The State Employees' Health Insurance Plan

State of Alabama

Effective January 1, 2011

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

INTRODUCTION

This summary of health care benefits of the State Employees' Health Insurance Plan (SEHIP) 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 of Alabama (BCBS) 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 SEHIP and reserves the right to change the terms and conditions and/or end the SEHIP at any time and for any reason.

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ELIGIBILITY AND ENROLLMENT Chapter 1

Visit our web page at www.alseib.org to download forms.

Eligible Employees

The term "employee" includes only:

1. Full-time State employees and employees of County Health Departments, who are paid by the State Comptroller, the State Department of Mental Health, Historic Blakeley, Ft. Payne Improvement Authority, Historic Ironworks Commission, Bear Creek Development Authority, International Motor Sports Hall of Fame, Space and Rocket Center, the Sports Hall of Fame, the State Docks, St. Stephens Historical Commission, USS ALABAMA Battleship Commission, Red Mountain Greenway Commission and County Soil & Water Conservation Districts are to be eligible for coverage under this plan.

2. Part-time employees are eligible if they agree to have the required premium paid through payroll deduction.

3. Members of the Legislature and the Lieutenant Governor are eligible during their term of office (excluding optional and supplemental plans.

Exclusion: You are not eligible for coverage if the SEIB determines that you are classified as an employee employed on a seasonal, temporary, intermittent, emergency or contract basis.

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 SEHIP.)

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 on you 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 health 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 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:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the SEIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. 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.

In the event of the death of an active employee, who carried family coverage, the eligible dependents may continue coverage by making the appropriate premium payment to the SEIB. The SEIB must be notified within 90 days of the death.

Exclusion: You may not cover your wife, husband, or other dependents if they are independently covered as a State employee.

PCET's with ALDOT may remain dependents if their employment is part of their educational training.

Enrollment & Commencement

Employees and dependents can enroll and coverage commences as stated. The provisions on waiting periods for preexisting may apply to you (see "Waiting Periods for Preexisting Conditions").

Employee

New employees who do not decline coverage will be enrolled as of the effective date of employment, subject to SEIB Rules and Procedures. An SEIB enrollment form (IB2) must be completed by the employee and his/her employer and submitted to the SEIB.

Part-time employees may elect coverage to be effective on their date of employment, subject to appropriate premium payment, or on the first day of the month following first payroll deduction.

Dependents

Before dependents are added to family coverage, the SEIB must receive appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.).

New employees may elect to have dependent coverage begin on the date of their employment or no later than the first day of the second month following their hire date, subject to appropriate premium payments.

You may enroll for the dependent's benefits, subject to appropriate premium payments, within 60 days of acquiring a new dependent and the effective date of coverage will be the date of marriage, birth or adoption.

Payroll deduction for insurance is taken from the last paycheck of the month for the next month's coverage. A **direct payment** for dependent coverage premium must be submitted with the enrollment form for any coverage period before payroll deduction. The deduction from your payroll check or the deposit by the SEIB of your direct payment does not constitute acceptance of coverage.

Waiting Periods for Preexisting Conditions

Each member is subject to a waiting period of 270 consecutive days before benefits for "preexisting conditions" are available. The 270-day waiting period begins with the employee or dependent's effective date. To be entitled to benefits under the contract, the entire 270-day waiting period must be served before the member receives services or supplies or is admitted to the hospital for preexisting conditions. NOTE: The 270-day waiting period does not apply to pregnancy and children under age 19.

A "preexisting 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.

Credit for Prior Coverage (Health Insurance Portability & Accountability Act of 1996)

Under the Health Insurance Portability and Accountability Act of 1996 (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:

- There is no greater than a 63-day break in coverage, and
- The last coverage was ”creditable coverage“ 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).

Creditable Coverage

If your coverage or the coverage of your dependents ceases under the SEHIP or under COBRA, you or your dependents may request a copy of a Certificate of Creditable Coverage from Blue Cross. The certificate will show 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 Blue Cross Customer Service no later than 24 months after the date on which your coverage ceases.

Transfers

Transfers from any other health insurance plan (including those of BCBS) will be required to serve the 270-day waiting period less any ’creditable coverage’ as described above.

Open Enrollment

Open enrollment is available for:

- employees who have declined coverage and now wish to enroll in the SEHIP,
- employees who wish to change plans,
- part-time employees who wish to begin coverage,
- employees who wish to add dependent coverage or add a dependent to existing family coverage.

The waiting period for preexisting conditions shall not be waived during open enrollment without proof of prior coverage.

Special Enrollment

Alabama law now allows active full-time employees to decline coverage in the SEHIP. The Health Insurance Portability and Accountability Act of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for employees and eligible dependents if:

1. the employee declined to enroll in the SEHIP because of other employer group coverage and submitted a completed "Declination of Coverage"; and
2. the employee gains a new dependent through marriage, birth or adoption; or
3. the employee or dependent loses the other employer group coverage because:
   a. COBRA coverage (if elected) is exhausted, or
   b. loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
   c. employer stopped contribution to coverage; and,
4. the employee requests enrollment in the SEHIP in writing no later than 30 days after the loss of other coverage.

Enrollment in the SEHIP for Subscribers of the Supplemental Coverage Plan

Eligible employees who enroll in the State Employees' Supplemental Coverage Plan may reenroll in the SEHIP at any time during the year. Coverage will be effective no later than the first day of the following month upon approval by the SEIB.

Active Employees Over 65

Active employees and their dependents over age 65 are covered under the same conditions as any employee under age 65. The SEHIP is primary for services covered by Medicare.

Re-Employed State Retiree

To comply with the Medicare, Medicaid and SCHIP Expansion Act, SEIB has to verify that it is the primary payer for all employees covered by the SEHIP, including re-employed Medicare retirees. This applies to all re-employed State retirees with a FICA deduction.

All re-employed State retirees must submit a Re-employed State Retiree Health Insurance Form to the SEIB. If the employee and/or dependent are Medicare eligible, SEHIP will be the primary payer and premiums will be adjusted.

It is very important that you notify the SEIB when your employment ends so that the SEIB can change the coverage back to Medicare when applicable.

Notice

Notice of any enrollment changes is the responsibility of the employee (for example, status changes or address changes). Please visit our web page at www.alseib.org to download applicable forms.

Status Changes

A status change form should be completed for an addition or deletion of dependent coverage. The Status Change Form must be submitted directly to the SEIB by mail or by visiting our website at www.alseib.org.

Address Changes

To change an address, a written request may be submitted to the SEIB office at PO Box 304900, Montgomery, Alabama 36130-4900 or by visiting our web page at www.alseib.org.

Employee Name Changes

Name changes are processed electronically once they are changed on payroll with your agency.

PREMIUMS Chapter 2

As the Plan Administrator for SEHIP, the SEIB is responsible for establishing the monthly premiums for the various rate classes. These rate classes are defined as follows:

- active employee, single
- active employee, family
- non-Medicare retiree, single
- non-Medicare retiree, family
- Medicare retiree, single
- Medicare retiree, dependent
- non-Medicare retiree with Medicare dependent
- Medicare retiree with non-Medicare dependent(s).

The premiums for these rate classes change from year to year. Contact the SEIB or your insurance clerk to determine what the applicable premium is for each rate class.

New employees will have 60 days from date of hire to apply for the non-tobacco user discount. When a spouse is added, the 60-day period will also apply.

Non-Tobacco User Premium Discount

If you (and your spouse if covered as a dependent under SEHIP) have not used tobacco products in the last twelve months, you may be eligible for a premium discount. In order to obtain the discount you must submit a completed non-tobacco user premium discount application to the SEIB. You may also qualify for the discount if you submit acceptable documentation to the SEIB each year verifying that you (and your spouse if covered as a dependent under SEHIP):

- have completed an SEIB approved tobacco usage cessation program; or
- cannot stop using tobacco products as advised by your physician because it is unreasonably difficult due to a medical condition.

New employees will have 60 days from date of hire to apply for the non-tobacco user discount. When a spouse is added, the 60-day period will also apply.

Contact the SEIB or your insurance clerk about how to apply for the discount.

Wellness Premium Discount

All active employees are eligible for a wellness premium discount. Subject to the limitations listed below, each plan year every active employee must be screened either through the SEIB's worksite wellness screening or by a healthcare provider (through the submission of a physician's certification form) for the following health risk factors:

- Blood Pressure
- Total Cholesterol
- Glucose
- Body Mass Index

You will be deemed at risk for one or more of these health risk factors if your:

- Blood pressure systolic reading is equal to or above 160 or your diastolic readings is equal to or above 100,
- Cholesterol reading is equal to or above 250,
- Glucose reading is equal to or above 200,
- Body mass index is equal to or above 35.

Employees who are deemed at risk for any of the above health risk factors may be eligible for an office visit referral copay waiver.

In order to receive the wellness premium discount within a given plan year, employees have three options:

1. Submission of health risk factor readings through worksite wellness program, all of which are within the risk criteria. or
2. Submission of health risk factor readings through worksite wellness program where one or more of the health risk factors are outside the risk criteria and the employee:
   a. submits a statement from employee's healthcare provider stating that employee has been counseled regarding the health risk factor(s); or
   b. verifies participation in a Weight Watchers, YMCA or other SEIB approved program; or
   c. provides a subsequent health risk factor reading(s) that the SEIB deems to be an improvement over previous aberrant reading(s). or
3. Submission of a completed physician certification form.

Exception: An employee may also receive the wellness premium discount is if it is deemed that the employee cannot participate in the Wellness program due to pregnancy, disability or other infirmity as documented by the employee's physician.

The effective date of the wellness premium discount depends on when the screening results and/or other required documentation are submitted to the SEIB. However, in order for the wellness premium discount to be effective on January 1 (provided that the criteria listed above are met), you must be screened no later than November 30 of the preceding year.

New employees will have 60 days from date of hire to apply for the wellness premium discount.

Federal Poverty Level Discount

If your combined family income is less than or equal to 200% of the Federal Poverty Level as defined by the federal law, you may be eligible for a percentage discount off the approved premium. In order for employees and retirees enrolled in the SEHIP to qualify for the discount, acceptable proof of total family income must be submitted to the SEIB.

Family income will be determined based upon current income in conjunction with the prior year's federal and state income tax returns. As a condition of participating in the Federal Poverty Level Discount Program, applicants must authorize the Alabama Department of Revenue (or the appropriate agency of the applicant's state of residence) to release to the SEIB all of the applicant's tax related information in their records for the current and prior tax year.

The premium discount will be applied as follows:

Greater than 200% of the FPL – employee pays 100% of the employee contribution
Equal to or less than 200% of the FPL – employee contribution reduced 10%
Equal to or less than 175% of the FPL – employee contribution reduced 20%
Equal to or less than 150% of the FPL – employee contribution reduced 30%
Equal to or less than 125% of the FPL – employee contribution reduced 40%
Equal to or less than 100% of the FPL – employee contribution reduced 50%

Certification of income level will be effective for twelve months. Thereafter, re-certification will be made annually on the employee's or retiree's birthday.

Employees Retired after September 30, 2005 - Premium Based on Years of Service

If you retired after September 30, 2005, you will be subject to a sliding scale premium structure based on your years of State service. The premium for retiree coverage is broken down into the "State share" and

the “retiree share.” The dollar amount of these shares is subject to change each year. Contact the SEIB to obtain the current dollar amounts.

Under the sliding scale, the retiree will still be responsible for the “retiree share” of the premium, however, the amount the State will pay toward the “State share” of the premium will increase or decrease based upon a retiree’s years of State service. For those employees retiring with 25 years of State service, the State would pay 100% of the “State share” of the premium. Each year less than 25, the amount the State will pay toward the “State share” would be reduced by 2% and the “retiree share” will be increased accordingly. Each year over 25, the amount the State pays toward the “State share” would be increased by 2% and the retiree share reduced accordingly. NOTE: The retiree sliding scale discount does not apply to the tobacco user premium.

Years of creditable service are determined by the Retirement Systems of Alabama. Effective for all employees retiring after July 31, 2008, Act 2008-280 authorizes the SEIB to exclude from RSA’s years of creditable service calculation any service not related to service as a State employee (as defined in Section 36-29-1 Code of Alabama 1974) except for creditable service related to the following:

- service in the United States armed forces, or
- service as an employee as defined in Sections 16-25A-1 and 16-25A-11 Code of Alabama 1974, or
- service as an employee of a postsecondary institution eligible for PEEHIP coverage as a retiree.

TERMINATION OF COVERAGE Chapter 3

When Coverage Terminates

Coverage under the SEHIP will terminate:

1. On the last day of the month in which your employment terminates. The SEIB may continue your coverage if you are absent from work because of injury or sickness, or if you are absent from work due to leave of absence or temporary layoff, but only for a limited period. Premiums may be required from the employee by direct pay. For details, contact the SEIB.
2. On the last day of the month in which you decline coverage or opt out of the SEHIP.
3. When the SEHIP is discontinued.

Coverage under the SEHIP will also terminate for a dependent:

1. On the first day of the following month in which such person ceased to be an eligible dependent.
2. If the dependent becomes covered as an employee.
3. When premium payments cease for coverage of a deceased active or deceased retired employee.
4. When dependent premium payments cease.

When dependent coverage is terminated, it is your responsibility to notify the SEIB to discontinue payroll deductions. If deductions are still being made from your paycheck after the month of termination, this does not mean that your dependents have coverage. It is your responsibility to request a refund from SEIB.

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 & Medical Leave Act

The SEIB will follow the provisions of the Family and Medical Leave Act as approved by the appropriate authority.

Employees on Leave without Pay (LWOP)

State health insurance coverage for employees on official leave without pay may be continued for a maximum of 12 months provided the employee elects to make the premium payment required for coverage directly to the SEIB. Official leave without pay is established when an employee has received approval of the Personnel Department (for classified employees) or appointing authority, where applicable, to be taken off the payroll for an extended period.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA) Chapter 4

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 SEHIP 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 notice carefully.***

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the SEHIP 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 SEHIP is lost because of a qualifying event. Under the SEHIP, 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 SEHIP 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. 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 SEHIP 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 SEHIP 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 SEHIP 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 SEHIP 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 SEHIP to similarly situated employees or family members.

When Your Agency 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 agency 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:

- Divorce,
- 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 SEHIP 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.

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 SEHIP.

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 SEHIP 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,
  - Employee or former employee gets divorced or legally separated or
  - If dependent child loses eligibility as a "dependent child" under SEHIP.

For the extension to apply, the above listed events must have caused the spouse or dependent child to lose coverage under the SEHIP 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 SEIB. 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 45 days from your date of election. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

Termination of Continuation Coverage

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

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

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 at least 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 1.866.836.9737 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
COBRA Section
Post Office 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.

RETIREE ELIGIBILITY AND ENROLLMENT Chapter 5

Eligible Retired State Employee
A retired employee of the State who receives a monthly benefit from the Employees' Retirement System or Teachers' Retirement System of Alabama or Judicial Retirement System.

Eligible Dependent - (see page 3)

Enrollment/Continuation
A retiring employee may elect coverage under the SEHIP by agreeing to have the monthly premium amount (if applicable) deducted from his retirement check. A retiring employee must make a direct payment (if applicable) to the SEIB for the month in which retirement is effective.

If coverage is declined at the date of retirement, SEIB will provide the retiree with a Declination of Coverage Form that must be completed and returned to the SEIB in order to be eligible for Special Enrollment.

Open Enrollment
Retired employees who do not elect to continue their coverage under the SEHIP may do so during the annual open enrollment held each November for coverage to be effective January 1. Retirees may elect to add family coverage. Contact the SEIB for details.

The waiting period for preexisting conditions shall not be waived during open enrollment without proof of prior coverage.

Special Enrollment Period

The Health Insurance Portability and Accountability Act of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for retired employees and eligible dependents if:

1. the retired employee declined to enroll in the SEHIP because of other coverage and submitted a completed "Declination of Coverage;" and
2. the retiree gains a new dependent through marriage, birth or adoption; or
3. the retiree or dependent loses the other employer group coverage because:
   a. COBRA coverage (if elected) is exhausted, or
   b. loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment), or
   c. employer stopped contribution to coverage; and,
4. the retiree requests enrollment in the SEHIP in writing no later than 30 days after the loss of other coverage.

Enrollment in the SEHIP for Subscribers of the Supplemental Coverage Plan
Eligible Non-Medicare retirees who enroll in the State Employees' Supplemental Coverage Plan may reenroll in the SEHIP at any time during the year.

Survivor Enrollment
In the event of the death of a retired employee, who carried family coverage, the eligible dependents may continue coverage by making appropriate premium payments to the SEIB. The SEIB should be notified within 90 days of the date of death.

Re-Employed State Retiree

To comply with the Medicare, Medicaid and SCHIP Expansion Act, SEIB has to verify that it is the primary payer for all employees covered by the SEHIP, including re-employed Medicare retirees. This applies to all re-employed State retirees with a FICA deduction.

All re-employed State retirees must submit a Re-employed State Retiree Health Insurance Form to the SEIB. If the employee and/or dependent are Medicare eligible, SEHIP will be the primary payer and premiums will be adjusted.

It is very important that you notify the SEIB when your employment ends so that the SEIB can change the coverage back to Medicare when applicable.

Provisions for Medicare

The SEHIP remains primary for members until the member is entitled to Medicare. Health benefits will be modified when you or your dependent becomes entitled to Medicare.

A Medicare retiree and/or Medicare dependent should have both Medicare Parts A and B to have adequate coverage with the State of Alabama.

If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, he/she must notify the SEIB.

Retirees, who become eligible for retirement because they reach age 60, may enroll for health insurance because they are now receiving retirement.

NOTE: The SEHIP is not a supplement to Medicare.

Medicare Part B

Effective October 1, 2006, retirees who are eligible for Medicare primary coverage but do not have Medicare Part B will:

- Not receive State primary coverage for services that would have been covered by Medicare Part B if they are enrolled as a Medicare retiree. State primary coverage for these services will be "carved out" and the Medicare retiree will be responsible for the payment of these claims.

- Pay the SEHIP an amount equal to the Medicare Part B premium in addition to the regular non-Medicare premium if they are enrolled as a non-Medicare retiree. These retirees have until the next available Medicare enrollment period to enroll in Medicare Part B. As of the effective date, the retiree will be changed to Medicare primary for Medicare Part B services and the State coverage will become secondary.

Retiree dependents that do not have Medicare Part B will be treated similarly. If the additional premium equal to the Medicare Part B premium is not paid to the SEHIP, State primary coverage will be "carved out" for all benefits Medicare Part B would have paid and the retiree and his/her Medicare dependent will be responsible for the payment of these claims.

Medicare Part D Prescription Drug Coverage

The SEIB has determined that the prescription drug coverage offered by the SEHIP is, on average for all plan participants, expected to pay out at least as much as the standard Medicare prescription drug coverage will pay. Therefore, your coverage is considered **"creditable"** for purposes of Medicare Part D.

Because your existing coverage is creditable, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage. People who do not have creditable coverage, or who drop creditable coverage and do not enroll in Medicare Part D within 63 days, may have to pay a penalty each month in the form of higher premiums when they do enroll in Medicare Part D.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY: 1.800.325.0778).

For more detailed information about Medicare plans that offer prescription drug coverage, please refer to the "Medicare & You 2006" handbook, or its updated version. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number)
- Call 1.800.MEDICARE (1.800.633.4227) (TTY 1.877.486.2048)

If you elect to enroll in the Medicare Part D prescription drug coverage, you must notify the SEIB because **you cannot have SEHIP prescription drug coverage if you are enrolled for Medicare Part D prescription drug coverage.** (This will not affect your SEHIP secondary payer coverage for medical claims or dental coverage.)

Sliding Scale Premium Based on Years of Service

Years of creditable service are determined by the Retirement Systems of Alabama. Effective for all employees retiring after July 31, 2008, Act 2008-280 authorizes the SEIB to exclude from RSA's years of creditable service calculation any service not related to service as a state employee (as defined in Section 36-29-1 Code of Alabama 1974) except for creditable service related to the following:

- service in the United States armed forces, or
- service as an employee as defined in Sections 16-25A-1 and 16-25A-11 Code of Alabama 1974, or
- service as an employee of a postsecondary institution eligible for PEEHIP coverage as a retiree.

Employees Retired after September 30, 2005 - Premium Based on Years of Service

If you retired after September 30, 2005, you will be subject to a sliding scale premium structure based on your years of State service. The premium for retiree coverage is broken down into the "State share" and the "retiree share." The dollar amount of these shares is subject to change each year. Contact the SEIB to obtain the current dollar amounts.

Under the sliding scale, the retiree will still be responsible for the "retiree share" of the premium, however, the amount the State will pay toward the "State share" of the premium will increase or decrease based upon a retiree's years of State service. For those employees retiring with 25 years of State service, the State would pay 100% of the "State share" of the premium. Each year less than 25, the amount the State will pay toward the "State share" would be reduced by 2% and the "retiree share" will be increased accordingly. Each year over 25, the amount the State pays toward the "State share" would be increased by 2% and the retiree share reduced accordingly. NOTE: The retiree sliding scale discount does not apply to the tobacco user premium.

Years of creditable service are determined by the Retirement Systems of Alabama. Effective for all employees retiring after July 31, 2008, Act 2008-280 authorizes the SEIB to exclude from RSA's years of creditable service calculation any service not related to service as a State employee (as defined in Section 36-29-1 Code of Alabama 1974) except for creditable service related to the following:

- service in the United States armed forces, or
- service as an employee as defined in Sections 16-25A-1 and 16-25A-11 Code of Alabama 1974, or
- service as an employee of a postsecondary institution eligible for PEEHIP coverage as a retiree.

Certain Retirees Required to Enroll in Other Employer Health Insurance Coverage If:

1. you retired after September 30, 2005, and
2. you become employed by another employer and are eligible for your other employer's group health insurance coverage, and
3. your other employer provides at least 50 percent of the cost of single health insurance coverage, you will be required to use your other employer's health benefit plan for your primary coverage.

If you fall within the above requirements and fail to enroll in your other employer's group health plan, the SEIB will:

- terminate your coverage in the SEHIP and
- recall all claims back to the date you were eligible for your other employer's group health plan.

BENEFIT CONDITIONS Chapter 6

To qualify as plan benefits, medical or dental 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 (this condition does not apply to dental);
- BCBS must determine before, during, or after services and supplies are furnished that they are medically or dentally necessary. All inpatient hospital stays and some outpatient procedures must be reviewed for medical necessity.
- PPO and Preferred Dentist benefits must be furnished while you are covered by the SEHIP and the provider must be a PPO provider or a Preferred Dentist 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 SEHIP 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 that began before the SEHIP or your coverage ends.

INPATIENT HOSPITAL BENEFITS Chapter 7

Preadmission Certification and Post admission Review

BCBS provides all health management for SEIB members and covered dependents. To be eligible for inpatient hospital benefits, all inpatient hospital 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 to the hospital.

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.

To obtain pre-admission certification:

- You or your provider must telephone BCBS before the proposed elective 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.

- If BCBS is notified of your pregnancy before the end of your second trimester and you participate in the Maternity Management Program, Baby Yourself, the $200 hospital deductible and applicable daily copays will be waived. Additional information is provided in the Utilization Review Section, Maternity Management Program.

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 physician 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 pre-certification, 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 a review whether your condition was for a medical emergency.

Subject to your rights of appeal, if you do not obtain pre-admission 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 $200. 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 than 96 hours following a cesarean section, or require that a provider obtain authorization from the SEHIP 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 Caesarean 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

For each certified hospital admission, the deductible for inpatient hospital benefits is $200 (with a $25 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.

The attending physician and patient make treatment decisions. 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
- lungs
- liver
- cornea
- pancreas
- small bowel
- skin
- kidney
- bone marrow*
- heart-valve

* As used for the SEHIP, 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 BCBS 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.")

Transplantation 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.

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 SEHIP;
- for recipient or donor lodging, food or transportation costs;
- for donor and procurement services and costs incurred outside the United States.

OUTPATIENT FACILITY BENEFITS Chapter 8

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

- Payment of the hospital's charges to treat an accidental injury within 72 hours after the injury.
- Payment of the hospital's charges for surgery in its outpatient department **after you pay a $100 copayment.**
- Facility charges for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention) **after a $100 copayment between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday and a $50 copayment at any other time**. 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.
- Payment of the hospital's charges for hemodialysis in its outpatient department **after you pay a $25 copayment**. Services received in a free-standing dialysis center are only covered under Major Medical.
- Bariatric Surgical Procedures are limited to one per lifetime, subject to prior authorization by BCBS. Benefits for these services are provided only when a PPO provider performs the services. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.
- Chemotherapy and radiation therapy services in the treatment of malignant disease **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 $10 copayment per test.**
- X-ray services covered in full (except the procedures listed in the section entitled "Outpatient Diagnostic Procedures" that have a $75 copay).
- Surgery **after a $100 copayment per visit**.

Certain outpatient surgical/diagnostic procedures require pre-certification. Contact BCBS at 1.800.551.2294 before receiving the following services:

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

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

Payment of the facility charges to treat an accidental injury within 72 hours after the injury and outpatient surgery are also covered in a Participating Ambulatory Facility. Contact BCBS to find out if a facility is a Participating Ambulatory Surgical Facility.

Outpatient Hospital Benefits in a Non-Participating Hospital in Alabama

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

OUTPATIENT DIAGNOSTIC PROCEDURES Chapter 9

It is your responsibility to make sure pre-certification is obtained for certain outpatient/surgical diagnostic procedures. Failure to comply may result in reduced benefits. If you do not obtain pre-certification of an outpatient/surgical diagnostic procedure, BCBS 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**.**

The following outpatient diagnostic procedures are subject to a $75 copay per test, limited to two co-payments per date of service:

- angiography/ arteriography
- cardiac cath/arteriography
- CAT scan
- Colonoscopy
- ERCP
- MRI
- MUGA-gated cardiac scan
- SPECT
- thallium scan
- UGI endoscopy.

Inpatient Hospitalization
It is your responsibility to notify BCBS about all admissions. 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.

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 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.

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 $200 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.

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.

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).

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.
- 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 Blue Cross Blue Shield.

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
1.800.551.2294

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.

When you use a PPO Provider, you will receive enhanced benefits. 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 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, subject to the deductible.

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

Please be aware that Blue Cross will recognize not **all** providers participating in the BlueCard PPO Program 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 BCBS of the PPO Fee Amount Payable for the following services when rendered by the PPO Provider to you.

PPO is an option and to take advantage of PPO you simply choose a PPO Provider from the BlueCard PPO directory. Your provider 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.**

- **Surgical Care Services -** 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 provider who assists in performance of surgical procedures when medically necessary. Surgeries performed in the office are subject to a $35 copay.

  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 -** the administration of anesthetic drugs by injection or inhalation (but not by local infiltration). The anesthesia must be administered by a PPO Physician (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 -** services for childbirth, for care of a pregnancy ending in miscarriage, and for the usual care before and after those services.

- **Newborn Care Services -** services for the **initial** inpatient newborn well-baby examination.

- **Inpatient Medical Care Services -** 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.

- **Diagnostic X-ray -** services are covered in full (except the procedures listed in the section entitled "Outpatient Diagnostic Procedures" that have a $75 copay) both in and out of the hospital. This includes the professional component for the provider to read and interpret the results in order to diagnose the condition and also the actual procedure. These benefits do not include examinations rendered in connection with the care of teeth, research studies, screening, routine physical exams and check-ups, pre-marital exams, or routine procedures provided upon admission to a hospital or for fluoroscopy without films. This benefit applies if the provider's office where the services are rendered is a PPO Provider's office. Sometimes your PPO Provider may refer some services to another provider. In this situation, if the other provider is not a member of PPO, you will receive your regular Major Medical benefits for the services rendered by that provider.

- **Radiation Therapy and Chemotherapy Services** - radiation therapy and chemotherapy when provided by a PPO Provider for treatment of cancer.

- **Office Care Services** - 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 $35 Physician copay or a $20 Nurse Practitioner copay for each visit.** Allergy treatments are not covered as a PPO service. These services are covered under Major Medical, 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 $10 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 Physician Services** - care and treatment by a PPO Provider in hospital emergency rooms in an emergency other than for surgery or childbirth. **You must pay a $35 Physician copay or a $20 Nurse Practitioner copay for each visit.**

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
- negotiated price that the on-site Blue Cross and/or Blue Shield plan (“Host Plan”) passes on to the SEHIP.

Often this “negotiated price” will consist of a simple discount that 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.

ROUTINE PREVENTIVE CARE Chapter 12

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 2 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 a $35 Physician copay or a $20 Nurse Practitioner or Physician Assistant copay for each visit.** If you receive Routine Preventive Care services from a non-PPO physician, 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 are 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 -** 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 Smear,** one per calendar year. All pap smears (including routine) are subject to a $10 copay per test.

- **HPV Screening, for females,** ages 30 and older, one every three years, subject to a $10 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

- **Colonoscopy** one every ten years subject to $75 outpatient facility copay per test, not to exceed two per date of service.

- **Complete Blood Count (CBC),** one per calendar year, subject to a $10 copay

- **Total Cholesterol,** one per calendar year, beginning at age 18,subject to a $10 copay

- **Blood Glucose,** one per calendar year, beginning at age 18, subject to a $10 copay

Well Child Benefits, birth through age 5

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 $35 Physician copay or a $20 Participating Nurse Practitioner or Physician Assistant copay for each visit.**

The following routine lab and diagnostic tests will be covered at 100% after a $10 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

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 $35 Physician copay or a $20 Nurse Practitioner or Physician Assistant copay for each visit.**

The following routine lab and diagnostic tests will be covered at 100% after a $10 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 18.

MENTAL HEALTH & SUBSTANCE ABUSE PREFERRED PROVIDER ORGANIZATIONS Chapter 13

The SEHIP 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

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 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 SEIB Facility will be covered at 80% of fee schedule with no deductible. You are responsible for the 20% copayment.

To be eligible for inpatient facility benefits, all inpatient admissions and stays must be reviewed, approved, and certified by BCBS as medically necessary. The SEIB contracts with BCBS for Utilization Management. 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.

Non-approved Outpatient Providers - When you visit a non-approved 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 $100 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 non-approved Licensed Professional Counselor or Licensed Social Worker

Nonapproved Inpatient Providers - Inpatient psychiatric care and substance abuse treatment received at a non-approved hospital will be covered at 80% of fee schedule after a $100 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 Blue Cross Blue Shield website at: www.bcbsal.org

PARTICIPATING CHIROPRACTOR BENEFITS Chapter 14

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.

Participating Chiropractors may be required to pre-certify 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.

To take advantage of the program, you should choose a Participating Pharmacy and show your ID card to the pharmacist. The Participating Pharmacist will file all claims for you. There are no benefits available for prescriptions that are purchased at a non-participating pharmacy. There are no benefits available if you fail to show your ID card to the pharmacist.

In 2002, the Alabama Legislature enacted a law that requires a pharmacist to dispense a generic equivalent medication to fill a prescription for a member covered by SEHIP when one is available unless the physician indicates in longhand writing on the prescription "Medically Necessary" or "Dispense as Written" or "Do Not Substitute." The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent and contain the same active ingredient, or ingredients, and shall be of the same dosage, form and strength. Brand name drugs that are dispensed when there is a generic equivalent will process at the same rate as the generic. You will be responsible for the difference in cost.

Prior Approval

BCBS reserves the right to place limits on or require prior approval on certain medications.

Step Therapy

The step therapy program requires that you have prescription history for a "first-line" medication before your plan will cover a "second-line" drug. In most cases, the "first-line" medication is a generic alternative for that classification of drugs. A first-line drug is recognized as safe and effective in treating a specific medical condition, as well as being a cost-effective treatment option. A second-line drug is a less-preferred or potentially more costly treatment option.

If your doctor wants you to "skip" steps, your doctor must submit a prior authorization request and receive approval for the drug to be covered.

Participating Pharmacies - Copay Amounts

A Participating Pharmacy is any pharmacy that has contracted with BCBS for the furnishing of prescription drugs. Eligible prescriptions are legend drugs prescribed by a provider. A legend drug is a medical substance whose label is required by the Federal Food, Drug and Cosmetic Act to bear the legend "Caution: Federal Law prohibits dispensing without a prescription." Compound prescriptions are covered if at least one drug in the compound is a legend drug.

Eligible prescription drugs dispensed by a Participating Pharmacy will be covered as follows:

Active employees and Non-Medicare retirees

- 30-day supply (non-maintenance drugs)
  - Tier 1 - $10 copay per prescription
  - Tier 2 - 20% of the cost of the prescription with a minimum copay of $25 and a maximum copay of $40 per prescription
  - Tier 3 - 20% of the cost of the prescription with a minimum copay of $55 and a maximum copay of $105 per prescription
- 60-day supply (Maintenance Drugs) only available for Tiers 1 & 2

Medicare retirees

- 30-day supply (non-maintenance drugs)
    - Tier 1 - $5 copay per prescription
    - Tier 2 - maximum copay of $**25** per prescription
    - Tier 3 - maximum copay of $**55** per prescription
- 60-day supply (Maintenance Drugs) only available for Tiers 1 & 2

NOTE: All Medicare Part B-eligible prescription drugs and diabetic supplies are excluded from coverage.

The maximum amount of prescription drug copays each member is responsible for paying in a calendar year is $2500.

In order to receive a maintenance quantity, the drug must be on the BCBS approved drug lists. You may receive a copy of the Maintenance Drug List or the entire Drug List by calling Blue Cross Customer Service at 1.800.824.0435.

In order for a drug to be considered a Maintenance Drug, the drug must meet the all following Maintenance Drug Criteria:

1. The drug has low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic response over a course of prolonged therapy.

2. The drug's most common use is to treat a chronic disease state.

3. The drug is administered continuously rather than intermittently.

4. Excluded are dosage forms that are not practical for large dispensing quantities (such as liquids) and drugs known for life-threatening toxicity when taken as an intentional overdose.

5. The Drug is an SEIB Tier 1 or Tier 2 drug.

Coverage for Fertility Drugs

The copay for oral and injectable fertility drugs will be 50% of the allowable charge.

TOBACCO CESSATION PROGRAM Chapter 16

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

Chapter 17

Effective January 1, 2010, 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.

DISCOUNTED VISION CARE PROGRAM Chapter 18

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 state 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 the SEIB at www.alseib.org or contact the SEIB at 1.866.836.9737.

HEARING BENEFITS Chapter 19

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

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 Physicians benefits) is the first **$100 of covered Major Medical** expenses incurred by or for each member during each calendar year, with the following exceptions 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% of the PPO fee schedule for services covered under the PPO program. The annual out-of-pocket maximum per person each calendar year is **$400 plus the Major Medical deductible, charges exceeding the** allowed amount **or PPO amount and non-covered expenses.** Covered medical expenses are paid at 100% of the 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%.

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 amount) 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. See the definition of "allowed amount" for the description of how multiple surgical procedures are paid. (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 co-payment.)

- 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 and hydrotherapy of the type and duration prescribed by the attending provider and performed by a licensed physical therapist who is not related to you by blood or marriage and does not reside in your home.

- 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 BCBS to the closest hospital that could furnish the treatment needed for your condition. A provider must certify that the ambulance service was necessary, if BCBS 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 allowed purchase price. If you can buy it for less than you can rent it, or if it is not available for rent, BCBS will pay its reasonable and customary 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 (RN) or a licensed practical nurse (L.P.N.) if: the services actually require the professional skills of an RN or L.P.N.; are provided outside 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 certified through case management; call 1.800.551.2294.

- 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 that 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 procedures 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 BCBS 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 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 physician, the services are covered in full with no deductible up to the $3,000 annual maximum. A hospitalization related to TMJ must be precertified 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:
  1. The provider must send BCBS a completed Predetermination of Benefits Request Form three weeks prior to the surgery.
  2. BCBS will review the information and determine whether the surgery is appropriate and will inform the provider of their decision before the surgery.
  3. If surgery for TMJ disorders is not pre-approved using the above guidelines, there will be no benefits.

SUPPLEMENTAL ACCIDENT BENEFITS Chapter 21

Supplemental Accident Benefits are provided when a member suffers accidental bodily injury. Treatment, care and services for the injury must be provided within 90 days of the date of the accident, must be medically necessary, and must be rendered, ordered or prescribed by the member's physician. (The injury must occur after the effective date of this benefit.)

Benefits are provided up to a MAXIMUM OF $500 for care because of a single accident. These benefits pay ***after Major Medical*** benefits are paid. The Major Medical coinsurance and deductible (or any portion remaining) that you pay will be paid as a part of the $500 maximum. (However, this will not reduce your Major Medical deductible amount for future Major Medical covered medical expenses.)

Covered services under this Supplemental Accident rider include:

- $35 PPO provider or $20 Nurse Practitioner or Physician Assistant office visit copay.
- Services of a provider for medical care and treatment and for surgical operations and procedures.
- Outpatient services provided by a hospital.
- X-ray and laboratory examinations and diagnostic tests.
- Professional ambulance service to the nearest hospital able to provide necessary care, when certified as necessary by a physician.
- Pre-certified private duty nursing services of a licensed professional nurse or licensed practical nurse that is neither related to the member by blood or marriage nor regularly resides in the member's home (if such nursing care is medically necessary).
- Anesthetics, including supplies and use of equipment, and the administration of anesthetic drugs and agents.
- Oxygen and use of equipment for its administration.
- Treatment by a provider of injuries to natural teeth, including replacement of the injured teeth.
- Purchase or rental of durable medical equipment.

The following services are not covered under the Supplement Accident rider:

- PPO Services (except $35 PPO Physician or $20 Nurse Practitioner **or** Physician Assistant office visit copay)
- Eye refractions;
- Fitting or furnishing of eyeglasses;
- Inpatient expenses from a hospital (i.e., hospital deductible, copays, private room difference, non-covered services);
- Services or expenses from a Doctor of Chiropractic (DC);
- Prescription drugs and medicines
- 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.
- Orthodontics

MEDICAL EXCLUSIONS Chapter 22

BCBS 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 provided after the date your coverage ends, whether or not your hospitalization began or services were provided before 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 BCBS prior to outpatient surgery to find out 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 that 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 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 your coverage under this contract) under any laws of the United States or of any state or 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 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, which 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. Benefits are those 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.

- 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 of the allowed amount.

- 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 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 pre-certification and re-certification of the services by BCBS.

- Services, care, treatment, or supplies provided 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 or a Preferred Provider, or a Participating Nurse Practitioner or Physician Assistant 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 any provider recognized by the SEIB and/or BCBS.

- Travel, even if prescribed by your physician.

- 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 Provider and Prescription drug copayments

- Prescription drugs for erectile dysfunction.

- Anesthesia services or supplies, or both, by local Infiltration.

- Services provided through tele-consultation.

DENTAL BENEFITS Chapter 23

Dental coverage is a part of the health insurance coverage provided to employees, retirees and dependents and is only provided for the diagnosis and treatment of dental disease or illness.

Preferred Dental Program

When you use a Preferred Dentist, the dentist will file your claim and Blue Cross will pay the dentist based on the Preferred Dental Fee Schedule. The dentist will accept this payment as payment in full after any co-payments you owe. Your **50% copayment** for Basic and Major Services will be based on this amount, providing you with lower overall out-of-pocket expenses than in the past. You will continue to pay your **$25 annual deductible** for Basic and Major Services.

When you do not use a Preferred Dentist, you are responsible for paying the dentist and filing your own claims. Blue Cross will pay you directly based on the Preferred Dental Fee Schedule. You will owe the dentist any difference between the charge and the Fee Schedule amount.

Maximum Dental Benefits

Covered dental expenses are provided up to a maximum dollar amount of **$1,500 for each member** during each calendar year.

Dental Benefit Period

Your dental benefit period is the calendar year beginning January 1 and ending on December 31 of each year. Each enrolled member of the family has the same benefit period.

Dental Deductible

There is no deductible for diagnostic and preventive services. There is a **$25 deductible per person** each calendar year for Basic and Major Services. The maximum deductible is met when three family members have satisfied their deductibles during a benefit period.

Diagnostic and Preventive Expenses

Diagnostic and Preventive Expenses are payable at 100% of Preferred Dental Fee Schedule and include:

- Two routine oral examinations per benefit period. Examinations include but are not limited to case history, charting of existing restorations and defects, and mobility evaluation.
- Two cleanings of teeth per benefit period. Charges for this treatment performed by a licensed dental hygienist are also included if rendered under the supervision and guidance of a licensed dentist.
- Full mouth dental X-rays (once every 36 consecutive months); supplementary bitewing X-rays (twice per calendar year); and other dental X-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

Emergency Office Visits

Emergency palliative treatment (excluding any procedures covered under the health plan).

Sealants

A substance placed on the occlusal surface of permanent 1st molars (teeth #3, 14, 19, and 30) to prevent decay. This service is only covered when rendered to a member under age 19 and applies only to first molars.

Basic and Major Services

Payable at 50% of Preferred Dental Fee Schedule subject to $25 deductible per person each year, basic and major services include:

- Fillings of amalgam, silicate, acrylic, synthetic porcelain and composite fillings to restore diseased or accidentally broken teeth.

- General Anesthesia - covered when medically necessary and administered in connection with oral surgery.

- Oral Surgery - surgical procedures performed in or about the mouth that involve but are not limited to the incision and excision procedures for the correction of diseases, injury or preparation of the mouth for dentures. Dental surgery includes charges for removal of teeth.

- Periodontics - treatment of the gum and tissues supporting the teeth; management of periodontal disease; gingivectomy and gingivoplasty (removal of diseased gum tissue and reconstructing gums); osseous/surgery (removal of diseased bone); mucogingivoplastic surgery (reconstruction of gums and mucous membranes by surgery); and management of acute infection and oral lesions.

- Endodontics - treatment of disease of the dental pulp and the surrounding structures, including pulpotomy, direct pulp capping and root canal treatment.

- Prosthodontics (dentures, bridgework and crowns); initial installation of fixed bridgework including inlays, veneers and crowns to form abutments; initial installation of partial or full removal dentures including adjustments during the six-month period following installation; addition of a tooth or teeth to an existing partial removable denture or to bridgework; installation of a permanent full denture that replaces and is installed within 12 months of a temporary denture; repair or re-cementation of inlays, veneers, crowns, bridgework, dentures, or relining of dentures; the replacement of an existing partial denture, full removable denture, crown or fixed bridgework is covered providing the existing denture, crown or bridgework cannot be made serviceable and was installed at least five years before its replacement; however, should additional extractions require the replacement of dentures or bridgework, the five-year requirement is waived.

- Orthodontic benefits are provided for the initial and subsequent treatment and installation of orthodontic equipment for dependent children up to age 19. Benefits are provided at 50% of the allowable amount and are subject to a separate lifetime limit of $1,000 per member.

    — The need for orthodontic services must be diagnosed and a treatment plan submitted by the dentist. The diagnosis must indicate that the orthodontic condition consists of handicapping malocclusion that is abnormal and is correctable.
    BCBS reserves the right to review the member's dental records, including necessary X-rays, photographs, and models, to determine whether orthodontic needs and treatment are within the limitations and exclusions of the contract.
    — If orthodontic treatment is terminated for any reason before completion, benefits will not be paid after the date the treatment was terminated. If services are resumed, benefits will be resumed to the extent of the remaining maximums applicable to the individual.

— The benefit payment for orthodontic services shall be only for months that coverage is in force. Benefits are not provided for treatment received prior to commencement of coverage. Claims for a course of treatment that was started prior to commencement of coverage but completed while coverage is in force will be investigated to determine the amount of the entire fee that should be allocated to the treatment that was actually received while covered.
— Any charge for the replacement and/or repair of any appliance furnished under the treatment plan shall not be paid.

Treatment Plan

A Treatment Plan is necessary so that your dentist knows if certain dental treatments are covered benefits. Your dentist should file a Treatment Plan to BCBS for the following:

- veneers
- crowns (including inlays and outlays)
- bridges

The Treatment Plan should include the proposed fees, appropriate records and diagnostic X-rays or periodontal charting. BCBS will notify your dentist of their determination on the proposed treatment.

Pre-Determination of Benefits

To assure you and the dentist that the proposed dental treatment is covered by your dental plan, pre-determination of benefits is recommended. Before beginning a course of treatment for which dentists' charges are expected to be $500 or more, or for crowns, bridgework or osseous surgery, a description of the proposed course of treatment and charges to be made must be filed on a BCBS dental claim form (Attending Dentist's Statement). Verification is then made as to the availability of these benefits under the dental plan and you and the dentist are notified before treatment.

Dental Limitations

The following limitations will apply to all benefits available under the dental plan:

- Benefits for examination and diagnosis will be provided not more than twice during any benefit period.
- Benefits for full mouth X-rays will be provided once each 36 months. Benefits for supplementary bitewings will be provided upon request but not more than twice during any benefit period.
- Benefits for routine prophylaxis cleaning will be provided not more than twice during any benefit period.
- Benefits for space maintainers (not made of precious metals) that replace prematurely lost teeth are available only for members under age 19.
- Fluoride or sealant treatment will be provided to eligible members under the age of 19 but not more than twice during any benefit period.
- Orthodontic treatment will be provided to eligible dependent children 19 and under only.
- In the event a member transfers from the care of one dentist to that of another during the course of treatment, or if more than one dentist provides services for one procedure, the SEHIP shall not pay more than the amount it would have paid had one dentist rendered the services.
- In all cases where there is more than one means of treatment and each option is a plan benefit, the SEHIP will provide benefits for the less costly procedure. The dentist may charge the patient for any services provided in excess of the benefits provided by the SEHIP.
- Administration of Nitrous Oxide is limited to a maximum allowable of $21 per visit for SEHIP dependents under the age of 12.

DENTAL EXCLUSIONS Chapter 24

No benefits shall be provided under the dental plan for the following:

- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, trustee or similar person or group.
- Dental services for which the member incurs no charge.
- Dental services for which coverage is available to the member, in whole or in part, under any Worker's Compensation Law or similar legislation whether or not the member claims compensation or receives benefits there under.
- Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
- Dental services provided or available to a member in whole or in part under the laws of the United States, or any state, or political subdivision thereof, or for which the member would have no legal obligation to pay in the absence of this or any similar coverage.
- Charges for dental care or treatment by a person other than a dentist unless the treatment is rendered under the direct supervision of a dentist.
- Gold foil restorations.
- Charges for failure to keep a scheduled visit with the dentist.
- Dental services or supplies that are not necessary, according to accepted standards of dental practice, or that do not meet accepted standards of dental practice, or that are not recommended by the attending dentist, or that are experimental in nature.
- Charges for sealants for members over age 19 and for oral hygiene and dietary information.
- Charges for sealants to occlusal surfaces of permanent teeth (other than second molars #2, 15, 18, and 31).
- Charges for plaque control program.
- Charges for implantology including but not limited to endosseous, transosseus and subperiosteal implants.
- Anesthetic services performed by and billed for by a dentist other than the attending dentist or his assistant.
- Dental services rendered or provided to the member prior to such member's effective date of overage, or subsequent to the effective date of such member's termination.
- Dental care or treatment not specifically identified as a covered dental expense.
- Appliances or restorations to alter vertical dimensions from its present state or restoring the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth

rehabilitation, restoration of tooth structure lost from the grinding of teeth or the wearing down of the teeth and restoration for mal-alignment of the teeth. This exclusion does not apply to services covered under orthodontic services.

- Service or expenses of any kind covered by Medicare.

- Services rendered or provided in any setting other than the dentist's office. Such settings include, but are not limited to, ambulatory surgical facility, outpatient department of a hospital, a hospital or any other type of facility.

- Services, care or treatment that BCBS determines not to have been medically necessary.

- Services or expenses of a dentist rendered to a member who is related to the dentist by blood or marriage or who regularly resides in the dentist's household.

- Services or expenses for intraoral delivery of or treatment by chemotherapeutic agents.

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 SEHIP'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: BCBS and other business associates of the SEHIP, have an agreement with the SEHIP 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 SEHIP, you agree that the SEHIP, and its business associates, may obtain, use, and release all records about you and your minor dependents needed to administer the SEHIP 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 SEHIP.

Use and Disclosure of Your Personal Health Information: Blue Cross Blue Shield of Alabama and other business associates of the SEHIP, have an agreement with the SEHIP 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 SEHIP, you agree that the SEHIP, and its business associates, may obtain, use, and release all records about you and your minor dependents needed to administer the SEHIP 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 SEHIP.

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

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 which 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. And you authorize BCBS to use and release to other persons or organizations 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 the 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 Provisions

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 Amount

When benefits for provider services are based on the allowed amount, the amounts of benefit payments are determined and made by BCBS upon consideration of the factors described in the definition of the Allowed Amount (see Glossary). If a provider charges you more than the amount of 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

The SEIB may amend any or all of the provisions of the SEHIP 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 SEHIP, make any agreement or promise, not specifically contained in the SEHIP, or waive any provision of the SEHIP.

Notice of Grandfather Status

The SEIB believes that the SEHIP 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 SEHIP 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 SEHIP 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 BENEFITS Chapter 26

Coordination of 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 that 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 an 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 SEHIP 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 SEHIP 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 SEHIP 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 SEHIP.

SUBROGATION Chapter 27

Right of Subrogation

If BCBS pays or provides any benefits for you under the SEHIP, 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 or dental 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 attorney's 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 SEHIP.

FILING A CLAIM, CLAIM DECISIONS & APPEAL OF BENEFIT DENIAL Chapter 28

The following explains the rules under SEHIP for filing claims and appeals with Blue Cross and for filing voluntary appeals with the SEIB. The procedures relating to BCBS's 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 Blue Cross must be received by Blue Cross 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 pre-certification of nursing services) that must be approved by BCBS in advance before they will be recognized as benefits. No communications with Blue Cross 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 Blue Cross 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 Blue Cross 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

Blue Cross' 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. Blue Cross 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, Blue Cross 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 SEHIP 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 directly to: BCBS of Alabama, 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) 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	Type of service	Contract number
Charge for each service	Name and address of provider	Diagnosis
Date of service	Date of accident (if applicable)	

Send the claim to: BCBS 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) are available from any BCBS office.

Dental Claims

Your dental plan includes a provision for pre-determination of benefits for bridgework, crowns, onlays and inlays and osseous surgery. The purpose of pre-determination of benefits is to assure you and the dentist that the proposed dental treatment is covered by your dental plan. If a patient expects to incur charges for one of the services listed above or for periodontic or prosthetic services (excluding full and partial dentures) in excess of $500, a Request for Pre-Determination of Benefits should be filed by the dentist on a dental claim form. The treatment plan along with pre-operative radiographs should be submitted to BCBS.

Include the findings of the oral examination, recommended course of treatment, and other information to identify the services to be rendered. Verification is then made as to the availability of these benefits under the dental plan and you and the dentist are notified in advance of treatment.

Preferred Dentists will file your dental claims when dental work is completed. Preferred Dentists are provided claim forms by BCBS to use in filing your claims.

However, if your dentist is not a Preferred Dentist, you may have to file the claim yourself by completing a dental claim form. Send the completed form to BCBS, Attention: Dental Claims Department. Be sure to have your dentist complete his portion of the form and sign the claim.

Blue Cross Preferred Care Benefits

One of the greatest advantages of visiting a PPO Provider, Preferred Dentist or PPO Facility is that you are relieved of any claim filing. PPO Providers agree to handle all claim filing procedures for you. All Participating Pharmacies will also file your claims 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 SEHIP can be post-service, pre-service, or concurrent. Claims for dental benefits are always post-service. 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 Blue Cross Customer Service Department. You can also go to the BCBS Internet web site at www.bcbsal.org 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 Blue Cross Health Management Department at 205.988.2245 (in Birmingham) or 1.800.248.2342 (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 BCBS 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 1.800.248.2342 (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 the 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:

1.800.824.0435

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 provider.

BCBS also has a special 24 hour-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:

- PPO Directories
- Brochures
- Claim forms
- Benefit Booklets
- Replacement ID cards
- Duplicate Claims Reports

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 is developed for this purpose. The form will help you provide BCBS 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 web site at www.bcbsal.org. 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 Blue Cross without following the rules just described for filing an appeal, Blue Cross will not treat your inquiry as an appeal. Blue Cross will, of course, 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 1.800.248.2342
- 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 the appropriate address listed below:

Blue Cross Blue Shield of Alabama
Attention: Health Management – Appeals
PO 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

Blue Cross 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 Chapter 29

General Information

Members of the State Employees' Health and Dental Plan have a right to question the decisions of the 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 administrator and/or the utilization review administrator, BCBS.

Informal Review

If you still feel that an enrollment or eligibility ruling was not appropriate or that the SEHIP's benefits were incorrectly applied (after exhausting the Administrative process with the Claims Administrator or the Utilization Review Administrator), 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. Should you still feel that the enrollment or eligibility ruling was not appropriate or that the SEHIP's benefits were not properly applied, you may file a request for an Administrative Review.

All requests for Administrative Review must be submitted on Form IB5. Forms are available through the SEIB office. Receipt of your Administrative Review will be acknowledged by returning a copy of the received form to you. Oral arguments will not be considered once the Administrative Review process has begun unless approved by the SEIB.

Administrative Review

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 and/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. 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.

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

Allowable Amount: The lesser of the fee for a procedure in the Preferred Dentist Fee Schedule or the amount charged by a dentist who is licensed to practice in Alabama. If services are provided by a dentist who is not licensed to practice in Alabama, the Allowable Amount is the amount of a dentist's charge that BCBS will recognize as covered expenses for medically/dentally necessary services provided by this plan.

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:** BCBS 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 Plan 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 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 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. This program is also known as "Comprehensive Managed Care" and "Individual Case Management," and 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.

Baby Yourself: A maternity management program administered by BCBS that offers a mechanism for identifying high-risk pregnancies and completely managing them to prevent complications at the time of delivery.

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: Company chosen by the SEIB, through competitive bid, to process benefit claims filed by members (also referred to as BCBS).

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 SEHIP.

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 SEIB, 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.

Covered Dental Benefits: The amount of benefits paid to or for you for dental services by a dentist that you incur while covered under this plan.

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.

Dentist: One of the following when licensed and when acting within the scope of his license at the time and place where the service is rendered: Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.).

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 SEIB 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 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 Blue Cross Plan 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 Blue Cross 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 Blue Shield Association.

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/Dental Necessity: Services or supplies that are necessary to treat your illness, injury, or symptom. To be medically or dentally necessary, services or supplies must be determined by BCBS to be:

- appropriate and necessary for the symptoms, diagnosis, or treatment of your medical or dental condition;
- provided for the diagnosis or direct care and treatment of your medical or dental condition;
- in accordance with standards of direct care and treatment of your medical or dental condition;
- in accordance with standards of good medical or dental practice accepted by the organized medical and dental 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 or dentally 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 State Employee or eligible dependent who has coverage under the SEHIP and whose application for coverage under the contract is made and accepted by the SEIB. A member also is a former dependent and/or employee eligible for and covered under COBRA.

Mental Health Preferred Provider Organization: Those providers who are contracted with BCBS’s Blue Choice Network and Certified Community Mental Health Centers (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 that is not a BCBS Participating Pharmacy.

Non-Preferred Dentist: A dentist licensed to practice dentistry in Alabama who is not a BCBS Preferred Dentist.

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.

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. During this time you may choose between the insurance carriers available and/or change from single to family coverage. If you make a change during the open enrollment period, waiting periods for preexisting conditions will not be waived.

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

Participating Chiropractor: A Doctor of Chiropractic who 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 BCBS has a contract for providing pharmacy services.

Participating Renal Dialysis Facility: Any free-standing hemodialysis facility with which BCBS 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.

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.

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.

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 BCBS to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical, surgical and dental procedures, such services and supplies to members entitled to benefits under the Preferred Care program.

PPO Fee Schedule: 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.

Preferred Dental Fee Amount Payable: Amount that will be paid to a Preferred Dentist. It is the fee for a procedure listed in the Preferred Dental Fee Schedule or the amount of the Preferred Dentist's charge, whichever is less.

Preferred Dental Fee Schedule: Schedule of dental procedures and the fee amounts for those procedures under the Preferred Dental Program.

Preferred Dentist: A dentist who has an agreement with BCBS to provide dental services to members entitled to benefits under the Preferred Dental 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 Dentist, Preferred Medical Laboratory, Preferred Outpatient Facility, or Preferred Nurse Practitioner or Physician Assistant Provider) who has an agreement with BCBS to furnish services or supplies to members entitled to benefits under the Preferred Care program.

Pregnancy: 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.

Prescription Drug Tiers: Tier 1: SEIB Generic; Tier 2: SEIB Preferred; Tier 3: SEIB Non-Preferred

Retired Employee: Former employee who receives a monthly benefit check from the State of Alabama.

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

State Employees' Insurance Board (SEIB): The State agency charged with the administration of a health benefit plan for state employees and their dependents. This agency is also referred to as SEIB.

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

Tele-consultation: 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: 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: Company chosen by the SEIB to administer your Utilization Review Program such as Preadmission Certification and Individual Case Management. The Utilization Review Administrator is BCBS.

STATE EMPLOYEES' INSURANCE BOARD
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: 334.263.8341
Toll Free: 1.866.836.9737
Website: **www.alseib.org**

Claims Administrator
Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244
Customer Service: 1.800.824.0435
Rapid Response: 1.800.248.5123
Fraud Hot Line: 1.800.824.4391
Website: **www.bcbsal.com**

Utilization Management
Precertification: 1.800.551.2294
Case Management: 1.800.551.2294
24-Hour Nurse Line: 1.800.551.2294

Group Number 13000
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