admission and stay, BCBS will pay no benefits for your hospital stay or for any related charges. If you obtain admission certification but not within the specified time limits, you will be responsible for a $500 deductible for the admission instead of the normal $100. It is your responsibility to make sure all procedures are correctly followed.

Inpatient Hospital Benefits for Maternity

The SEIB 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 normal vaginal delivery, or less that 96 hours following a cesarean section, or require that a provider obtain authorization from the LGHIP or insurance issuer for prescribing a length of stay not in excess of the above periods. However, if the inpatient hospital stay is greater than 48 hours for vaginal delivery and 96 hours for Cesarean Section, post admission review must be obtained from BCBS.

NOTE: Newborns who remain hospitalized after the mother is discharged will require certification of medical necessity from BCBS.

Deductible

The deductible for each certified inpatient hospital admission is **$100 (with a $50 per day copay for the second through the fifth day).** You are responsible for payment of the deductible and copayment to the hospital. There is a separate deductible for each admission or readmission of each member to a hospital except when:

- There is more than one admission to treat the same pregnancy.
- Two or more family members with family coverage are admitted for accidental injuries received in the same accident, or
- You are transferred directly from one hospital to another.

Inpatient Hospital Benefits in a Non-Participating Hospital in Alabama

If you receive inpatient hospital services in a Non-Participating Hospital in the Alabama service area, no benefits are payable under the plan unless the services are to treat an accidental injury.

Women's Health and Cancer Rights Act

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.

Treatment decisions are made by the attending physician and patient. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Organ and Tissue Transplant Benefits

Inpatient and/or outpatient benefits are available for eligible transplantation services and expenses for the following organs and tissues:

• heart	• liver	• pancreas	• skin
• bone marrow*	• lungs	• cornea	• kidney
• heart value	• small bowel		

*As used for the LGHIP, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

Benefits shall be payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in a hospital or facility with which Blue Cross has a written contract. You may call Customer Service for the name of the facility nearest you. The approval of a hospital or facility for transplantation services is limited to the specific types of organs and tissues stated in the approval.

For transplantation services to be considered eligible for coverage, prior benefit determination from BCBS shall be required in advance of the procedure. BCBS shall obtain the necessary medical information and make a determination as to whether the services are in accordance with generally accepted professional medical standards and not "investigational." (See "Glossary.")

Transportation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. The initial transplantation evaluation at the transplant facility does not require a prior benefit determination through BCBS.

If the member is the recipient of a human organ or tissue transplant previously stated, donor organ procurement costs are covered, limited to search, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other medically necessary procurement costs.

Organ and Tissue Transplant Benefits are excluded:

- For services or expenses for replacements of natural organs with artificial or mechanical devices, in all hospitals and facilities for all organs without exception;
- When donor benefits are available through other group coverage;
- When government funding of any kind is provided;
- When the recipient is not covered under the LGHIP;
- For recipient or donor lodging, food or transportation costs;
- For donor and procurement services and costs incurred outside the United States.

OUTPATIENT FACILITY BENEFITS

The benefits below are available for charges by a facility for the types of services and supplies listed (except bed, board, and nursing care) when ordered by a provider and furnished in its outpatient department while you are not an inpatient:

- Services to treat an accidental injury within 72 hours after the injury.
- Facility charges for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention) **after a $100 copayment.** Claims with emergency room charges that do not meet medical emergency guidelines will be considered under Major Medical.
- Payment of the hospital's charges for sleep disorder services rendered in an approved sleep disorder clinic. Please contact the BCBS Customer Service Department for a list of the approved facilities.
- Chemotherapy and radiation therapy services **after a $25 copayment per visit.**
- Hemodialysis services **after a $25 copayment per visit.**
- IV therapy **after a $25 copayment per visit**
- Laboratory and pathology services **after a $3 copayment per test.**
- X-ray services **after a $100 copayment per visit**.
- Surgery **after a $100 copayment or cost per visit**.

It is your responsibility to make sure that your provider obtains prior authorization from CareCore National, BCBS's radiology review organization, for certain outpatient diagnostic procedures. Failure to comply may result in reduced benefits. If you do not obtain prior authorization of an outpatient diagnostic procedure listed below, BCBS will pay no benefits for your outpatient procedure or for any related charges. If you obtain prior authorization, but not within the specified time limits, you will be responsible for a $25 penalty for the outpatient procedure. You are also responsible for being aware of the limitations of your benefits, such as the 270-day waiting period for preexisting medical conditions**.**

  - CAT Scan
  - MRI
  - PET Scan
  - MUGA-gated Cardiac Scan
  - Angiography/ Arteriography
  - Cardiac Cath/Arteriography

- **Bariatric Surgical procedures are limited to one per lifetime, subject to prior authorization by BCBS.** Benefits for these services are provided only when the services are performed by a PPO provider. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.

However, if you are admitted as an inpatient in any hospital immediately after receiving any of the above outpatient services (or within seven days after receiving tests) no outpatient hospital benefits will be available to you for those services, and those services instead will be covered as inpatient hospital benefits.

Also, if you are admitted as a hospital inpatient more than seven days after the pre-operative tests, no benefits will be paid for them under any part of this contract.

Facility charges for outpatient physical therapy are covered *only* under Major Medical.

Outpatient Hospital Benefits in a Non-Participating Hospital in Alabama

If you receive outpatient hospital services in a Non-Participating Hospital in the Alabama service area, no benefits are payable under the plan unless the services are to treat an accidental injury.

PPO (Preferred Provider Organization) Outpatient Facility Benefits

You and your covered dependents are eligible for additional benefits when you choose a PPO facility. The facility will file all claims and the following facility services are covered in full after you pay a copayment. These services are in addition to the services listed under "Outpatient Hospital Benefits" above. **If you do not use a PPO Facility, claims for these services will be paid under Major Medical.**

Pre-certification

Certain outpatient surgical/diagnostic procedures require prior authorization. Contact BCBS at 800.551.2294 before receiving the following services:

- Blepharoplasty
- Reduction Mammoplasty
- Septo/Rhinoplasty
- Uvula Procedure
- Bariatric Surgery

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit.

It is your responsibility to make sure precertification is obtained for certain outpatient/surgical diagnostic procedures. Failure to comply may result in reduced benefits. If you do not obtain precertification of an outpatient/surgical diagnostic procedure, Blue Cross will pay no benefits for your outpatient procedure or for any related charges. If you obtain certification, but not within the specified time limits, you will be responsible for a $25 penalty for the outpatient procedure. You are also responsible for being aware of the limitations of your benefits, such as the 270-day waiting period for preexisting medical conditions**.**

UTILIZATION MANAGEMENT

Hospital Review Program

Non-Emergency Hospitalization

It is your responsibility to notify BCBS about all non-emergency admission requests at least seven days prior to hospitalization. Failure to notify BCBS may result in a **$500 deductible** on the hospital admission. NOTE: BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits, such as the 270-day waiting period for preexisting medical conditions.

All non-emergency hospital admissions must be authorized by BCBS BEFORE EXPENSES ARE INCURRED.

When you go to the doctor, present your LGHIP I.D. card, which has BCBS's written instructions on it. If your doctor recommends hospitalization, call the BCBS toll-free number at 1.800.551.2294. Remember that anyone may make the call for you, but it is your responsibility to ensure that BCBS is notified at least seven days prior to hospitalization.

When you call BCBS please have the following information ready:

- Name, address, date of birth, and contract number of subscriber
- Name, contract number, and employer of subscriber
- Date of admission
- Admitting diagnosis, and requested length of stay
- Name, address, and telephone number of hospital
- Name, address, and telephone number of attending provider
- Insurance carrier and group policy number

BCBS will evaluate the proposed admission based on your individual treatment needs. When a BCBS staff doctor and your doctor reach an agreement on your treatment plan, BCBS will notify you, your doctor and the hospital. If you have not received a written authorization by your admission date, call BCBS for the status of your case.

Emergency Hospitalization

If you or an eligible dependent are hospitalized for an emergency, make sure BCBS is notified on the first business day after the admission. Show your LGHIP I.D. card to your physician and to the hospital admitting office. If you do not notify BCBS, the $500 deductible may be applied. Remember anyone can make the call, but it is your responsibility to ensure that notification has been made.

Maternity Management

"Baby Yourself", SEIB's Maternity Management Program offers a mechanism for identifying high-risk pregnancies and managing them to prevent complications at the time of delivery. As soon as a pregnancy is confirmed, the patient or the doctor should call BCBS at 1.800.551.2294. **By participating in "Baby Yourself" and notifying** BCBS **before the end of the second trimester, your $100 deductible and applicable daily copay(s) will be waived.** After asking some questions regarding her pregnancy and medical history, BCBS's nurse contacts her doctor to obtain additional clinical information.

Following BCBS's evaluation, the expectant mother and her provider are sent information further explaining the program. Additionally, the expectant mother is sent a special Baby Yourself kit that includes educational materials related to pregnancy and childcare.

Continued Stay Review
If your hospital stay must be extended beyond the days initially authorized, BCBS will contact your provider 24 hours before your scheduled discharge to obtain clinical data and process a request for extension-of-stay authorization. At the completion of the review, BCBS will confirm discharge or authorize additional days for your stay.

Retrospective Review
If you fail to notify BCBS about a hospitalization or outpatient procedure, you may request a Retrospective Review for medical necessity. Requests for retrospective review must be submitted to BCBS either in writing or by telephone. All information required to process the retrospective review must be submitted to Blue Cross within one year from the date the claims report is issued by BCBS.

In order to expedite the retrospective review process you may mail a copy of your medical records to BCBS. The records can be obtained from the hospital or treating provider. You will be responsible for any and all charges associated with retrieval and copying of medical records for medical review. Upon determination of medical necessity the claim will be processed according to the plan benefits and will include any applicable penalty for failure to pre-certify.

Case Management
You may be eligible to receive certain alternative benefits through individual case management when your condition is catastrophic or requires long term care. The program is administered by BCBS. To contact them call 1.800.551.2294.

BCBS will screen precertifications to determine whether your medical condition makes you a suitable candidate for individual case management. To be eligible you must be receiving or eligible to receive benefits under the LGHIP for the condition and the alternative benefits are likely to be less expensive than the benefits they replace.

If BCBS determines that you are a suitable candidate for individual case management, they will notify you. The letter will tell you that you are eligible to receive Alternative Benefits if you, your provider and BCBS can agree to an Alternative Benefit plan. Except for exceptions stated in your Alternative Benefits plan, all terms and conditions of the contract apply to you while you receive Alternative Benefits. The benefits provided under the Alternative Benefits plan combined with those provided under the rest of the contract cannot exceed the contract maximums.

Alternative Benefits are available to you only when they replace services, care, treatment or supplies covered by another section of this contract. For example, alternative benefits may not be made available for treatment of a "preexisting condition" or as an alternative to any benefit excluded (such as radial keratotomy), except certain investigational procedures that BCBS determines appropriate for your Alternative Benefits plan. If you have a life-threatening condition, have exhausted and been unresponsive to all available non-investigational therapy and the only remaining possibility is "Investigational," BCBS may, upon consideration, determine that your medical condition makes you a suitable candidate for Alternative Benefits even though they are "Investigational." Its consideration will include but is not limited to whether the "Investigational study" is approved by appropriate bodies such as the National Cancer Institute or the Institutional Review Board; the number of such procedures that have been performed and the survival rate; the scientific evidence available; and the cost relative to conventional and other "Investigational" therapies.

Because individual case management is designed to provide the most appropriate benefits for each individual case, the Alternative Benefits plan for any member may differ from another member's plan even if they have

the same medical condition. Providing Alternative Benefits to you or any other member is not to be construed as a waiver of the right to administer and enforce the contract exactly as it is written.

If you believe that you should receive Alternative Benefits, you may write BCBS explaining the reasons for your belief. If BCBS determines that you are a candidate for individual case management, they will contact you and begin the process. If BCBS determines that your medical condition does not make you a suitable candidate for Alternative Benefits or it is determined that you are not eligible for Alternative Benefits, they will write you of that decision. After receiving the decision you may write for reconsideration stating all the reasons why you believe that you are still entitled to Alternative Benefits. You may also submit any additional written information that you think is related to your request for reconsideration. If you fail to submit a request for reconsideration within sixty days of the decision you waive any right to challenge that decision later.

You must follow the procedures in this section before you can bring legal action against BCBS for Alternative Benefits. This does not change your right to have individual claims reviewed under the section titled "Filing a Claim, Reviewing Claim Decision and Appeal of Benefit Denial."

BCBS will terminate your Alternative Benefits when any of the following happens:

- The time limit (if any) of the written Alternative Benefits plan expires.
- BCBS determines that the Alternative Benefits being provided to you are no longer Medically Necessary or are no longer cost effective.
- You receive care, treatment, services, or supplies that are not set forth in the Alternative Benefits plan. This does not apply if care, treatment, services or supplies were for a separate medical condition.
- Your coverage ends.
- Something happens under the terms of the LGHIP to terminate the Alternative Benefits or to make you ineligible to receive Alternative Benefits.
- You tell BCBS, in writing, that you wish to stop Alternative Benefits. This will terminate your Alternative Benefits no more than five days after receipt of your notice by BCBS.

Appeal of Utilization Management Decision

BCBS provides a three-step appeals process that either the patient or the attending provider can initiate. All information required to process the appeal must be submitted to BCBS within one year from the date the claims report is issued by BCBS.

Reconsideration

The attending provider or patient can initiate reconsideration by contacting BCBS at 1.800.551.2294 to discuss any case for which requested services were reduced or non-authorized. A staff physician who did not participate in the original non-authorization will perform the reconsideration. Based on the telephone discussion, the BCBS physician will determine whether the original decision was appropriate or should be amended. Proper documentation is provided to the patient and the attending provider after the review.

Appeal

When a disagreement between the attending provider and a BCBS physician is not resolved by reconsideration, review of the case can be initiated by the attending provider and/or patient via a telephonic or written request to:

Blue Cross Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298
Customer Service: 1.800.321.4391

Medical records are obtained and reviewed once a written release has been received from the patient. If the Committee finds additional medical information to justify the authorization, the services are certified. If not, the non-authorization is upheld. If an original adverse decision is reversed by the Committee, the attending provider, patient and claims office are notified in writing.

Independent Review

The attending provider or patient appellant may appeal the decision of the Appeals Committee by requesting an independent review in writing or by telephone. BCBS contracts with independent physician reviewers who have active medical practices, appropriate board certification, and expertise in the clinical area of the case under appeal. The independent physician is provided with BCBS's records and any additional information that might be required. Decisions by the independent physician will be final and not subject to further appeal to BCBS by the attending provider or patient. Once a final decision is made, notification letters are sent to the patient, provider and claims office.

PPO (PREFERRED PROVIDER ORGANIZATION) BENEFITS

When you use a PPO Provider, you will receive enhanced benefits with no deductible. When you DO NOT use a PPO Provider in Alabama for services covered under the PPO program, covered services are paid at 80% of the PPO fee schedule under Major Medical Benefits, subject to the deductible.

Outside Alabama, PPO services rendered by a non-PPO Provider are paid at 80% of the allowed amount under Major Medical Benefits, subject to the deductible.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the Blue Card Preferred Provider Organization (PPO) Program. Please call 1.800.810.BLUE (2583) or access the Blue Card website at: www.bcbs.com/helptravel/finder.html to find out if your provider is a PPO member.

Please be aware that not all providers participating in the Blue Card PPO Program will be recognized by Blue Cross as approved providers for the type of service being furnished as explained more fully in "Benefit Conditions."

Preferred Provider (PPO) Benefits

These benefits consist of payment by Blue Cross of the PPO Fee Amount Payable for the following services when rendered by the PPO Provider to you. There is no Major Medical deductible for covered PPO services when you visit a PPO Provider.

To take advantage of PPO you simply choose a PPO Provider from the BlueCard PPO directory. Your doctor will file all claims for PPO benefits. When your PPO Provider requests the services of another Provider for you, that Provider must also be a PPO Provider in order for you to receive PPO benefits for his or her services, i.e., an anesthesiologist when surgery is performed or an independent laboratory or radiologist for diagnostic services. **The PPO co-payments do not apply to the Major Medical deductible or out-of-pocket maximum and are not eligible for coverage under Major Medical Benefits.**

Out-of-Area Co-Pay and Co-Insurance

When you obtain health care services through the BlueCard Program outside the Alabama service area, the amount you pay for covered services is calculated based on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield plan ("Host Plan") passes on to the LGHIP.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claim transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average savings with your health care provider or with a specified group of providers. The price that reflects expected average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over or under estimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your payment for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular

claim or to add a surcharge. Should any state statutes mandate payment calculation methods that differ from the usual BlueCard method noted above in the first paragraph of this section or require a surcharge, Blue Cross would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

PPO Services Paid at 100%

- **Surgical Care Services**, which are services for operations and cutting procedures and the usual care before and after operations, for reducing fractures and dislocations, for the endoscopic procedures recognized and accepted by Blue Cross, and of an assisting PPO Provider who assists in performance of surgical procedures when medically necessary. Surgical services related to TMJ surgery are limited to an annual maximum of $3,000 when you use a PPO Provider and $1,000 when you do not use a PPO Provider. If you start treatment with a Non-PPO Provider and change to a PPO Provider, the maximum stays at $1,000.
- **Anesthesia Services,** which consist of the administration of anesthetic drugs by injection or inhalation (but not by local infiltration). The anesthesia must be administered by a PPO Provider (other than the operating surgeon, obstetrician, their assistants, or a hospital employee) in connection with surgical care or obstetrical care services for which you are entitled to benefits under this contract.
- **Obstetrical Care Services,** which are services for childbirth, for care of a pregnancy ending in miscarriage, and for the usual care before and after those services.
- **Newborn Care Services,** which are services for the **initial** inpatient newborn well baby examination.
- **Inpatient Medical Care Services,** which are visits by a PPO Provider for your care or treatment while you are an inpatient and entitled to inpatient hospital benefits under this contract. However, you will not receive benefits for inpatient medical care services if you receive benefits for surgical care, obstetrical care, or radiation therapy services during the same hospital stay because medical care services are included in the surgical, obstetrical or radiation therapy fee. However, if Blue Cross decides inpatient medical care was medically necessary and unrelated to the condition for which you were hospitalized you will receive medical care services benefits.

  You will not be responsible for non-covered medical services when you use a PPO Provider, except when there is a signed agreement on file in the PPO Provider's office, taking patient responsibility for non-covered services. In which case, you will be responsible for the total charges for the non-covered medical services.
- **Consultation Services,** limited to one consultation each for medicine, surgery, and maternity by a PPO Provider while an inpatient during each period of continual hospitalization. The consultation must be for an illness or injury requiring the special skill or knowledge of the PPO Provider.
- **Administration of Radiation Therapy and Chemotherapy Services**.

Services Requiring a Copayment

- **Bariatric Surgical Procedures** are limited to one per lifetime, subject to prior authorization by BCBS. Benefits for these services are provided only when the services are performed by a PPO Provider. All physician and anesthesia services related to Bariatic Surgical procedures are limited to 50% of the allowable rate.

- **Office Care Services**, which consist of the examination, diagnosis, and treatment for an illness or injury in a PPO Provider's office. The term "treatment" is inclusive of in-office **minor surgery. You must pay a $30 Physician copayment or $20 Nurse Practitioner or Physician Assistant copayment for each visit.** Allergy treatments are not covered as a PPO service. These services are covered under Major Medical Benefits, subject to the deductible.

- **Outpatient Diagnostic Lab and Pathology,** coverage is provided for outpatient diagnostic lab and pathology services when performed by a PPO Provider. The member pays a $3 copay per test. Sometimes the Provider may refer services to another provider. In this situation, if the other provider is not a member of the PPO, the Major Medical benefits for the services provided will be used. Ask the PPO Provider to refer all services that he/she does not perform to a PPO Provider so that PPO benefits will be received.

- **Emergency Room Provider Services,** which consist of care and treatment by a PPO Provider in hospital emergency rooms and freestanding emergency clinics in an emergency other than for surgery or childbirth. **You must pay a $30 Physician copayment or a $20 Nurse Practitioner** or Physician Assistant **copayment for each visit.**

- **Routine Hepatitis B (over age 12) Immunization Services**, which consist of immunizations to members over the age of 12 given by a PPO Provider for prevention of hepatitis B. **You must pay a $25 copay per injection.**

ROUTINE PREVENTIVE CARE

Routine Preventive Care Visits, which consists of office visits for routine preventive examinations performed by a PPO Provider in his/her office. Office visits for routine preventive examinations are limited to one exam each calendar year from age two to any age. Gynecological examinations for women are limited to one exam per calendar year. Routine exams are comprised of a comprehensive history, a comprehensive examination of the heart, lungs, ear, nose, throat, etc., counseling, anticipatory guidance, and risk factor reduction interventions. **You must pay the $30 Physician copay or the $20 Nurse Practitioner or Physician Assistant copay for each visit.** If you receive Routine Preventive Care services from a non-PPO Provider, benefits will be paid under Major Medical. Please note: Services provided by a non-participating Nurse Practitioner or Physician Assistant are not covered.

The following routine lab and diagnostic tests will be covered when performed in conjunction with routine preventive care visits (applicable outpatient facility copays will apply):

- **Routine Immunization Services** - immunizations given for prevention of chicken pox, diphtheria, tetanus, pertussis, poliomyelitis, rubella, mumps, measles, meningitis, Hib (meningitis, epiglottitis and joint infections), influenza (flu shots), pneumococcal vaccine, HPV vaccine (females ages 9-26), shingles vaccine (ages 60 and older), and hepatitis B (under age 13).
- **Routine Mammogram Screening Services**, which consist of one baseline exam for women between the ages of 35 and 39, yearly exams for women ages 40 and over. This does not include the routine office visit or laboratory charges.
- **Routine Pap Smears,** one per calendar year. All pap smears (including routine) are subject to a $3 copay per test.
- **HPV Screening,** for females, ages 30 and older, one every three years, subject to a $3 copay.
- **Routine Prostate Specific Antigen (PSA) Screening,** consists of routine PSA screenings, limited to one screening each calendar year for males 40 and over.
- **Colorectal Cancer Screening for ages 50 and older:**
  - Fecal Occult Stool Test once every calendar year
  - Flexible sigmoidoscopy once every three years
  - Double contrast barium enema once every five years
  - Routine Colonoscopy one every ten years.
- **Complete Blood Count (CBC),** one per calendar year.
- **Total Cholesterol,** one per calendar year, subject to a $3 copay
- **Blood Glucose,** one per calendar year, subject to a $3 copay

Well Child Benefits, birth through age 5
Consists of office visits for routine physical examinations of your dependent child performed by a PPO Provider in his/her office. Office visits for routine physical examinations are limited to nine during the first two years of your child's life and one visit every twelve months thereafter through age 5. **You must pay a $30 Physician copayment or a $20 Nurse Practitioner or Physician Assistant copayment for each visit.**

The following routine lab and diagnostic tests will be covered at 100% after a $3 copayment per test when performed in conjunction with routine preventive care visits:

- One lead screening before age 24 months
- One urinalysis before age five
- One TB skin testing, once during child's first year of life and once between ages 1 and 4.

Well Child Benefits, ages 6 through 17
Consists of office visits for routine physical examinations of your dependent child performed by a PPO Provider in his/her office. Office visits for routine physical examinations are limited to one every calendar year. **You must pay a $30 Physician copayment or a $20 Nurse Practitioner or Physician Assistant copayment for each visit**.

The following routine lab and diagnostic tests will be covered at 100% after a $3 copayment per test when performed in conjunction with routine preventive care visits:

- One Complete Blood Count every two calendar years
- One TB Skin Test between ages 14 and 17.

MENTAL HEALTH AND SUBSTANCE ABUSE PREFERRED PROVIDER ORGANIZATIONS (PPO)

The LGHIP is designed to provide the following mental health and substance abuse benefits:

- Outpatient Care
  - —- Individual Therapy/Counseling
  - —- Family Therapy/Counseling
- Emergency Services
- Inpatient and Outpatient Services in a SEIB Approved Facility
- Alcohol and Drug Abuse Counseling; limited to $9,600 annually and $12,000 lifetime

Your benefit coverage will vary depending on whether you choose an approved or non-approved provider. Your coverage with an approved provider is as follows:

Approved Outpatient Providers - When you visit a Certified Regional Mental Health Center or other approved provider (list available at www.bcbsal.org), outpatient treatment for mental and nervous disorders will be covered up to a maximum of 20 visits each calendar year at $14 copay per visit. (Other copayments may apply based on the services received.) Mental illness day hospitalization, intensive day treatment and supportive day treatment are covered up to a maximum of 60 days each calendar year at 80% of fee schedule with no deductible. You can receive up to 40 outpatient substance abuse sessions covered at 100% of fee schedule with no deductible at an approved day/evening or weekend treatment program.

Approved Inpatient Providers - Inpatient psychiatric care and substance abuse treatment received at an approved hospital will be covered at 80% of fee schedule after a $200 facility deductible per admission.

To be eligible for inpatient facility benefits, all inpatient admissions and stays (except medical emergencies that must have Post-admission Review) must be reviewed, approved, and certified by BCBS as medically necessary before you are admitted. The SEIB has employed BCBS as the Utilization Review Administrator. BCBS can be reached at 1.800.551.2294.

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

To take advantage of benefits provided by the approved providers under the SEIB's Preferred Provider Organization (PPO), contact SEIB, BCBS Customer Service, or visit www.bcbsal.org. When you make an appointment identify yourself as having the SEIB's Mental Health and Substance Abuse PPO.

Nonapproved Outpatient Providers - When you visit a nonapproved psychologist or psychiatrist, outpatient treatment for mental and nervous disorders will be covered for up to a maximum of 20 visits per calendar year at 80% of fee schedule after a $200 annual deductible. You will be responsible for 20% of fee schedule, **plus** any difference between the fee schedule amount and the amount the provider charges. There is **no coverage** for services provided by a nonapproved Licensed Professional Counselor or Licensed Social Worker or facility that is solely classified as a **substance abuse outpatient or residential facility.**

Nonapproved Inpatient Providers - Inpatient psychiatric care and substance abuse treatment received at a nonapproved hospital will be covered at 80% of fee schedule after a $200 deductible per admission. You are responsible for 20% of fee schedule, plus any difference between the fee schedule amount and the amount that the Facility charges. This amount can be substantial, as much as 40% of your bill, and is not eligible for coverage under any other part of your contract. Admission Precertification is the same as in an Approved Facility.

Note: The term "fee schedule" refers to the SEIB's negotiated fee that the approved facilities and providers have agreed to accept for providing psychiatric or substance abuse services. The fee schedule applied to non-approved facilities is consistent with the fee paid to the approved facilities.

NOTE: A comprehensive listing of all approved mental health providers is available on the BCBS website at: www.bcbsal.org

PARTICIPATING CHIROPRACTOR BENEFITS

The Participating Chiropractor Program offers members several advantages when they visit a Participating Chiropractor. Services are covered at 80% of the Chiropractic Fee Schedule with no deductible. Participating Chiropractors have agreed to file all claims and accept Blue Cross' payment (along with the 20% coinsurance due from the patient) as payment in full; the patient will not be balance-billed for any "over-range" charges. All benefit payments will go to the Participating Chiropractor.

Precertification is required after the 18th visit. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.

Participating Chiropractors may be required to precertify services during the course of your treatment. If so, the Participating Chiropractor will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

TOBACCO CESSATION PROGRAM

A Tobacco Cessation Program is now provided by the SEIB for its covered members. Program literature can be obtained through our Wellness Program and on our website. For more information about available programs, please call ***Alabama's Tobacco Quitline at 1.800.QUIT.NOW (1.800.784.8669)***. Online resources and support are also available through the following organizations:

American Cancer Society	www.cancer.org www.everydaychoices.org
Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov
National Cancer Institute	www.cancer.gov
American Lung Association	www.lungusa.org/tobacco
Mayo Clinic	www.mayoclinic.org

The SEIB will reimburse each member 80% of the cost of the program, with no deductible. There is a lifetime maximum benefit of $150. Tobacco cessation seminars and all forms of nicotine replacement are covered services. Forward your name, address, contract number and a copy of tobacco cessation program receipts to:

State Employees' Insurance Board
Wellness Division
PO Box 304900
Montgomery, AL 36130-4900

Prescription medications for tobacco cessation are covered through the Prescription Drug Program and are not subject to the $150 lifetime maximum benefit.

All claims must be filed with the SEIB, not BCBS.

PHYSICIAN SUPERVISED WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING PROGRAMS

The SEIB will cover approved physician supervised weight management and nutritional counseling programs. The SEIB will reimburse up to 80% of the cost of a physician supervised weight management program and/or nutritional counseling, with no deductible, not to exceed $150 per calendar year. You can apply for reimbursement by forwarding your name, address, contract number, daytime phone number, copy of the program receipt(s), and program contact information to:

State Employees' Insurance Board
Wellness Division
PO Box 304900
Montgomery, AL 36130-4900
866.838.3059

Medications, either by prescription or over the counter, are excluded from the program. Food and Dietary Supplements, except for those distributed by the Physician Supervised Weight Management Plan, are excluded from the program.

You must file your claims for this benefit with the SEIB, not BCBS.

SEIB DISCOUNTED VISION CARE PROGRAM

The SEIB has contracted independently with eye care providers across the state to form the Routine Vision Care Network. **This is not a Blue Cross provider network**. Check with your provider or visit our web page at www.alseib.org prior to receiving services to determine whether the provider is a participating provider.

Under the Routine Vision Care Network, participating providers will offer the following discounted services:

Routine vision examination (one per year)……..…….$40 Member payment
Routine vision examination-with dilation (one per year)……..…….$45 Member payment
Initial contact lens fitting……..…….…….$25 Member payment*
Follow-up contact lens visit……..……..…….$25 Member payment

* Initial contact lens fitting fee of $25 is in addition to the routine vision examination fee.

Routine vision care examinations, initial contact lens fitting and follow-up contact lens visits are subject to the member payments stated above and will be accepted by the participating provider as full and complete. Be sure you identify yourself as a local government employee before receiving services.

Laser vision corrective surgery is available at a discounted rate through Participating Vision Care Providers. You may obtain a list of Participating Providers at: www.alseib.org or contact SEIB at 1.866.836.9137.

HEARING BENEFITS

The maximum benefit is $100 per member per year toward the purchase of any hearing aid or hearing aid supplies.

Forward your name, address, contract number and a copy of receipts to:

Hearing Benefits
State Employees' Insurance Board
P O Box 304900
Montgomery, AL 36130-4900

NOTE: All claims must be filed within 365 days from date of service.

MAJOR MEDICAL BENEFITS

Services not covered under the BlueCard PPO program are paid at 80% of the allowed amount under Major Medical subject to the deductible. Non-PPO Providers in Alabama will be paid 80% of the PPO fee schedule for services covered under the PPO program. You will receive enhanced benefits with no deductible for many services when you use a PPO Provider.

Deductible

The deductible for Major Medical benefits (except for PPO Provider benefits) is the first $200 of covered Major Medical expenses incurred by or for each member during each calendar year, with the following expenses or modifications:

- Only one deductible is applicable to covered Major Medical expenses incurred for treatment of accidental injuries received in the same accident by two or more family members with family coverage.
- When there are more than three family members under family coverage, the deductible is applicable only to three of the family members in each calendar year.

You are responsible for payment of your covered Major Medical expenses to which the deductible applies.

Payment of Benefits

Major Medical benefits consist of payment of certain percentages of the total amount of covered Major Medical expenses after the applicable Major Medical deductible and subject to certain limits.

After the payment of the calendar year Major Medical deductible, covered medical expenses for services not covered under the PPO program are paid at **80% of the allowed amount.** Non-PPO Providers in Alabama are paid at 80% the PPO fee schedule for services covered under the PPO program. The annual out-of-pocket maximum per person each calendar year is **$1,000 plus the Major Medical deductible, charges exceeding the allowed or PPO amount and non-covered expenses.** Covered medical expenses and point-of-sale prescription drugs are paid at 100% of allowed amount after that for the remainder of the year. The term, "out-of-pocket maximum" means the amount you must pay during each benefit period before covered expenses are paid at 100% of allowed amount. **Non-covered expenses and charges exceeding the allowed amount do not apply toward the out-of-pocket maximum.**

Non-covered expenses: PPO services by a non-PPO provider, all Mental Health and Substance Abuse treatment, and charges exceeding the allowed amount do not apply toward the out-of-pocket maximum.

Covered Major Medical Expenses

Major Medical benefit payments for covered medical expenses do not include any services provided by a nonparticipating hospital located in Alabama whether in cases of accidental injury or otherwise. Covered Major Medical Expenses are the charges (or the **allowed amounts**) incurred by you for the following services and supplies performed or ordered by a Provider.

- Semi-private room and board, general nursing care and all normal and necessary hospital services and supplies when hospital benefits have expired. Major Medical Benefits for services and supplies provided to inpatients are subject to the requirements and limitations of preadmission certification and post-admission review.
- Outpatient services provided by a hospital.

- A provider's services for medical care and treatment, obstetrical care, surgical procedures and administering anesthetic drugs or agents. (The PPO Provider co-payments neither count toward the out-of-pocket expense nor are they included as covered medical expenses thereafter. You must continue to pay the copayment.)
- Allergy testing and treatment. This coverage is offered only under the Major Medical benefit regardless of whether a PPO Provider is used.
- Anesthetics and their administration, including supplies and use of equipment, and the administration of anesthetic agents by injection or inhalation (but not by local infiltration) for the purpose and effect of achieving muscular relaxation, loss of sensation, and/or loss of consciousness, when rendered for a member by a Provider (other than the operating surgeon or obstetrician or his/her assistant or an employee of a hospital) in connection with covered surgical care or obstetrical care.
- Physical therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that precertification has been obtained. Please call 1.800.551.2294.
- Speech therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that preauthorization has been obtained. Please call 1.800.551.2294.
- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that precertification has been obtained. Please call 1.800.551.2294.
- Radiation therapy, chemotherapy, and IV therapy.
- Diabetic education is covered at 100% of the allowance, with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1.800.551.2294.
- Prosthetic devices such as an artificial arm and orthopedic devices such as a leg brace.
- Medical supplies such as oxygen, crutches, splints, casts, trusses and braces, syringes and needles (other than insulin supplies), catheters, colostomy bags and supplies and surgical dressings.
- Professional ambulance service approved by Blue Cross to the closest hospital that could furnish the treatment needed for your condition. A provider must certify that the ambulance service was necessary, if Blue Cross requests it.
- Treatment by a Provider of injuries to natural teeth that result from accidental injury caused by a force outside the oral cavity (mouth) and body, including replacement of the injured teeth within 12 months of such injury. Benefits are limited to services provided and expenses incurred within 12 months of the date of injury whether treatment is completed in that time or not. The accidental injury must occur while this contract is in effect. Charges incurred for accidental injury to natural teeth caused by a force inside the body or the oral cavity (mouth) including, but not limited to, biting, chewing, clenching and grinding are not covered medical expenses.
- Dentist's or oral surgeon's services for treatment of fractures and dislocations of the jaw and for excision of dentigerous cysts, or bone tumors.
- Rental of durable medical equipment prescribed by a Provider for therapeutic use in a member's home, limited to the amount of its reasonable and customary purchase price. If you can buy it for less than you can

rent it, or if it is not available for rent, Blue Cross will pay its allowed purchase price. Some examples of durable medical equipment are wheelchairs and hospital beds.

- Hemodialysis services provided by a Participating Renal Dialysis Facility.
- Private duty nursing services of a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.) if: the services actually require the professional skills of a R.N. or L.P.N.; are provided outside of a hospital or other facility; and are provided by a person not related to you by blood or marriage or a member of your household. No benefits are provided for any custodial care. In order to be covered, private duty nursing services must be **pre-certified** by BCBS.
- Home health care is covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency; limited to 6 services in a home setting (including, but not limited to physical, occupational, and speech therapy) per person each 30 consecutive days; services in excess of this maximum must be certified through case management; call 1.800.551.2294.
- Benefits for organ transplants after the hospital portion has paid, limited to the specific provisions stated in the "Inpatient Hospital Benefits" section.
- Speech therapy performed by a qualified speech therapist who is not related to the member by blood or marriage if rendered because of injury or disease, up to 30 sessions each calendar year. Speech therapy is not covered for delayed language development or articulation disorders.
- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to hand therapy and services related to lymphedema.
- Visits for manual manipulation of subluxations and all related services, such as lab and X-ray. Preauthorization must be obtained from Blue and Blue Shield of Alabama after your 12th visit if your care will require more than 18 visits in a 12-month period. If preauthorization is not obtained, coverage for all services associated with the 19th and subsequent visits will be denied.
- Non-surgical management of temporomandibular joint disorders (TMJ), including office visits and adjustments to the orthopedic appliance, is limited to an annual maximum of $450. Professional services related to TMJ surgery are limited to an annual maximum of $1,000 if you do not use a PPO Medical Doctor and $3,000 if you do use a PPO Doctor. When you do not use a PPO Doctor, the services are covered under Major Medical at 80% of the **allowed amount** after the deductible, up to the $1,000 maximum. When you use a PPO Provider, the services are covered in full with no deductible up to the $3,000 maximum. A hospitalization related to TMJ must be pre-certified through BCBS.
- Outpatient Surgical management of temporomandibular joint (TMJ) disorders must be pre-approved at least three weeks prior to surgery before benefits are available. The guidelines and stipulations established are as follows:
  - The Provider must send Blue Cross completed Predetermination of Benefits Request Form three weeks prior to the surgery.
  - Blue Cross will review the information and determine whether or not the surgery is appropriate and will inform the Provider of their decision prior to the surgery.
  - **If surgery for TMJ disorders is not pre-approved using the above guidelines, there will be no benefits.**
- Coverage for oral and injectable fertility drugs will be 50% of the allowable charge.
- **Point-of-sale drug benefits. (See Prescription Drug section.)**

NOTE for Retirees on Medicare and Medicare dependents of retirees: All Medicare Part B-eligible prescription drugs and diabetic supplies are excluded from coverage.

PRESCRIPTION DRUGS

Active Employees and Non-Medicare Retirees
Prescription Drug Card Program

Generic drugs covered at 100% of the allowance, subject to $5 copay per prescription when you use a **Participating Pharmacy**.

Point-of-Sale Drug Program

Brand-name drugs covered at 80% of the allowance, subject to the calendar year Major Medical deductible when you use a **Participating Pharmacy**.

- You are responsible for paying the pharmacy for your prescription.
- Claims authorization number required.
- File your prescription claim with Blue Cross Blue Shield of Alabama, using the Major Medical Point-of-Sale Prescription Drug Claim form (CL-94) or you can file your claim online at www.bcbsal.org.

NOTE: No benefits are available for prescriptions purchased at a Non-Participating Pharmacy.

Medicare retirees and Medicare Dependents of retirees covered under LGHIP's Employer Group Waiver Plan (EGWP)
Prescription Drug Card Program for Generic Drugs

Preferred/Extended Supply Network Pharmacies
$ 5 copay for 30-day supply
$10 copay for 60-day supply
$10 copay for 90-day supply

Non-Preferred Pharmacies
$ 5 copay for 30-day supply
$10 copay for 60-day supply
$15 copay for 90-day supply

$0 copay for Zostavax (shingles), Flu and Pneumonia Vaccine

Point-of-Sale Drug Program for Brand Drugs
Retail & Extended Supply Network Pharmacies

20% coinsurance after the $100 drug deductible is met. Deductible applies only to Medicare covered Part D Drugs.

NOTE: All Medicare Part B-eligible prescription drugs, to include Hepatitis Vaccines and all diabetic supplies are excluded from EGWP coverage since they are covered by Part B.

Drugs purchased at an out-of-network pharmacy may be covered under certain circumstances, such as for an illness while traveling outside the plan's service area where a network pharmacy is unavailable. Drugs purchased at an out-of-network pharmacy may require higher cost-sharing. Additionally, you may have to pay the full charge for the drug and submit documentation to receive reimbursement.

If you are not enrolled in EGWP, you have no prescription drug coverage through the Local Government Health Insurance Plan. Please see the EGWP plan documents to know the rules you must follow to receive coverage with this Medicare prescription drug plan.

MEDICAL EXCLUSIONS

Blue Cross will not provide benefits for the following, whether or not a Provider performs or prescribes them:

- Services or expenses that BCBS determines not to have been medically necessary.
- Services, care, or treatment furnished after the date your coverage ends, whether or not your hospitalization began or services were furnished prior to that date and whether or not the services were for a condition you had prior to that date. This contract does not provide benefits for services or supplies provided while the contract is not in effect.
- Services or expenses related to sleep disorders provided in a non-approved sleep disorder clinic.
- 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 to correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit, cosmetic surgery is not. (See "Women's Health and Cancer Rights Act" for exceptions.) Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

  - Contact prior to outpatient surgery to find our whether a procedure will be reconstructive or cosmetic.
  - Some surgery is always cosmetic, such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts, (except as provided by the Women's Health and Cancer Rights Act), hair implants for male pattern baldness and correction of frown lines on the forehead. In other surgery, such a blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why the procedure was done. For example, a person with a deviated septum may request a septoplasty to correct breathing problems and sinus infections. During surgery the Provider may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve appearance, but reconstructive if done because excess skin hindered your vision.

- 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. 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. With the exception of braces, which are never covered under the medical plan, this exclusion does not apply to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under Other Covered Services.
- 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, even if medically or dentally necessary, are not covered under the medical plan even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident.

- Services or supplies furnished by a facility that is solely classified as a **substance abuse outpatient or residential facility**.

- Services or expenses in any federal hospital or facility except as provided by federal law.
- Services or expenses in cases covered in whole or in part by worker's compensation or employers' liability laws, state or federal, whether or not you fail to file a claim under that law; liability under the law is enforced against or assumed by the employer; the law provides for hospital or medical services as such; or your employer has insurance coverage for benefits under the law.
- Services or expenses covered in whole or part (or would be covered except for your coverage under this contract) under any laws of the United States or of any state or other governmental agency or political subdivision providing for furnishing of or payment for care or treatment through insurance or otherwise, even if the law does not cover all your expenses.
- Services or expenses to which you would be entitled to coverage under Medicare (Title I of the United States Public Law 89-97, as amended), whether or not you properly made application or submitted claims to obtain the Medicare coverage. This exclusion does not apply when it would be contrary to federal law.
- Services or expenses for sanitarium care, convalescent care, skilled nursing facilities, or rest cures.
- Services or expenses for custodial care. Care is "custodial" when it is mainly for the purpose of providing room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a provider for a person who is mentally or physically disabled. Custodial care does not include specific medical, surgical, or psychiatric treatment that will enable a person to live outside an institution.
- Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies.
- Services or expenses for routine foot care such as removal of corns or calluses or the trimming of nails (except Mycotic nails).
- Hospital admissions or stays primarily for services to rehabilitate such as (but not limited to) physical therapy, speech therapy, or occupational therapy. If BCBS determines that services during a continuous hospital confinement have developed into primarily rehabilitative services that portion of the stay beginning on the day of such development shall not be covered.
- Services or expenses during a stay in a hospital when BCBS determines that the services could have been provided on an outpatient instead of inpatient basis in view of your condition and the nature of the services provided. However, Major Medical Benefits for services during such a hospital stay will be provided as though the services were provided on an outpatient basis. Some examples are hospital admissions or stays primarily for diagnosis, diagnostic study, medical observation, rehabilitation, physical therapy or hydrotherapy.
- Services or expenses related to sexual dysfunctions, sexual inadequacies or related to surgical sex transformations.
- Services or expenses for or related to the pregnancy, including the six-week postpartum period, of any dependent other than the employee's wife.
- Services or expenses for an accident or illness resulting from war, or any act of war, declared or undeclared, or from riot or civil commotion.
- Services or expenses for treatment of injury sustained in the commission of a crime (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.
- Services or expenses for which a claim is not properly submitted to BCBS.
- Services or expenses for treatment of any condition including, but not limited to, obesity, diabetes, or heart disease, that is based upon weight reduction or dietary control. This exclusion does not apply to Bariatric Surgical procedures if medically necessary and in compliance with BCBS‘s guidelines. Bariatric Surgical procedures are limited to one per lifetime, subject to prior authorization by BCBS. Benefits for those services are provided only when the services are performed by a PPO Provider. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.
- Services or expenses for which you have no legal obligation to pay, or for which no charge would be made if you had no health coverage.

- Services or expenses for or related to organ or tissue transplantations except specifically as allowed.
- 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 dental occlusion and include such services as equilibration, shaping the teeth, reshaping the teeth, restorative treatment, prosthodontic treatment, full mouth rehabilitation, dental implants, orthodontic treatment or a combination of these treatments
- Services or expenses for or related to Assisted Reproductive Technology.
- Eyeglasses or contact lenses or related examination or fittings. (However, one pair of eyeglasses or one pair of contact lenses or one pair of each will be covered under Major Medical if medically necessary to replace the human lens function as a result of intraocular surgery
- Services or expenses for eye exercises, eye refractions, visual training orthoptics, refractive keratoplasty and radial keratotomy.
- Services or expenses for personal hygiene, comfort or convenience items including, but not limited to, air-conditioners, humidifiers, whirlpool baths, and physical fitness equipment or apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weight or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, using equipment for muscle strengthening, according to a preset protocol, and related services performed during the same therapy session are also excluded.
- Services or expenses for recreational or educational therapy except diabetic education in an approved diabetic education facility.
- Services or expenses for acupuncture, biofeedback and other forms of self-care or self-help training.
- Services provided to you or expenses incurred by you for or during a hospital admission or stay for other than a medical emergency unless BCBS has approved and precertified the admission and stay before you were admitted. Also excluded are services provided to you or expenses received by you during a hospital admission for a medical emergency if BCBS is not notified by its next business day of your admission, or if it determines that the admission was not medically necessary.
- Services or expenses of private duty nurses except as stated as covered previously, including the requirements for precertification and re-certification of the services by BCBS.
- Services, care, treatment, or supplies furnished by a facility that is not a Participating Ambulatory Surgical Facility, a Participating Hospital, Participating Renal Dialysis Facility, a Non-Participating Hospital, a Preferred Care Outpatient Facility, Preferred Provider or a Participating Nurse Practitioner as defined under this contract.
- Services or expenses of a Provider or other provider rendered or provided to a member who is related to the Provider or other provider by blood or marriage or who regularly resides in the provider's household.

  By way of example and not by way of limitation, a "provider" includes a physician, a licensed registered nurse (RN), a licensed practical nurse (LPN) or a licensed physical therapist.
- Travel, even if prescribed by your Provider.
- Services or expenses of any kind provided by a Non-Participating Hospital located in Alabama for Major Medical benefits or any other benefits under this contract, except inpatient and outpatient hospital benefits in case of accidental injury.
- Services or expenses for which a claim has not been received by BCBS within 365 days after services were rendered or expenses incurred.
- X-ray or laboratory services performed for a hospital or provider by the Alabama State Health Department.
- PPO Doctor copayments.
- Prescription drugs for erectile dysfunction.
- Services from a Non-Participating Pharmacy.

- Anesthesia services or supplies, or both, by local Infiltration.
- Services provided through teleconsultation.
- Physical, Speech, and/or Occupational therapy for the 16th and subsequent visits that was not preauthorized.

GENERAL PROVISIONS

Privacy of Your Protected Health Information

The confidentiality of your personal health information is important to the SEIB. Under a new 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 health care operations. Information is contained in the LGHIP's notice of privacy practices. You may request a copy of this notice by contacting the SEIB.

Use and Disclosure of Your Personal Health Information: Blue Cross Blue Shield of Alabama and other business associates of the LGHIP, have an agreement with the LGHIP that allows them to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required under HIPAA. By applying for coverage and participating in the LGHIP, you agree that the LGHIP, and its business associates, may obtain, use, and release all records about you and your minor dependents needed to administer the LGHIP or to perform any function authorized or permitted by law. You further direct all persons to release all records about you and your minor dependents needed to administer the LGHIP.

HIPAA Exemption: As a non-federal governmental health plan, the State of Alabama can elect to exempt the LGHIP from certain provisions of HIPAA. The State of Alabama has elected to exempt the LGHIP from the following HIPAA requirement:

> **Parity in the application of certain limits to mental health benefits:** Group health plans that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The privacy provisions of the Health Insurance Portability and Accountability Act require that you be notified at least once every three years about the availability of the State Employees' Insurance Board's privacy practices [45 CFR 164.520(c)(1)(ii)]. Accordingly, you may obtain a copy for our privacy practices by going to our website at www.alseib.org or you can request a copy by writing to us at:

State Employees' Insurance Board
Attn: Privacy Officer
P. O. Box 304900
Montgomery, AL 36130-4900.

Incorrect Benefit Payments

Every effort is made to process claims promptly and correctly. If payments are made to you or to a provider who furnished services or supplies to you, and BCBS finds at a later date that the payments were incorrect, you or the provider will be required to repay any overpayment or BCBS may deduct the amount of the overpayment from any future payment to you or the provider. If BCBS does this, they will notify you.

Responsibility for Actions of Providers of Services

BCBS and the State Employees' Insurance Board (SEIB) will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. BCBS and SEIB will not be responsible if any provider of service fails or refuses to admit you to a facility, or treat you, or provide services to you. BCBS and SEIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

Any misrepresentation by you in application for or in connection with coverage under the contract will make your coverage invalid as of your effective date, and in that case BCBS and SEIB will not be obligated to return any portion of any fees paid by or for you. Any misrepresentation by SEIB in application for or in connection with the contract will make the entire contract invalid as of the contract effective date, and in that case BCBS will not be obligated to return any fees paid by the group for you or any other member.

Any employee or retiree knowingly and willfully submitting materially false information to the SEIB or engaging in fraudulent activity that causes financial harm to the LGHIP, may be required, upon a determination by the SEIB, (1) to repay all claims and other expenses, including interest, incurred by the plan related to the intentional submission of false or misleading information or fraudulent activity and (2) be subject to disqualification from coverage under the LGHIP.

Obtaining, Use, and Release of Information

By submitting your application for coverage or any claims for benefits you authorize BCBS to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records that in its judgment are necessary or desirable for processing your claim, performing our contractual duties or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to BCBS any such records or information it requests.

Your authorization allows BCBS to use and release to other persons or organization any such records and information as considered necessary or desirable in its judgment. Neither BCBS or any provider or other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

Responsibility of Members and Providers to Furnish Information

By submitting an application for coverage or a claim for benefits you agree that in order to be eligible for benefits:

- A claim for benefits must be properly submitted to and received by BCBS.
- A provider, hospital, or other provider that has furnished or prescribed any services or supplies to a member must provide the records, information, and evidence BCBS requests in connection with benefits claimed or paid for the services or supplies.
- A member who receives services or supplies for which benefits are claimed must provide the records, information and evidence BCBS requests.

Refusal by any member or provider of services to provide BCBS records, information, or evidence reasonably requested will be grounds for denial of any further payments of benefits to or for this member or provider.

Providers of Services Subject to Contract Provision

Any hospital, provider, or other provider of services or supplies for which benefits are claimed or paid will be considered, through acceptance of the benefits or payment, to be bound by this contract's provisions.

Benefit Decisions

By submitting a claim for benefits you agree that any determination BCBS makes in deciding claims or administering the contract that is reasonable and not arbitrary or capricious will be final.

Charges for More than the Allowed Amounts

When benefits for provider's services are based on **allowed amounts**, the benefit payments are determined and made by BCBS upon consideration of the factors described previously in the definition of Allowed Amount. If a provider charges you more than the **allowed amount** paid by BCBS as benefits, you are responsible for the charges in excess of the **allowed** amount.

Applicable State Law

This contract is issued and delivered in the State of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

Plan Changes

- Any or all of the provisions of the LGHIP may be amended by the State Employees' Insurance Board at any time by an instrument in writing.
- No representative or employee of BCBS is authorized to amend or vary the terms and conditions of the LGHIP, make any agreement or promise, not specifically contained in the LGHIP, or waive any provision of the LGHIP.

Notice of Grandfather Status

The SEIB believes that the LGHIP is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the LGHIP may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.

Rescission

Under the Patient Protection and Affordable Care Act (the ACA), the SEIB cannot rescind your coverage once you are covered under the LGHIP unless you perform an act, practice, or omission that constitutes fraud, or unless you make an intentional misrepresentation of material fact as prohibited by the terms of the SEHIP. The SEIB must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded.

A rescission is a retroactive cancellation or discontinuance of coverage. A cancellation of coverage is not a rescission if (a) the cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively due to a failure to timely pay required premiums or contributions towards the cost of coverage.

COORDINATION OF MEDICAL BENEFITS

Coordination of Medical Benefits (COB) is a provision designed to help manage the cost of health care 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 health care 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.

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

1. If the other plan has no COB provision, it is primary.

2. Employee/Dependent: The plan covering a patient as an employee, member, or subscriber (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 employer, Medicare secondary payer rules may require the order of payment be reversed. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

3. Dependent Child-Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. If the other plan does not use this "birthday rule" the other plan's rule will be used.

4. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:
   a. first, the plan of the parent with custody;
   b. second, the plan of the spouse of the parent with custody;
   c. third, the plan of the parent without custody; and
   d. last, the plan of the spouse of the parent without custody.

   If the divorced or separated parents have joint legal custody, benefits are determined as if the parents are not separated or divorced (see paragraph 3 above).

   If there is a court order that specifically states that one parent must provide for the child's health expenses or provide health insurance coverage for the child, benefits are determined in this order:
   a. first, the plan of the court-ordered parent;
   b. second, the plan of the spouse of the court-ordered parent;
   c. third, the plan of the non-court-ordered parent; and,
   d. last, the plan of the spouse of the non-court-ordered parent.

5. Active/Inactive Employee: When a patient is covered under one plan as a active employee and under another plan as a retired or inactive employee (e.g., a former employee receiving COBRA benefits), the plan which covers the patient as an active employee is the primary over a plan which covers the patient as a laid-off or retired employee. This applies to the employee's dependents as well unless the dependents have other coverage due to their own current or former employment status.

6. Longer/Shorter Length of Coverage: If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

If our records indicate the LGHIP 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 the LGHIP is secondary according to the above rules, it will calculate benefits as if it were the primary plan, applying all applicable cost-sharing provisions. The LGHIP will then reduce, on a dollar for dollar basis, any benefits that it would have paid by the benefits paid pursuant to the primary plan. In many cases, this will result in no payment of benefits under the LGHIP.

SUBROGATION

Right of Subrogation

If BCBS pays or provides any benefits for you under the LGHIP it is **subrogated** to all rights of recovery that you have in contract, tort, or otherwise against any person or organization for the amount of benefits BCBS has paid or provided. BCBS may use your right to recover money from that other person or organization. Your right to be made whole is superseded by BCBS's right of subrogation.

Right of Reimbursement

Separate from and in addition to the right of subrogation, if you or a member of your family recovers money from the other person or organization for any injury or condition for which benefits were provided, you agree to **reimburse** BCBS from the recovered money the amount of benefits we have paid or provided. That means that you will pay to BCBS the amount of money recovered by you through judgment or settlement from the third person or his insurer, as well as from any person, organization, or insurer up to the amount of benefits paid or provided by us. Our right to reimbursement comes first even if others have paid for part of your loss or if the payment you receive is for, or is described as for, your damages (such as for personal injuries) other than health care expenses or if the member recovering the money is a minor.

Right to Recovery

You agree to promptly furnish BCBS all information that you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with BCBS in protecting and obtaining its reimbursement and subrogation rights in accordance with this Section. **You may receive questionnaires requesting more information. Any member who has not responded within 30 days of receiving three questionnaires will have their claims suspended until they have complied with the questionnaire.**

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

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

FILING A CLAIM, CLAIM DECISIONS, AND APPEAL OF BENEFIT DENIAL

The following explains the rules under LGHIP for filing claims and appeals with BCBS and for filing voluntary appeals with the SEIB. The procedures relating to pre-certification, pre-approval or review of certain benefits, including inpatient hospital benefits, private duty nursing, and certain surgical/diagnostic procedures, case management and certain predeterminations are explained in other sections of this booklet.

Filing of Claims Required

A claim prepared and submitted to BCBS must be received by BCBS before it can consider any claim for payment of benefits for services or supplies. In addition, there are certain services (such as Preadmission Certification and precertification of nursing services) that must be approved in advance before they will be recognized as benefits. No communications with BCBS by you, your provider, or anyone else about the existence or extent of coverage can be relied on by you or your provider or will be binding in any way on BCBS when the communications are made before the services or supplies are provided and a claim for them is submitted and received.

Who Files Claims

Providers of services who have agreements with BCBS generally prepare and submit claims directly to BCBS. Claims for services or supplies furnished to you by providers without agreements with BCBS must be prepared and submitted by either you or the provider. For services requiring preadmission or precertification requests and approvals, the responsibility and manner for submitting requests are mentioned previously.

Who Receives Payment

- BCBS agreements with some providers require it to pay benefits directly to them. On all other claims it may choose to pay either you or the provider. If you or the provider owes BCBS any sums, it may deduct from its benefit payment the amount that it is owed. Its payment to you or the provider (or deduction from payments to either) of amounts owed will be considered to satisfy its obligation to you. BCBS does not have to honor any assignment of your claim to anyone, including a provider. Nothing in the contract gives a provider the right to sue for recovery from BCBS for benefits payable under the contract.

- If you die or become incompetent or are a minor, BCBS pays your estate, your guardian or any relative that in its judgment is entitled to the payment. Payment of benefits to one of these people will satisfy its obligation to you.

How to File Claims

When you use your benefits, a claim must be filed before payment can be made. The LGHIP will pay for covered services you receive after the effective date of your coverage.

Hospital Benefits

In most cases, presenting your identification card is all you will need to establish credit for you and your dependents for admission to any hospital in Alabama and across the nation. Benefit payments are normally made to the hospital.

If care is received in a hospital outside of Alabama, reimbursement will be made through the Blue Cross Blue Card Program. If a hospital outside of Alabama does not file claims with BCBS, you should file the claim yourself directly to: Blue Cross Blue Shield, 450 Riverchase Parkway East, Birmingham, Alabama 35298.

Note: Preadmission Certification and Post Admission Review is required for all hospital admissions and for many outpatient diagnostic tests and surgeries. Ask your provider to contact BCBS at 1.800.551.2294.

Provider Services and Other Covered Expenses

To file a claim for provider services and other covered Major Medical expenses, present your identification card to the provider of service. Benefit payments are normally made directly to the provider.

However, if the provider does not file for benefits, claims should be filed directly by you. When it is necessary for you to file claims, complete a Medical Expense Claim Form (CL-438) or Major Medical Point-of-Sale Prescription Drug Claim Form (CL-94) and obtain itemized bills from the provider to attach. It is to your advantage to file your claims as they are incurred or at least every three months. The itemized bills must contain:

• Patient's full name	• Contract number	• Name and address of provider
• Type of service	• Date of service	• Diagnosis
• Charge for each service	• Date of accident (if any)	

Send the claim to: Blue Cross Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298. You should always make copies for your personal records before filing. For your convenience, Medical Expense Claim Forms (CL-438) or Major Medical Point-of-Sale Prescription Drug Claim Forms (CL-94) are available from any Blue Cross Blue Shield of Alabama office.

Blue Cross Preferred Care Benefits

One of the greatest advantages of visiting a PPO Provider or PPO Facility is that you are relieved of any claim filing. Provider and PPO Facilities agree to handle all claim filing procedures for you.

When Claims Must Be Submitted

All claims for benefits must be submitted properly by you or your provider of services within 365 days of the date you receive the services or supplies. Claims not submitted and received by BCBS within this 365-day period will not be considered for payment of benefits.

Receipt and Processing Claims

Claims for medical benefits under the LGHIP can be post-service, pre-service, or concurrent. The following explains how BCBS processes these different types of claims and how you can appeal a partial or complete denial by BCBS 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. BCBS has developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling the BCBS Customer Service Department. You can also go to the BCBS Internet website at www.bcbsal.com and request a copy of the form.

For urgent pre-service claims, your provider is deemed to be your authorized representative unless you advise BCBS otherwise in writing.

Post-Service Claims

What Constitutes a Post-Service Claim?

For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), BCBS must receive a properly completed and filed claim from you or your provider. If BCBS receives a submission that does not qualify as a claim, it will notify you or your provider of the additional information needed. Once BCBS receives that information, it will process the submission as a claim.

Processing of Claims

Even if BCBS has received all of the information needed to treat a submission as a claim, from time to time it might need additional information in order to determine whether the claim is payable. The most common example of this is medical records needed to determine whether services or supplies were medically necessary. If additional information is needed, BCBS will ask you to furnish it, and will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. BCBS will send you a copy of its request. However, you will remain responsible for seeing that BCBS gets the information on time.

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

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

Pre-Service Claims

What is a Pre-Service Claim?

A pre-service claim is one in which you or your provider are required to obtain approval before services or supplies are rendered. For example, your provider is required to obtain precertification from BCBS of certain physical therapy, occupational therapy, and chiropractor benefits. Pre-service claims pertain only to the medical necessity of a service or supply.

In order to file a pre-service claim with BCBS, you or your provider must call the BCBS Health Management Department at 205.988.2245 (in Birmingham) or 1.800.551.2294 (toll-free). You must give your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person BCBS 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 BCBS during its regular business hours. Urgent pre-service claims can be submitted at any time.

Urgent Pre-Service Claims

BCBS 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 indicates that your claim is urgent, BCBS will treat it as such.

If your claim is urgent, BCBS will notify you of the decision within 72 hours. If more information is needed, BCBS will let you know within 24 hours of your claim. They will tell you what further information is needed. You will then have 48 hours to provide this information to BCBS. You will receive notice of the decision within 48 hours after BCBS receives the requested information. If the requested information is not received, your claim will be considered denied at the expiration of the 48-hour period you were given for furnishing the information.

Non-Urgent Pre-Service Claims

If your claim is not urgent, you will receive a decision within 15 days. If more information is needed, BCBS will let you know before the 15-day period expires. You will then have 90 days to provide needed information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. However, you will remain responsible for seeing that the information is provided on time. You will be notified of the decision within 15 days after BCBS receives the requested information. If the requested information is not received, your claim will be considered denied at the expiration of the 90-day period you were given for furnishing the information.

Concurrent Care Determinations

Determinations by BCBS to Limit or Reduce Previously Approved Care

If BCBS has previously approved a course of treatment to be provided over a period of time or number of treatments, and later decides to limit or reduce the previously approved course of treatment, BCBS 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 established 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 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 BCBS or through your treating physician. The phone numbers to call in order to request an extension of care are 205.988.2245 (in Birmingham) or 1.800.551.2294 (toll-free).

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, BCBS will give you its decision within 24 hours of when your request is submitted. If your request is not made before this 24 hour time frame, and your request is urgent, BCBS will give you its determination within 72 hours. If your request is not urgent, BCBS 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, as appropriate.

Your Right to Information

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

Member Satisfaction

If you are dissatisfied with the adverse benefit determination of a claim, you may file an appeal with BCBS. You cannot file a claim for benefits under the plan in federal or state court unless you exhaust these administrative remedies.

Customer Service

If you have questions about your coverage, or need additional information about how to file claims, you should contact BCBS. BCBS Customer Service (located in Birmingham) is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is:

1.800.321.4391

When you call about a claim, be sure to have the following information available:

- Your contract number
- Name of your employer
- Date of service
- Name of the provider

BCBS also has a special 24 hours a day, 7 days a week, Customer Service request line, called Rapid Response, for you to use when you need claim forms and other printed materials relevant to your benefits.

Rapid Response is quick and easy to use, so we encourage you to use it when you need materials such as:

- Claim Forms
- Replacement ID Cards
- Brochures
- Benefit Booklets

A voice activated system will ask for your name, complete mailing address, daytime phone number, what materials you are requesting, how many you need, and the contract number from your ID card. If you know the BCBS form number, you can request the item by that number.

The numbers for Rapid Response are:

205.988.5401 in Birmingham or 1.800.248.5123 toll-free.

Your request is recorded and will be mailed to you the next working day if you answer all the questions completely. Allowing mailing time, you should receive your requested materials within 3-5 days (excluding weekends and holidays).

Blue Cross Blue Shield Appeals

In General

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

- Any determination by BCBS with respect to a post-service claim that results in your owing any money to your provider other than co-payments you make, or are required to make, when you see your provider;
- The denial by BCBS of a pre-service claim; or,
- An adverse concurrent care determination (for example, BCBS denies your request to extend previously approved services).

In all cases other than determinations by BCBS to limit or reduce previously approved care, you have 180 days following an adverse benefit determination by BCBS within which to submit an appeal.

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, BCBS recommends that you use a form that it has developed for this purpose. The form will help you provide Blue Cross with the information that it needs to consider your appeal. To get the form, you should call the BCBS Customer Service Department. You may also go to the Internet website at www.bcbsal.com. Once there, you may ask BCBS to send you a copy of the form.

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

Please note that if you call or write BCBS without following the rules just described for filing an appeal, BCBS will not treat your inquiry as an appeal. BCBS will, of course, use best efforts to resolve your questions or concerns.

How to Appeal Pre-Service Adverse Benefit Determinations

You may appeal an adverse benefit determination by BCBS 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 (in Birmingham) or 1.800.551.2294 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy call 205.220.7202.
- For care from a Participating Chiropractor call 205.220.6128.

If in writing, you should send your letter to: Blue Cross Blue Shield of Alabama
Attention: Health Management – Appeals
P. O. Box 362025
Birmingham, Alabama 35236

Your written appeal should provide BCBS 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 BCBS without following the rules just described for filing an appeal, BCBS will not treat your inquiry as an appeal. BCBS will, of course, use best efforts to resolve your questions or concerns.

Conduct of the Appeal

BCBS will assign your appeal to one or more persons within the organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires BCBS to make a medical judgment (such as whether services or supplies are medically necessary), BCBS will consult a health care professional who has appropriate expertise. If BCBS consulted a health care professional during its initial decision, it will not consult that same person or a subordinate of that person during our consideration of your appeal.

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

BCBS will consider your appeal fully and fairly.

Time Limits for Consideration of Your Appeal

If your appeal arises from the denial of a post-service claim, BCBS will notify you of its decision within 60 days of the date on which you filed your appeal.

If your appeal arises from the denial of a pre-service claim, and if your claim is urgent, BCBS will consider your appeal and notify you of its decision within one business day or, if during a long weekend, within 72 hours. If your pre-service claim is not urgent, BCBS will give you a response within 30 days.

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

If your appeal relates to a decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), BCBS will make a decision on your appeal within one business day or 72 hours if over a long weekend (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

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

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

- You may ask the BCBS Customer Service Department for further help; or
- If you have exhausted your appeals with BCBS and you are still dissatisfied, you may file a voluntary appeal with the SEIB, as described under “SEIB Appeals Process.”

SEIB APPEALS PROCESS

General Information

Members of the LGHIP have a right to question the decisions of the State Employees' Insurance Board (SEIB). Issues involving eligibility and enrollment should be addressed directly with the SEIB. Before addressing an issue involving a benefit claim with the SEIB, however, you should exhaust all administrative procedures with the claims and health management administrator, BCBS.

Informal Review

If you still feel that an enrollment or eligibility ruling was not in conformity with the rules and procedures of the LGHIP or that the LGHIP's benefits were incorrectly applied, you should then contact the SEIB for an Informal Review. In many cases the problem can be handled over the phone through the Informal Review process without the need for a Formal Review or appeal.

Administrative Review

If you are unsatisfied with the informal review decision, you may then request an administrative review. All requests for administrative review must be submitted to the SEIB legal department. If it is determined that an administrative review is merited, you will be sent a form LG06 to complete and return to the SEIB. Receipt of your Administrative Review will be acknowledged by returning a copy of the received form to you.

A request must be received in the SEIB office within 60 days following receipt of the final notice of a partial or total denial of your claim from the claims administrator or the utilization review administrator. A copy of the decision of the claims administrator or the utilization review administrator must be attached to the Administrative Review request form. Upon receipt of the completed form, the Administrative Review Committee will review the grievance usually within sixty (60) days. Oral arguments will not be considered once the Administrative Review process has begun unless approved by the SEIB. The Administrative Review Committee shall issue a decision in writing to all parties involved in the grievance.

Note: Decisions of the claims administrator and/or the utilization review administrator will be reviewed to determine if the review was conducted in a fair and equitable manner. Medical decisions will not be questioned.

Formal Appeal

If you do not agree with the response to your Administrative Review, you may file a Formal Appeal before the Board of Directors. Requests for a Formal Appeal must be received in the SEIB office within 60 days following the date of the Administrative Review decision.

The subject of a Formal Appeal shall be limited to exclusions or exceptions to coverage based on extenuating or extraordinary circumstances, or policy issues not recently addressed or previously contemplated by the Board.

Generally, a decision will be issued within ninety (90) days following receipt of the request form. The number of days may be extended by notice from the SEIB. The decision by the Board is the final step in the administrative proceedings and will exhaust all administrative remedies.

Items That Will Not Be Reviewed Under the Administrative Review or Formal Appeal Process:

- Medical Necessity
- Cosmetic Surgery
- Investigational Related Services
- Custodial Care
- Allowed Amounts

If you have not received a decision or notice of extension of the Administrative Review or Formal Appeal within 90 days, you may consider your request denied.

GLOSSARY

Accidental Injury: A traumatic injury to you caused solely by an accident that occurs while you are covered by the contract.

Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that BCBS will 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:

- **Preferred Providers:** Blue Cross and Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the preferred provider normally accepts this rate (subject to any applicable copays, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered services or care. The negotiated price applies only to services that are covered under the LGHIP and also covered under the contract that has been signed with the preferred provider. Please be aware that not all participating or contracting providers are preferred providers. Each local Blue Cross and/or Blue Shield plan determines which of its participating or contracting providers will be considered preferred providers.

- **Non-Preferred Providers:** The Allowed Amount for care for non-preferred providers or for services or supplies not included in a preferred provider's contract is normally determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to preferred providers, or may be based on the average or anticipated charge or discount for care in the area or state, or for care from that particular type of provider. When the local Blue Cross and/or Blue Shield plan does not provide us with appropriate pricing data or when we are determining the Allowed Amount for services or supplies by a non-preferred provider (or for services and supplies not included in the contract with the provider), BCBS of Alabama determines the Allowed Amount using historical data and information from various sources such as, but not limited to:

  - The charge for the same or a similar service;
  - The relative complexity of the service;
  - The preferred provider allowance for the same or a similar service;
  - The average expected or estimated provider discount for the type of provider in the service area, as reported by the Blue Cross and Blue Shield Association from time to time;
  - Applicable state health care factors;
  - The rate of inflation using a recognized measure; and,
  - Other reasonable limits, as required with respect to outpatient prescription drug costs.

  Non-preferred providers include providers that have not signed a contract with the Blue Cross and/or Blue Shield plan where services are rendered as well as participating or contracting providers who have not been designated by the local Blue Cross and/or Blue Shield plan as preferred providers.

  In this situation 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.

Alternative Benefits: A benefit program that gives you and your family an alternative to lengthy hospitalizations. It is designed to provide the patient with the best environment for recovery and in the most cost effective long-term arrangement. Also known as "Comprehensive Managed Care" and "Individual Case Management." This program is administered by BCBS.

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 intra fallopian transfer, zygote intra-fallopian transfer, pro-nuclear stage tubal transfer, artificial insemination and/or intrauterine insemination.

Blue Card Program: An arrangement among Blue Cross Plans whereby a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur.

Blue Cross Blue Shield of Alabama: The company chosen by the State Employees' Insurance Board, through competitive bid, to process benefit claims filed by members (also referred to as BCBS) and to administer your Utilization Review Program such as Preadmission Certification and Individual Case Management.

Certification of Medical Necessity: The written results of BCBS's review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours of the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not consider whether your admission is excluded by the LGHIP.

Chiropractic Fee Schedule: The schedule of Chiropractic procedures and fee amounts for those procedures under the Participating Chiropractic benefits that is on file at the Claims Administrator's office.

Claims Administrator: The company chosen by the State Employees' Insurance Board, through competitive bid, to process benefit claims filed by members. The Claims Administrator is BCBS.

COBRA: See the explanation in the "Termination of Coverage" section of this booklet.

Cosmetic Surgery: Any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, trauma or congenital anomalies. For further information on "Cosmetic Surgery", see the "Exclusions" section.

Custodial Care: Care primarily for the purpose of providing room and board (with or without routine nursing care, training in personal hygiene and other forms of self care or supervisory care by a provider) for a person who is mentally or physically disabled. Custodial care does not include specific medical, surgical or psychiatric treatment that would reduce a member's disability to the extent necessary to enable him to live outside an institution providing medical care.

Dependent: See explanation in the "Eligibility and Enrollment Section".

Durable Medical Equipment: Equipment approved by BCBS 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 (a) made to withstand repeated use, (b) mainly for a medical purpose rather than for comfort or convenience, (c) useful only if you are sick or injured, (d) related to your condition and prescribed by your physician for your use in your home, and (e) determined by BCBS to be medically necessary to diagnose or treat your illness or injury, help a malformed part of your body work better, or keep your condition from becoming worse.

Effective Date: The date on which the coverage of each individual member begins as listed in the State Employees' Insurance Board records.

Emergency Treatment: Treatment rendered in a hospital, clinic or doctor's office for an injury or illness that requires immediate care or treatment, and must be performed within 48 hours after the injury is sustained or the illness first becomes manifest. A condition that requires immediate care or treatment means only a permanent

health-threatening condition. The condition must be one for which failure to receive care or treatment could result in deterioration to the point where the patient's permanent health would be in jeopardy, bodily functions would be significantly impaired, or serious dysfunction would occur in any organ or other part of the patient's body. Emergency treatment includes ambulance service to the facility where treatment is received.

Employee: See explanation in the "Eligibility and Enrollment Section".

Family Coverage: Coverage for an employee and one or more dependents.

Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

Home Plan: The BCBS Plan that providers or subscribers send claims to when the subscriber receives medical care in a different Plan's geographic area. A group's Home Plan is the Plan that has control of the group.

Hospital: A Participating or Non-Participating hospital as defined in this section.

Host Plan: The BCBS Plan associated with the provider that furnishes services to a subscriber from a different Plan. It is a Plan that helps the Home Plan service the group.

Inpatient: A registered bed patient in a hospital.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies either not recognized by BCBS as having scientifically established medical value or not in accordance with generally accepted standards of medical practice.

BCBS's determination of whether a particular treatment, procedure, facility, equipment, drug, drug usage, or supply is "Investigational" will be made based on the following criteria:

- Technology or treatment must have final approval from the appropriate government regulatory bodies for the specific use for which it is prescribed or used;
- Scientific evidence must permit conclusions concerning the effect of the technology or treatment on health outcomes;
- Technology or treatment must improve the net health outcome;
- Technology or treatment must be as beneficial as any established alternatives;
- Improvement must be attainable outside the Investigational setting;
- Classification by Medicare;
- Classification by the Blue Cross Association.

Local Government Health Insurance Plan (LGHIP): A self-insured health benefit plan administered by the State Employees' Insurance Board.

Local Government Unit: Any agency of the state, any county, any municipality, any municipal foundation, any fire or water district, or authority, or cooperative, any regional planning and development commission, the Association of County Commissions of Alabama, the Alabama League of Municipalities, the Alabama Retired State Employees' Association, the Alabama State Employees Credit Union, Easter Seals Alabama, Alabama State University, the Alabama Rural Water Association, Rainbow Omega, Inc., the ARC of Alabama, Inc. and any of the affiliated local chapters of the ARC of Alabama, Inc., United Ways of Alabama and its member United Ways, any railroad authority, or any solid waste disposal authority organized pursuant to the Code of Alabama, 1975, Section 36-29-14, as last amended.

Management Program: A program known as “Baby Yourself” is administered by BCBS that offers a mechanism for identifying high-risk pregnancies and completely managing them to prevent complications at the time of delivery.

Medical Emergency: A sudden and unexpected onset of a medical condition with symptoms that are acute and of such severity as to require immediate medical attention to prevent permanent danger to the health, other serious medical results, serious impairment to bodily function, or serious and permanent lack of function of any bodily organ or part.

Medical Necessity: Services or supplies necessary to treat your illness, injury, or symptom. To be medically necessary, services or supplies must be determined by BCBS to be:

- 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 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;
- Is not “investigational;”
- In cases of medical care, performed in the least costly setting or method required by your medical condition. A "setting" may be your home, a provider's office, a Participating 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 provider if any of your services can be performed on an outpatient basis, or in a less costly setting.

Medicare: The Health Insurance for the Aged Program under Title XVIII of the Social Security Act (P.L. 89-97) as amended.

Member: An active/retired local government unit employee or eligible dependent who has coverage under the LGHIP and whose application for coverage under the contract is made and accepted by the State Employees’ Insurance Board. A member is also a former dependent and/or employee eligible for and covered under COBRA. Elected officers of the local government unit are eligible for coverage while they are in office.

Mental Health Preferred Provider Organization: Those providers who have contracted with the State Employees' Insurance Board (SEIB) through the Certified Community Mental Health Center (CMHC) to provide certain mental health and substance abuse services.

Mental and Nervous Disorders: Mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or non-organic; whether of biological, non-biological, genetic, chemical or non-chemical origin; and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neuro-hormonal systems. This is intended to include disorders, conditions and illnesses listed in DSM-IIIR (Diagnostic and Statistical Manual of Mental Disorders).

Non-Participating Chiropractor: A Doctor of Chiropractic (DC) who is not a Participating Chiropractor.

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the

requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those classified or classifiable under standards of the American Hospital Association as "special" hospitals, such as those classified as for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease, or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

Non-Participating Pharmacy: Any pharmacy which is not a BCBS Participating Pharmacy.

Non-PPO Provider: Any provider that is not a PPO Provider with any Blue Cross and/or Blue Shield Plan.

Non-Preferred Home Health Care Agency: Any home health care agency that is not a Preferred Home Health Care Agency.

Non-Preferred Hospice: Any hospice that is not a Preferred Hospice.

Officer: An elected official of the local government unit.

Out-of-Area Mental Health Benefits: Benefits for mental health services, including services for chemical dependency, if the subscriber lives permanently outside of Alabama and the subscriber or his dependents or both receive treatment outside Alabama.

Open Enrollment: The annual open enrollment period is held each November for a January 1 effective date.

Participating Ambulatory Surgical Facility: Any facility with which BCBS has a contract for furnishing health care services.

Participating Chiropractor: A Doctor of Chiropractic that has a contract with the Claims Administrator for the furnishing of chiropractic services.

Participating Hospital: Any hospital with which the Claims Administrator (BCBS) has a contract for furnishing health care services.

Participating Pharmacy: Any pharmacy with which Blue Cross Blue Shield of Alabama has a contract for providing pharmacy services.

Participating Renal Dialysis Facility: Any free-standing hemodialysis facility with which Blue Cross Blue Shield of Alabama has a contract for furnishing health care services.

Physician: One of the following when licensed and acting within the scope of that license at the time and place you are treated or receive services: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic (D.C.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), and Psychologists who are licensed by the state in which they practice (Ph.D., or Psy.D. or Ed.D.), as defined in Section 27-1-18 of the Alabama Code.

Preadmission Certification and Post-admission Review: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or by the next business day after the admission in the case of emergency admissions, based upon medically recognized criteria. The program is administered by BCBS.

PPO: Preferred Provider Organization.

PPO Allowance: The amount that any Blue Cross and/or Blue Shield Plan has agreed to pay its PPO Provider for plan benefits.

PPO Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Provider program and other Preferred Provider programs as applicable.

Preexisting Condition: Any condition, no matter how caused, for which you received medical advice, diagnosis, care, or for which treatment was recommended or received during the six months before your coverage began.

Preferred Care: A program whereby providers have agreements with Blue Cross Blue Shield of Alabama to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical and surgical procedures, such services and supplies to members entitled to benefits under the Preferred Care program.

Preferred Provider: Any provider of health care services or supplies when licensed and acting within the scope of that license at the time and place you are treated and receive services (such as a Preferred Physician, Preferred Medical Laboratory, Preferred Outpatient Facility, Preferred Physician Assistant or Preferred Nurse Practitioner Provider) who has an agreement with Blue Cross Blue Shield of Alabama to furnish services or supplies to members entitled to benefits under the Preferred Care program.

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, lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Retired Employee: See explanation in the “Eligibility and Enrollment Section”.

Semi-Private Room Accommodations: A hospital room containing 2, 3 or 4 beds.

Special Care Unit: A specially equipped unit, set aside as a distinct patient care area, staffed and equipped to treat seriously ill patients requiring extraordinary care on a concentrated and continuous basis. Some examples are intensive care, coronary care, or burn care units.

State Employees' Insurance Board: The State agency charged with the administration of the LGHIP Program. This agency is also referred to as SEIB.

Subscriber: The individual whose application for coverage is made and accepted.

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider.

Total Disability: The complete inability of an active employee to perform any and every duty pertaining to his occupation or employment, or the complete inability of a retired employee or a dependent to perform the normal activities of a person of like age and sex.

Urgent-Care Center: A primary care provider that provides professional services by a licensed provider in a clinic setting, not requiring an appointment, and offering services outside traditional office hours.

Utilization Review Administrator: The company chosen by the State Employees' Insurance Board to administer your Utilization Review Program such as Preadmission Certification and Individual Case Management. The Utilization Review Administrator is BCBS.

Local Government Health Insurance Program
Benefit Plan Administered By:

State Employees' Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900

Phone: 334.263.8326
Toll-Free: 1.866.836.9137
Web site: www.alseib.org

Claims Administrator
& Utilization Management

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Customer Service: 1.800.321.4391
Rapid Response: 1.800.248.5123
Fraud Hot Line: 1.800.824.4391
Baby Yourself® Maternity Program: 1.800.551.2294
Case Management: 1.800.551.2294
Medical/Surgical Precertification: 1.800.551.2294
Web site: www.bcbsal.com

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