# SEIB

## Optional Insurance Plan

**Dental** | **Cancer** | **Hospital Indemnity** | **Vision**

January 1, 2017

*Administered by*

# Southland Benefit Solutions, LLC

PO Box 1250 • Tuscaloosa, Alabama 35403 • Telephone 866-327-6674
www.southlandseib.com

**Discrimination is Against the Law**

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

The SEIB:

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

If you need these services, contact 1-866-698-7428.

If you believe that the SEIB has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Section 1557 Coordinator, 201 South Union Street, Montgomery, Alabama, 36104; Direct: (334) 263-8413; Fax (334) 263-8711; Email: 1557Grievance@alseib.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

# Multi-Language Interpreter Services

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-698-7428.

**Korean**: 주의 :만약 당신이 말하는 스페인어 ,당신은 당신의 처리 무료 언어 지원 서비스에 있다 . 전화는 1-866-698-7428.

**Chinese**: 注意： 如果讲西班牙语，有免费的援助语言及其处置服务。调用 1-866-698-7428.

**Vietnamese:** Chú ý: Nếu bạn nói tiếng Tây Ban Nha, bạn có lúc xử lý ngôn ngữ miễn phí dịch vụ hỗ trợ của bạn. Gọi đến 1-866-698-7428.

**Arabic**: ـى الـدعوة .اللغويـــة بالمســـاعدة خـدماتها من التخلـــص وفـــي ،الإســـبانية يتحـــدث كـان إذا :تنبيـــــه
1-866-698-7428.

**German:** Achtung: Wenn Sie Spanisch sprechen, müssen Sie Ihre kostenlose Hilfe Serviceleistungen zur Verfügung. Aufruf an die 1-866-698-7428.

**French:** ATTENTION : Si vous parlez espagnol, vous avez à votre disposition linguistique gratuite assistance services. Appel à la 1-866-698-7428.

**Gujarati:** ચુના: જો તમે જરાતી બોલતા હો, તો િ ન:લ્ક ુભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-866-698-7428.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-698-7428.

**Hindi:** ध्यान दें: यिद स्पेनिश बोलते हैं, अपने निपटान पर सेवाओं की भाषाई सहायता नि: शुल्क है। कॉल 1-866-698-7428.

**Laotian:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວ ້າພາສາ ລາວ, ານ ໍບລິການຊ່ວຍເຫ ຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-698-7428.

**Russian:** ВНИМАНИЕ: Если вы говорите на испанском языке, вы имеете в вашем распоряжении бесплатные помощи услуги. Вызовите 1-866-698-7428.

**Portuguese:** Atenção: Se fala espanhol, tem em seus serviços de eliminação de assistência linguística. Ligue para o 1-866-698-7428.

**Turkish:** Dikkat: İspanyolca, elden çıkarma ücretsiz dil yardım hizmetlerinde varsa. Aramak için 1-866-698-7428.

**Japanese:** 注意: あなたがスペイン語を話す場合、あなたはあなたの処分無料言語アシスタンスサービスであります。1-866-698-7428.

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**STATE EMPLOYEES' INSURANCE BOARD**
**201 South Union Street, Suite 200**
**PO Box 304900**
**Montgomery, Alabama 36130-4900**
**Phone: (334) 263-8341**
**Toll Free: 1-866-836-9737**
**www.alseib.org**

## Introduction

This summary of health care benefits available to you through the State Employees' Insurance Board Optional Insurance Plan (Optional Plan) is designed to help you understand your coverage. 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 SEIB and Southland Benefit Solutions (Southland). The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the plan and reserves the right to change the terms and conditions and/or end the plan at any time and for any reason.

Participation in this plan is completely voluntary, based on elections you make for yourself and your dependents in the time and manner described below.

The Optional Plan offers a package of four plans of insurance, including dental, cancer, hospital indemnity, vision. They are administered by Southland Benefit Solutions (Southland) at no cost to the employee.

The plan year begins on January 1 and runs through December 31.

**THE INFORMATION IN THIS BOOKLET IS NOT A SUBSTITUTE FOR THE LAW. IF A DIFFERENCE OF INTERPRETATION OCCURS, THE LAW GOVERNS. THE LAW MAY CHANGE AT ANY TIME ALTERING INFORMATION IN THIS HANDBOOK. THE STATE EMPLOYEES' INSURANCE BOARD RESERVES THE RIGHT TO CHANGE BENEFITS DURING THE PLAN YEAR.**

## Eligibility and Enrollment Requirements

### Eligible Employees

The term employee includes only: 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 Alabama 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.

**Exclusion:** You are not eligible for coverage if you are classified on the State of Alabama's records as an employee employed on a part-time, seasonal, temporary, intermittent, emergency or contract basis unless you receive a W-2 and work an average of 30 hours per week, or 130 hours per month during a designated measurement period as stipulated under the Affordable Care Act.
Primary coverage cannot be with the State Employees Health Insurance Plan, TRICARE, Medicaid or Medicare.

### Eligible Retired State Employee

A retired employee with at least 10 years of service to the state who receives a monthly benefit from the Employees' Retirement System or Teachers' Retirement System of Alabama or Judicial Retirement Fund.

### Eligible Dependents

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, or
   c. your stepchild;

3. Your grandchild, niece, or nephew:
   a. under 19 years of age, and
   b. for whom the court has granted custody to you or your spouse;

4. An incapacitated dependent over age 25 will be considered for coverage provided the 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 submitted 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 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 contributing 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 spouse or other dependents, if they are independently covered as a state employee.

Professional civil engineer trainees with ALDOT may remain dependents if their employment is part of their educational training.

**Enrollment of Employee or Retiree**
An eligible employee or retiree may enroll at any time by submitting an enrollment form directly to the SEIB (not through your payroll clerk) declining coverage in the SEHIP and electing coverage in the Optional Plan. Once the form has been approved by the SEIB, coverage in the SEHIP will terminate as of the last day of the month during which the enrollment form was received and coverage in the Optional Plan will begin as of the first day of the following month.

Employees or retirees may enroll for either individual or family coverage. Members enrolled for family coverage cannot change to single coverage outside of the open enrollment period unless all dependent(s) become ineligible due to age, death or divorce.

Participants must remain in the Optional Plan for at least 12 months. If enrollment is effective on any day other than January 1, coverage will remain in effect through the end of the next full plan year.

A state employee may not be added as a dependent under another employee's SEHIP coverage regardless of whether he or she has declined coverage in the SEHIP.

**Enrollment of Dependents**
Participating employees must enroll their eligible dependents under this plan by filing a completed enrollment form directly with the SEIB.

If the employee does not have a dependent at the time of coverage, the employee must enroll for the dependents' benefits within 60 days of acquiring a new dependent. If an enrollment form is submitted to the SEIB and approved within 60 days following the date of marriage, birth, adoption, etc., the effective date will be the date of the coverage event.

If the employee has dependent coverage, the employee must enroll a new dependent(s) before any claims can be paid for the new dependent.

**Open Enrollment Back into the SEHIP**
After a participant has been in the Optional Plan for the time period required under the SEIB rules and procedures, he or she may terminate coverage in the Optional Plan and re-enroll in the SEHIP during the SEHIP's open enrollment period.

**Special Enrollment in the Optional Plan or Back into the SEHIP**
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for eligible employees and retirees and their eligible dependents if:

1. The employee or retiree declined to enroll in the SEHIP because of other coverage; and

2. The employee or retiree gains a new dependent through marriage, birth or adoption; or

3. The employee or retiree loses the other 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 or retiree submits the enrollment request to the SEHIP in writing no later than 30 days after the loss of other coverage.

**Change of Benefits**
The benefits in effect at the date of admission into the hospital or other covered health care facility of the employee or the employee's dependent will be the benefits payable until the date of discharge from the hospital or covered health care facility even though benefits under this program are changed during such confinement.

**Insurance Commences**
Insurance commences no later than the first day of the second month following receipt and approval of the enrollment application by the SEIB.

## General Provisions

**Privacy of Your Protected Health Information**

The confidentiality of your personal health information is important to the SEIB. Under 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. This section of this booklet explains some of HIPAA's requirements. Additional, information is contained in the Optional Plan Notice of Privacy Practices. You may request a copy of this notice by contacting the SEIB.

**Use and Disclosure of Your Personal Health Information**

Southland, and other business associates of the SEIB, has an agreement with the SEIB 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 Optional Plan, you agree that the Optional Plan, and its business associates, may obtain, use, and release all records about you and your minor dependents needed to administer the Optional Plan 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 plan. If you or any provider refuses to provide records, information or evidence we request within reason, we may deny your benefit payments. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law.

The privacy provisions of HIPAA 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 visiting www.alseib.org, or you can request a copy by writing to us at:

**State Employees' Insurance Board**
**Attn: Privacy Officer**
**PO Box 304900**
**Montgomery, AL 36130-4900**

**Disclosures of Protected Health Information to the Plan Sponsor**

In order for your benefits to be properly administered, the Optional Plan needs to share your protected health information with the plan sponsor (the state of Alabama). Following are circumstances under which the Optional Plan may disclose your protected health information to the plan sponsor:

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

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

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the Optional Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.

- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.

- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.

- The plan sponsor will promptly report to the Optional Plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.

- The plan sponsor will allow you or the Optional Plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the Optional Plan must follow in this regard. There are some exceptions.

- The plan sponsor will amend, or allow the Optional Plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.

- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years. You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.

- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the Optional Plan and to the U.S. Department of Health and Human Services, or its designee.

- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the Optional Plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the Optional Plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

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

- Benefits Administration and Operations
- Legal
- Finance

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

**Security of Your Personal Health Information**
Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

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

- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

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

**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 Southland finds at a later date that the payments were incorrect, you or the provider will be required to repay any overpayment or Southland may deduct the amount of the overpayment from any future payment to you or the provider. If Southland does this, they will notify you.

**Responsibility for Actions of Providers of Services**
Southland 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. Southland and the 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. Southland and the 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 this plan will make your coverage invalid as of your effective date, and in that case Southland and the SEIB will not be obligated to return any portion of any fees paid by or for you.

**Obtaining, Use and Release of Information**
By submitting your application for coverage or any claims for benefits you authorize Southland 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 Southland any such records or information it requests. Further, you authorize Southland to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither Southland 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 Southland.

- 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 Southland 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 Southland requests.

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

**Applicable State Law**
This Plan is administered in the state of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

**I.D. Card**
An identification card will be provided by Southland.

**Claim Forms**
Claim forms may be obtained from Southland (www.SouthlandSEIB.com) and may also be downloaded from the SEIB website at www.alseib.org.

**Claims Administrator**
The claims administrator for the Optional Plan is:

**Southland Benefit Solutions**
**PO Box 1250**
**Tuscaloosa, Alabama 35403**
**1-866-327-6674**

**Payment and Claim Filing Limitation**
All claims must be submitted in writing and such writing must be received by Southland **no later than 365 days** following the date covered expenses are incurred. If a claim is not submitted and received by Southland within this period, the claim for that benefit will not be paid.

Claim forms must be completed, with proper documentation and certification from the health care provider, upon submission. Failure to provide a completed claim form may cause delays in claims processing and may be cause for the denial of the claim.

Claim forms resubmitted in an effort to obtain coverage not normally provided will not be accepted and will be denied.

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

**Termination of Coverages**
Coverage remains in effect through the last day of the month in which employment terminates.

Coverage will be terminated in accordance with applicable federal and state laws and regulations. Please see the section “Continuation of Coverage” in this brochure which outlines your rights under the Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8].

**Incorrect Benefit Payments**
Every effort is made to promptly and correctly process claims. If payments are made to you in error, or to a provider who furnished services or supplies to you, and Southland later determines that an error has been made, you or the provider will be required to repay any overpayment. If repayment is not made, Southland may deduct the amount of the overpayment from any future payment to you or the provider. If this action is taken, Southland will notify you in writing.

**Fraudulent Claims**
Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. In addition to any disciplinary action already in place, any employee or retiree knowingly and willfully submitting false information to the SEIB will be required to repay all claims and other expenses incurred by the Optional Plan related to the false or misleading information, plus interest.

**Coordination of Benefits**
There is no coordination of benefits for the hospital indemnity and the cancer plans. There is coordination of benefits for the dental and vision plans. Specifically, dental and vision plan benefits will be secondary to all other coverages available to any claimant. The total amount that is payable under all plans will not be more than 100% of the maximum allowable expenses.

**Customer Service**
If you have questions about your coverage, or need additional information about how to file claims, you should contact Southland. Southland Customer Service, located in Tuscaloosa, is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is 1-866-327-6674.

**Southland Appeal Process**
In the event payment of a claim is denied by Southland and the insured is of the opinion such denial was improper, the insured has the right of appeal. The appeal procedure is as follows:

1. To appeal, the insured must submit a request for review, in writing, to Southland within 60 days from the date any writing is received by the insured from Southland denying payment of a claim. This request must contain the specific reasons the insured contends claim denial was improper. Within the same time period, insured may submit any other evidence which insured contends supports his or her position.

2. Southland will review the claim; any written requests or other evidence received from the insured and advise the insured of its final determination.

3. If the insured is still of the opinion that claim denial is improper, insured may obtain a judicial review of Southland's decision by the Circuit Court of Montgomery, Alabama.

**SEIB Appeal Process**

**General Information**
Members of the Optional Plan have a right to question the decisions of the SEIB. However, all issues regarding benefit determinations should be addressed through the Southland appeal process. Issues involving eligibility and enrollment should be addressed directly with the SEIB.

**Informal Review**
If you feel that an enrollment or eligibility ruling was not appropriate or that the Plan's benefits were incorrectly applied (after exhausting the administrative process with the claims administrator), you may 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 Plan'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 in an administrative review process unless approved by the SEIB.

**Administrative Review**

An administrative review request must be submitted to the SEIB office within 60 days following receipt of the final notice of a partial or total denial of your claim from Southland or within 60 days of the receipt of any determination of the SEIB. A copy of the decision of Southland or the SEIB 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 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 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 request for a formal appeal before the Board of Directors. Requests for a formal appeal must be submitted to the SEIB office within 60 days following the date of the administrative review's 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.**

If your request for a formal appeal is granted, generally, a decision will be issued within 90 days following approval of the request for formal appeal. 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:

- 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.

## Continuation of Group Health Coverage (COBRA)

### Introduction

The Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8] requires that the SEIB offer covered employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where coverage under the plan would otherwise end. COBRA coverage can be particularly important because it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it.

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 Optional Plan 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 Optional Plan is lost because of a qualifying event. Under the Optional Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

### Who is a Qualified Beneficiary?

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 Optional Plan 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.

### COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the Optional Plan 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.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time.

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 buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform the SEIB that you do not intend to return to work, whichever occurs first.

### COBRA Rights for a Covered Spouse and Dependent Children

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the Optional Plan 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 Optional Plan 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 Optional Plan as a dependent child.

**What Coverage is Available?**
If you choose COBRA 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 plan to similarly situated employees or family members.

**When is COBRA Coverage Available?**
COBRA continuation coverage will be offered to qualified beneficiaries only after the SEIB has been notified that a qualifying event has occurred.

**When Should Your Agency Notify the SEIB?**
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 Should You 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 Optional Plan 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.

**How is COBRA Coverage Provided?**
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.

After the SEIB receives timely notice that a qualifying event has occurred, the SEIB will (1) notify you that you have the option to buy COBRA, and (2) send you a COBRA election notice.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the SEIB Option Insurance Plan, or (2) the date on which the SEIB notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage.

You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date the election notice is sent back to the SEIB.

Once the SEIB has been notified of your qualifying event, your coverage under the Optional Plan will be retroactively terminated and payment of all claims incurred after the date coverage ceased will be rescinded. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, the SEIB will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that the Optional Plan may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the Optional Plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

**What will be the Length of COBRA 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 the Optional Plan.

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 a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the SEIB, the 18- month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non- disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29- month period will run from the date of the termination of employment or reduction in hours.

  For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

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

  For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under Extensions of COBRA for Second Qualifying Events for more information about this.

  For this disability extension of COBRA coverage to apply, you must give the SEIB timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event; (2) the date on which coverage would be lost because of the initial qualifying event; (3) the date of Social Security's determination; or (4) the

date on which you, or the qualified beneficiary, is informed, through the furnishing of the SPD or COBRA general notice, of the responsibility to notify the Plan and the procedures for doing so. You must also notify the SEIB within 30 days of any revocation of Social Security disability benefits.

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

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

  For this 18-month extension to apply, you must give the SEIB timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later.

**Can New Dependents be added to Your COBRA Coverage?**
You may add new dependents to your COBRA coverage under the circumstances permitted under the Optional Plan. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. For example, if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the SEIB of Social Security's disability determination as explained above.

**How Does the Family and Medical Leave Act Affect my COBRA Coverage?**
If you are on a leave of absence covered by 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.

**How Much is my COBRA Coverage?**
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 months 19 through 29 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.

**When is my COBRA Coverage Premium Due?**
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.

**When Does my COBRA Coverage End?**
The law provides that your COBRA continuation coverage may be terminated for any of the following reasons:

1. The SEIB no longer provides group health coverage;
2. The premium for your continuation coverage is not paid on time;
3. You become covered, after electing continuation coverage, under another group plan;
4. You become entitled to Medicare; or
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 Optional Plan. For example, if you submit fraudulent claims, your coverage will be terminated.

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.

**Are There Other Coverage Options Besides COBRA Continuation Coverage?**
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.Healthcare.gov.

**Keep the SEIB Informed of Address Changes**
In order to protect your family's rights, you must 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 334-263-8341 or by mail at the contact listed below. For more information about your COBRA rights, HIPAA and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

**SEIB Contact Information**
All notices and requests for information should be sent to the following address:

**State Employees' Insurance Board**
**COBRA Section**
**201 South Union Street, Suite 200**
**PO Box 304900**
**Montgomery, AL 36130-4900**

is a Southland network of Participating
Dentists benefiting SEIB members

**Here Are The Top 3 Reasons To Use One Of Our Participating Dentists:**

1. **THEY SAVE YOU MONEY**
2. **THEY SAVE THE SEIB MONEY**
3. **THEY SAVE YOU & THE SEIB MONEY**

DentaNet is one of the largest independent dental networks in the State of Alabama.
The network is designed to save you money.
One important reason you purchase benefits is to save money.

For a listing of Statewide DentaNet providers, visit
www.southlandseib.com

**FACT** DentaNet is the network of participating dentists designed to benefit SEIB members.

**FACT** DentaNet is one of the largest dental networks in the state of Alabama.

**FACT** By using DentaNet providers, SEIB members save money.

# QUESTION: ARE YOU SAVING MONEY?

If you participate in the SEIB Optional Insurance Plan,
you probably purchased dental insurance to save money.

DentaNet providers are all over the state.

To find a participating DentaNet provider in your area,
visit **www.southlandseib.com** or call us,
toll-free, at **1-866-327-6674** today.
You'll be glad you did.

## Dental Benefits Program

Plan Summary*
Dental Benefit Schedule

| | **Plan I** (Employee only) | **Plan II** (Employee & Full Family) |
|---|---|---|
| Maximum benefits applicable per person per plan year: | $1,250 | $1,000 |
| **Diagnostic & Preventive Services:** Based on Reasonable & Customary Charges | | |
| Deductible | None | None |
| Oral Examinations | 100% | 100% |
| Cleaning of Teeth | 100% | 100% |
| Fluoride Applications for Children | None | 100% |
| Space Maintainers for Children | None | Limited |
| X-Rays | 100% | 100% |
| Emergency Office Visits | 100% | 100% |
| Sealants | None | 100% |
| | | |
| **Basic & Major Services:** Based on Reasonable & Customary Charges | | |
| Deductible | **None** | **$25.00** |
| Fillings | 80% | 60% |
| General Anesthetics | 80% | 60% |
| Oral Surgery | 80% | 60% |
| Periodontics | 80% | 60% |
| Endodontics | 80% | 60% |
| Dentures | 80% | 60% |
| Bridgework | 80% | 60% |
| Crowns | 80% | 60% |

**NO ORTHODONTIC BENEFITS**

1. Space maintainers are limited to $125.00 per unit.
2. Deductibles are applied per person, per plan year with a maximum of three (3) per family.
3. Oral surgery excludes any procedures covered under a Group Medical Program.
4. No benefits are provided for replacement of teeth removed before coverage is effective.
   - Expenses are incurred at the preparation date and not the installation, service, or “Seating” date.
   - Benefits are not provided for temporary partials.

**Covered Dental Expenses**
Charges of a dentist or medical doctor which an employee is required to pay for services that are necessary for the diagnosis, prevention, or treatment of a dental condition, but only to the extent that such charges are reasonable and customary, and only if rendered in accordance with broadly accepted standards of dental practice.

Expenses are incurred at the preparation date and not the installation, service, or "seating" date.

**The maximum benefits applicable per person, per plan year are Plan I (employee) $1,250.00, Plan II (employee and full family) $1,000.00.**

**Reasonable and Customary Charges**
The terms reasonable and customary charges refer to the actual fee charged by a dentist in Alabama for a service rendered, but only to the extent the fee is reasonable, taking into consideration the following items:

The usual fee which the individual dentist in Alabama most frequently charges the majority of his patients for service rendered;

The prevailing range of fees charged in the same areas by dentists in Alabama of similar training and experience for service rendered; and

Circumstances or complications requiring additional time, skill and experience.

**Diagnostic and Preventive Expenses**
This plan will pay all reasonable and customary charges for:

Oral examinations and office visits, but not more than two (2) examinations or office visits in a plan year. An examination and office visit are synonymous for the purposes of this benefit. This category includes procedures performed by a dentist that aid in making diagnostic conclusions about the oral health of the individual patient and the dental care required. This limitation would not apply to emergency office visits.

Prophylaxis includes cleaning and scaling of teeth, but not more than two (2) times in a plan year. Charges for this type of treatment performed by a licensed dental hygienist are also included if rendered under the supervision of a licensed dentist.

Topical application of fluoride: Benefits are provided to cover topical application of fluoride for two (2) treatments per plan year. Benefits are available to insured persons to age nineteen (19).

Space maintainers are fixed or removable appliances designed to prevent adjacent and opposing teeth from moving, and/or that replace prematurely lost or extracted teeth. Coverage is for charges incurred to maintain existing space. Benefits are available to insured persons to age fourteen (14). Benefits are limited to $125.00 per space maintainer unit. However, no benefits will be provided for replacement of lost space maintainer units or replacement of outgrown space maintainer units which have been prescribed during the same plan year.

X-rays: Dental x-rays including full mouth x-rays, but not more than once in any 36 consecutive months. Supplementary bitewing x-rays, but not more than twice in a plan year.

Sealants: Pit and fissure sealants are the prophylactic application of composite resin material to cavity prone enamel pits and fissures. Benefits are provided for covered individuals to age 19. Limited to a one-time basis, per tooth.

**Other Covered Dental Expenses**
This plan will pay the percentage of reasonable and customary charges as shown in the Dental Benefit Schedule for the following:

Restorations, which includes fillings inlays, onlays, crowns and the treatment necessary to restore the structure of a tooth or teeth. Benefits are provided for a replacement of gold or crown restoration if the restoration was installed while covered under this plan and at least five years prior to this replacement.

Multiple restorations on one tooth will be paid on the same basis as a multiple surface restoration rather than as an individual restoration. Bonding will be considered equal to crowning with acceptance and replacement restrictions the same.

Endodontics: Procedures used for the prevention and treatment of diseases of the dental pulp and the surrounding structures.

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

Periodontics: Procedures for the treatment of the gum and tissue supporting the teeth.

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

Prosthodontics: Services performed to replace one or more teeth except third molars (wisdom teeth), extracted while the patient is covered under the plan. The plan will not cover replacement of existing bridgework or dentures; however, the plan will cover the installation of a permanent full denture that replaces, or is installed within 12 months of a temporary denture, repairing or re-cementing inlays, crowns, bridgework, dentures or relining of dentures. The plan will also cover the replacement of an existing partial by a new partial; replacement of a full denture or bridgework; or the addition of teeth to an existing denture or bridgework, but only if:

A. The existing denture or bridgework was provided while coverage under this plan was in effect, the existing denture or bridgework is at least five years old and cannot be made serviceable; or
B. The replacement or addition of teeth is required to replace one or more natural teeth extracted or accidentally lost while insured.

No benefit shall be provided under the plan for dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.

**No benefits are provided for replacement of teeth removed before coverage is effective.**

**Pre-Determination of Benefits**

Before beginning a course of treatment for which dentists' charges are expected to be $150.00 or more, a description of the proposed course of treatment and charges to be made should be filed on the claim form with Southland. Southland will then determine the estimated benefit payable for covered dental expenses expected to be incurred and advise the employee and the dentist before treatment begins. Services must be completed within a reasonable length of time from date predetermination was processed.

Emergency treatments, oral examinations including prophylaxis and dental x-rays are considered part of a course of treatment, but these services may be rendered before the pre-determination of benefit procedure has begun.

A course of treatment is a planned program of one or more services or supplies whether rendered by one or more dentists for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

After the course of treatment is completed, the Plan benefit shall be paid in accordance with the final claim submitted by the dentist. In the event of any change in the final claim or treatment, Southland shall adjust

payment accordingly. In the event the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

In the event there is no claim for a predetermination of benefits, the benefit will be paid based upon the information submitted to Southland at the time of the claim.

**Alternate Procedures**
When it is determined that several methods of treatment exist to treat a particular problem, then benefits will be paid based on the least costly scheduled amount so long as the result meets generally acceptable dental standards. Unless prior written consent is received from Southland, dental benefits are limited to the least costly procedure.

**Coordination of Dental Benefits**
If an enrolled member is covered under more than one group dental plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the maximum allowable expenses. SEIB dental benefits will be secondary to all other dental coverages available to a claimant.

**DentaNet Benefits**
The dental coverage administered by Southland will offer a dental network to members and dependents enrolled in the dental plan. Under the Southland dental network, known as "DentaNet", MEMBERS HAVE THE OPPORTUNITY TO USE THE NETWORK DENTISTS BUT STILL HAVE THE FREEDOM TO USE ANY DENTIST. DentaNet dentists cannot balance bill you for the difference between the negotiated fee schedule and what they normally charge. On services requiring you to pay a coinsurance fee, the coinsurance payment will be based on a negotiated fee. The SEIB and its members save money when DentaNet dentists are used.

**Extension of Dental Benefits**
Even though the coverage for an enrolled member has terminated, the member will be entitled to extended coverage for the purpose of the completion of any dental service for which a treatment plan has been approved by the administrator, provided that the services are completed within 30 days of such approval.

**Dental Exclusions**
No benefits are payable for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan.

2. Replacement of teeth removed before coverage is effective.

3. Work done for appearance (cosmetic) purposes. Facing on crowns and pontics posterior to the second bicuspid, are always considered to be cosmetic.

4. Work done while not covered under this plan.

5. Services or supplies in connection with orthodontia except for extractions.

6. Extra sets of dentures or other appliances.

7. Broken appointment.

8. Replacing lost or stolen prosthetic appliances.

9. Completion of claim forms or filing of claims.

10. Educational or training programs, dietary instructions, plaque control programs, and oral hygiene information.
11. Implantology (implants).
12. Periodontal splinting.
13. Work covered under the group hospital medical indemnity plan.
14. Experimental procedures.
15. Drugs or their administration.
16. Anesthetic services billed by anyone other than the attending dentist or his assistant.
17. Services and supplies not ordered by a dentist or physician and not reasonably necessary for treatment of injury or dental disease.
18. Appliances, restorations, and procedures to alter vertical dimension including, but not limited to, harmful habit.
19. Services, appliances, or supplies that exceed the reasonable and customary charges in Alabama.
20. Treatment of an accident related to employment or sickness if either or both are covered under Worker's Compensation or similar laws.
21. Work that is otherwise free of charge to patients or charges that would not have been made if there were no insurance.
22. Work that is furnished or payable by the Armed Forces of any government.
23. Services or supplies furnished by the United States, state or local government.
24. Services received for injuries or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan.
25. Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state of Alabama participates in the cost thereof.
26. Such other expenses as may be excluded by regulations of the board.
27. Gold foil restorations.
28. Pulp capping or acid etching as a separate procedure.
29. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
30. Periodontal cleaning aids or devices.
31. Specific charges for infection control and/or protection supplies, including but not limited to, gloves, masks, gowns, shoes or other items.

32. Microscopic bacteriological examinations.
33. Antimicrobial irrigation.
34. Temporomandibular joint (TMJ) disorders.
35. Benefits are not provided for temporary partials.
36. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider.
37. All claims not submitted in writing, not completed, without the requisite certification of the health care provider, or received by Southland more than 365 days following the claim incurrence.
38. Hospital expenses for dental work performed in the hospital.

## Cancer Program

A. **Hospital Confinement**: $250.00 per day for first 90 consecutive days of hospital confinement for inpatient charges; $500.00 per day thereafter. Readmission 30 days after discharge starts $250.00 daily payment again. No limit on number of confinement or dollar amount.

In-hospital benefit (per day) under this plan does not cover charges for outpatient or same-day surgery UNLESS you are admitted on an inpatient basis where you are charged for a private or semi-private room. Emergency room, outpatient room, observation room, or a similar type room is not to be considered as a private or semi- private room and benefits are not provided for such charges under this plan.

B. **Hospice Care**: Actual charges to a maximum of $50.00 per day for care provided by a licensed Hospice agency, organization or unit that provides to persons terminally ill, and to their families, a centrally administered and autonomous continuum of palliative and supportive care. The care must be directed and coordinated by the Hospice organization in the patient or family home. This benefit does not apply to non-terminally ill patients, nor does it apply to home health care or custodial care benefits. Lifetime maximum of $3,000 per insured.

C. **Cancer Surgery**: Actual charges for operation depending on type of surgery (see schedule of policy), to a maximum of $2,400.00. Hospitalization not required. No limit on number of operations.

D. **Anesthesia**: Actual charges to a maximum of $400.00 per operation. No limit on number of operations.

E. **Radiation & Chemotherapy**: Actual charges to a lifetime maximum of $10,000.00 for cobalt therapy, x-ray therapy or chemotherapy injections. Hospitalization not required. Diagnostic tests not included.

F. **Blood & Plasma**: Actual charges to a lifetime maximum of $2,000.00. Includes transfusions, administration, processing and procurement, and cross-matching (excludes other laboratory expenses). Hospitalization not required.

G. **Nursing Service**: Actual charges for full-time private care and attendance to $80.00 per day for R.N., L.P.N., or L.V.N. for each day the insured is eligible for Hospital Confinement Benefit.

Such services to be rendered by a person who does not ordinarily reside in the same household with the covered person, and who is not related by blood, marriage or legal adoption to the covered person. No lifetime maximum.

H. **Attending Physician**: Actual charges to a maximum of $20.00 per day for physician other than the surgeon for each day the insured is eligible for Hospital Confinement Benefit. No lifetime maximum

I. **Prosthetic Devices**: Actual surgery charges to a maximum of $500.00 for each surgically implanted prosthetic device which is prescribed as a direct result of cancer surgery. Lifetime maximum of $1,000.00 per insured.

J. **Ambulance**: Actual charges to a maximum of $100.00 per trip to and from hospital where insured is confined as an in-patient. Limit two trips per confinement. No lifetime maximum.

**Schedule of Operations**
(Maximum Amounts Payable)

If two or more surgical procedures are performed by the same surgical approach or in the same operative field the amount paid by the Plan will be that of the more expensive of the two procedures performed.

| **ABDOMEN:** | |
|---|---|
| Paracentesis | 100.00 |
| Exploratory laporatomy | 600.00 |
| Cholecystectomy | 800.00 |
| **BLADDER:** | |
| Cystoscopy | 150.00 |
| Cystectomy | |
| (Partial) | 1,000.00 |
| (Complete) | 1,800.00 |
| TUR bladder tumors | 600.00 |
| **BRAIN:** | |
| Exploratory Craniotomy | 1,200.00 |
| Burr holes not followed by surgery | 300.00 |
| Excision brain tumor | 2,400.00 |
| **BREAST:** | |
| Needle Biopsy | 150.00 |
| Cutting Operation Biopsy | 300.00 |
| Mastectomy | |
| (Simple) | 800.00 |
| (Radical) | 200.00 |
| Lumpectomy | 400.00 |
| **CERVIX:** | |
| D&C | 200.00 |
| Colposcopy | 200.00 |
| Abdominal and Vaginal | 800.00 |
| Hysterectomy/uterus only | 1,200.00 |
| Uterus, tubes, & ovaries | 200.00 |
| **CHEST:** | |
| Thoracentesis | 100.00 |
| Bronchoscopy | 300.00 |
| Mediastinoscopy | 300.00 |
| Thoracostomy | 800.00 |
| Pneumonectomy | 1,600.00 |
| Wedge Resection | 1,200.00 |
| Lobectomy | 1,400.00 |
| **ESOPHAGUS:** | |
| Esophagoscopy | 300.00 |
| Resection of Esophagus | 1,600.00 |
| Esophagogastrectomy | 1,400.00 |

**EYE:**

| | |
|---|---|
| Enucleation | 400.00 |
| P32 uptake | 200.00 |

**INTESTINES:**

| | |
|---|---|
| Sigmoidoscopy | 150.00 |
| Proctosigmoidoscopy | 150.00 |
| Colonoscopy | 300.00 |
| Cutting Operation of rectum for biopsy | 300.00 |
| Colostomy/or revision of | 400.00 |
| Heostomy | 400.00 |
| Colectomy | 1,000.00 |
| Abdominal-Perineal approach for removal of cancer of sigmoid colon or rectum | 2,000.00 |
| Resection small instestine | 2,000.00 |

**KIDNEY:**

| | |
|---|---|
| Nephrectomy | 2,000.00 |

**LIVER:**

| | |
|---|---|
| Needle Biopsy | 150.00 |
| Wedge Biopsy | 300.00 |
| Resection of liver | 1,000.00 |

**LYMPHATIC:**

| | |
|---|---|
| Excision of lymph node | 200.00 |
| Splenectomy | 800.00 |
| Axillary node dissection | 800.00 |
| Lymphadenectomy | |
| (Unilateral) | 800.00 |
| (Bilateral) | 1,000.00 |

**MANDIBLE:**

| | |
|---|---|
| Mandibulectomy | 1,600.00 |

**MISCELLANEOUS:**

| | |
|---|---|
| Bone Marrow Biopsy or Aspiration | 150.00 |
| Pathological Fracture Hip | 1,000.00 |

**MOUTH:**

| | |
|---|---|
| Hemiglossectomy | 400.00 |
| Glossectomy | 800.00 |
| Resection of Palate | 800.00 |
| Tonsil/Mucous membrane | 600.00 |

**PANCREAS**

| | |
|---|---|
| Jejunostomy | 1,000.00 |
| Pancreatactomy | 2,400.00 |
| Whipple Procedure | 2,400.00 |

**PENIS:**

| | |
|---|---|
| Amputation | |
| (Partial) | 300.00 |
| (Complete) | 600.00 |
| (Radical) | 800.00 |

**PROSTATE:**

| | |
|---|---|
| Cystoscopy | 150.00 |
| TUR Prostate | 600.00 |
| Radical Prostatectomy | 1,400.00 |

**SALIVARY GLANDS:**

| | |
|---|---|
| Biopsy | 400.00 |
| Partidectomy | 800.00 |
| Radial Neck Dissection | 1,600.00 |

**SKIN:**

| | |
|---|---|
| Excision of lesion of skin | 150.00 |
| With flap or graft | 400.00 |

**SPINE:**

| | |
|---|---|
| Laminectomy | 1000.00 |
| Cordotomy | 600.00 |

**STOMACH:**

| | |
|---|---|
| Gastroscopy | 300.00 |
| Partial Gastrectomy | 1,000.00 |
| Gastrectomy | 1,400.00 |
| Gastrojejunostomy | 1,000.00 |

**TETIS:**

| | |
|---|---|
| Orchiectomy | 400.00 |

**THROAT:**

| | |
|---|---|
| Laryngoscopy | 300.00 |
| Laryngectomy | |
| (Without neck dissection) | 800.00 |
| (With neck dissection) | 1,600.00 |
| Tracheostomy | 300.00 |

| **THYROID:** | |
|---|---|
| Thyroidectomy | |
| Partial (one lobe) | 600.00 |
| Total (both lobes) | 800.00 |

| **VULVA:** | |
|---|---|
| (Partial) | 1,200.00 |
| (Radical) | 600.00 |

**Limitations and Exclusions**

A. This policy pays only for loss resulting from hospitalization for definitive cancer treatment including direct extension, metastatic spread or recurrence. Pathologic proof must be submitted to support each claim. This policy does not cover any other disease, sickness or incapacity, and benefits are not provided for premalignant conditions, with malignant potential or human immunodeficiency virus.

B. No benefits are payable for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan;

2. Hearing aids and examinations for the prescription or fitting of hearing aids;

3. Cosmetic surgery or treatment, specifically but not limited to, coverage for reconstruction which is prescribed as a direct result of cancer surgery. Please see Provision I under Coverage.

4. Benefits for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay such charge;

5. Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan;

6. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;

7. Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state of Alabama participates in the cost thereof;

8. Such other expenses as may be excluded by regulations of the Board;

9. Expenses due to Convalescent Long Term Care, Nursing Home confinement or rehabilitation (the recovery of health and strength after disease, sickness or injury);

10. All claims not submitted in writing, not completed, without the requisite certification of the health care provider or received by Southland more than 365 days following the claim incurrence.

11. Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

## Definitions

### A. Cancer Defined - Positive Pathology Required

Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, or leukemia.

Such cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology to practice Pathologic Anatomy, or an Osteopathic Pathologist. Diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or post- mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis does not meet this standard.

### B. Hospital Defined

Hospital means a lawfully operating institution engaged mainly in providing treatment for sick or injured persons on an inpatient basis at the patient's expense. The treatment must be under the supervision of a licensed physician. The hospital must maintain diagnostic and therapeutic facilities on premises for surgical and medical treatment of such persons. These facilities must be supervised by a staff of legally qualified physicians and must include a laboratory, x-ray equipment and operating room. Permanent, full-time facilities for the care of overnight resident bed patients must be maintained.

The hospital must have surgical facilities on premises where major surgery is performed on a regular routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

Hospital does not include the institution, or part thereof, used as: a Hospice unit including any beds designated as a Hospice; a swing bed; a convalescent home; a rest home; a rest or nursing facility; pain clinic; psychiatric unit; rehabilitation unit; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or treatment for persons suffering from mental disease or disorders, care for the aged, drug and/or substance addicted or alcoholics.

## Hospital Indemnity Program

### Plan Summary Coverage

| | **Plan I** (Employee Only) | **Plan II** (Employee & Full Family) |
|---|---|---|
| *In hospital benefit (per day) | $150.00 | $75.00 |
| *Maternity (per day) | $150.00 | $75.00 |
| *Intensive care Benefit (per day) | $300.00 | $150.00 |
| *Convalescent or long –term care /Rehabilitation (per day) | $150.00 | $75.00 |
| Supplemental accident | $1000.00 | $1000.00 |
| Ambulance Benefit | $100.00 | $100.00 |

* In-hospital, maternity, intensive care and convalescent or long term care benefits are exclusive and non-duplicating.

1. In hospital benefits are limited to 365 days per covered accident or illness; benefits will be paid for any admission on an in-patient basis where charges are incurred for a private or semi-private room.
2. Limited to 90 days' lifetime maximum.
3. Limited to $1,000.00 per plan participant and/or dependent, per plan year.
4. Ambulance benefits limited to the amount of actual charges to a maximum of $100.00 per trip to or from a hospital where the insured is confined as an in-patient. No lifetime maximum.

**Definitions**

Convalescent or Long Term Care Facility is an institution which is used primarily as a rest facility, nursing facility or facility for the aged or for rehabilitation (the recovery of health and strength after disease, sickness or injury). Convalescent care may include home confinement. In no event, however, shall a convalescent or long term care facility include any institution which is a hospital as defined in this policy, or any institution primarily used for the care and treatment of drug addicts, alcoholics, and/or mental or nervous disorders or a hospice facility. Assisted living facilities are not covered by this plan and benefit will not be provided.

Convalescent or Long Term Care Facility Confinement Coverage or Home Confinement Coverage is provided for a lifetime maximum of 90 days in the aggregate for payment of nursing care services. These benefits are payable only if all the following criteria are met:

A. The attending physician certifies that 24 hour nursing care by a Registered Graduate Nurse or Licensed Practical Nurse is medically necessary for recuperation.

B. The convalescent or long term care facility confinement is preceded by at least three consecutive days of hospital confinement for which benefits were payable.

C. It is due to the same sickness or injury and commences within 14 days after a previous hospital, convalescent or long term care facility confinement for which benefits were payable.

D. The condition of the Plan participant or dependent requires 24-hour a day nursing services by registered graduate nurses or licensed practical nurses, such services to be rendered by a person who does not ordinarily reside in the same household with the covered person, and who is not related by blood, marriage or legal adoption to the covered person.

Hospital means a lawfully operating institution engaged mainly in providing treatment for sick or injured persons on an inpatient basis at the patient's expense. The treatment must be under the supervision of a licensed physician. The hospital must maintain diagnostic and therapeutic facilities on premises for surgical and medical treatment of such persons. These facilities must be supervised by a staff of legally qualified physicians and must include a laboratory, x-ray equipment and operating room. Permanent, full-time facilities for the care of overnight resident bed patients must be maintained. The hospital must have surgical facilities on premises where major surgery is performed on a regular routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

Hospital does not include the institution, or part thereof, used as: a Hospice unit including any beds designated as a Hospice; a swing bed; a convalescent home; a rest home; a rest or nursing facility; pain clinic; psychiatric unit; rehabilitation unit; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or treatment for persons suffering from mental disease or disorders, care for the aged, drug and/ or substance addicted or alcoholics.

In-Hospital Benefit: In-hospital benefit (per day) under this plan does not cover charges for outpatient or same- day surgery UNLESS you are admitted on an inpatient basis where you are charged for a private or semi-private room. Emergency room, outpatient room, observation room, or a similar type room is not to be considered as a private or semi-private room and benefits are not provided for such charges under this plan.

Injury means an accidental injury of the insured or dependent sustained while this policy is in force.

Mental/Nervous Disorder/Addiction Treatment: Mental or nervous disorder means neurosis, psychoneurosis, psychopathy, psychosis, chemical imbalance or mental or emotional disease or disorders of any kind, including treatment for alcoholism and/or drug addiction. **Benefits for treatment of mental or nervous disorders and alcoholism and/or drug addiction treatment are limited to a maximum of 14**

**days' confinement in a hospital as an in-patient per plan year;** provided, however, the facility is not required to include a laboratory, x-ray equipment or an operating room.

Alcoholism and/or drug addiction treatment is further limited to a maximum of one admission of not more than 14 days' confinement as an inpatient per plan year. This benefit is further limited to a lifetime maximum of two admissions of not more than 14 days per admission for the treatment of substance abuse.

Qualified Practitioners are any duly licensed physicians operating within the scope of their license, including podiatrist and doctors of chiropractic.

Supplemental Accident Benefit: this benefit will pay incurred expenses up to the benefit amount shown, when an insured sustains injury as a result of an accident if such injury **does not result in hospital confinement during the period ending one year from the date of such accident,** and such injury is incurred while the coverage is in force and within **90 days of the date of such accident. Benefits will be limited to a maximum of $1,000.00 per plan participant and/or dependent, per plan year.**

Inclusive in the $1,000.00 maximum benefit per participant and/or dependent, per plan year, are covered charges due to, or for, treatment of accidental injury by adjustment or manipulation of the spine or soft tissues, including but not limited to analysis, related x-ray and laboratory examinations, and related support, immobilization, and physical therapy procedures, include only those made by or on behalf of qualified practitioners and are limited to a maximum of:

1. $25.00 per visit;
2. Two visits in any seven consecutive days (all accidental injuries and qualified practitioners combined);
3. Thirty visits per plan year (all accidental injuries and qualified practitioners combined).

Accidental injury means all such injuries of a covered person occurring while this plan is in force and caused by an external, violent force that was not expected, could not have been reasonably foreseen and was unrelated directly or indirectly to all other causes.

**Exclusions**

No benefits are payable for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan;
2. Hearing aids and examinations for the prescription or fitting thereof;
3. Cosmetic surgery or treatment, except to the extent necessary for correction of damage caused by accidental injury while covered by the plan or as a direct result of disease covered by the plan;
4. Benefit for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay such charge;
5. Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan;
6. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
7. Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state participates in the cost thereof;

8. Such other expenses as may be excluded by regulations of the Board;
9. Outpatient or same-day surgery for illness;
10. Expenses or charges for emergency rooms, outpatient rooms, same-day surgery rooms, observation rooms, or similar type rooms;
11. Dental treatment as a result of any cause, whether accidental or non-accidental;
12. All claims not submitted in writing, not completed, with the requisite certification of the health care provider, or received by Southland more than 365 days following the claim incurrence.

# Vision Program

**Coverage and maximum benefits**

| Examination actual charges not to exceed: | $40.00 |
|---|---|
| Lenses not to exceed: | |
| Single Vision | $50.00 |
| Bifocals | $75.00 |
| Trifocals | $100.00 |
| Lenticular | $125.00 |
| Contacts | $100.00 |
| Frames | $60.00 |

* Plan provides either contact or lenses and frames, but not both in any plan year.

** It is the responsibility of the member to submit a claim for either lenses or contacts and the payment will be made based on the date the claim is received.

**Limitations**

Examinations: One in any plan year.

Lenses: One new prescription or replacement in any plan year. Benefits are not available under the plan for both lenses and contacts in the same plan year.

Contacts: One new prescription or replacement in any plan year. Plan provides either contacts or lenses and frames, but not both in any plan year.

Frames: One new or replacement in any plan year.

Vision Examination**:** Consisting of one or more, but not limited to the following component services when performed by a licensed ophthalmologist or optometrist:

- case history
- external examination of the eye and adnexa
- determination of refractive status
- ophthalmoscopy
- application of pharmaceutical agents for diagnostic purposes when indicated and allowed by state law
- tonometry test for glaucoma when indicated
- binocular measure
- summary finding and recommendations
- prescribing corrective lenses, if needed

**Definitions**

Bifocal Lenses: Lenses containing two foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

Contact Lenses: Lenses which fit directly on the eyeball under the eyelids.

Frames: A standard eyeglass frame into which two lenses are fitted.

Lens or Lenses: Ophthalmic corrective lens or lenses, glass or plastic, ground or molded, as prescribed by an ophthalmologist or optometrist, to be fitted into a frame.

Lenticular Lenses: Special non-contact lenses for persons who have cataracts.

Ophthalmologist: A licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of his or her license, performs vision examinations, prescribes lenses to improve visual acuity, and performs surgical procedures to the eye.

Optician: A person qualified in the state in which the service is rendered to supply eye-glasses according to prescriptions written by an ophthalmologist or optometrist, to grind or mold lenses or have them ground or molded according to prescription, to fit them into a frame and to adjust the frame to fit the face.

Optometrist: Any doctor of optometry legally qualified to practice optometry in the state in which vision care services are rendered, who performs vision examinations and prescribes lenses to improve visual acuity.

Trifocal Lenses: Lenses containing three foci, usually arranged with the focus for distance above, for intermediate distance in the middle, and for near vision below.

**Exclusions**

Vision care plan benefits will not be provided for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan;
2. Services or supplies for which coverage is provided or available under any other medical benefit program maintained by the State Employees' Insurance Board, or by Workers' Compensation Laws, or by any safety lens program;
3. Drugs or any other medication;
4. Any medical or surgical treatments;
5. Special or unusual treatment such as orthoptics, vision training, sub- normal vision aids, aniseikonia lenses or tonography;
6. Services or supplies not prescribed by a licensed physician, optometrist, or ophthalmologist, and lenses which do not require a prescription;
7. Service or supplies which are experimental in nature or are not approved by the American Ophthalmology Association;
8. The extra charge for oversized, photo sensitive, or anti-reflective lenses, whether or not medically necessary;
9. Sun glasses, including lenses and frames;
10. Follow-up visits, fitting fees, dispensing fees, coating or care kits;
11. Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
12. All claims not submitted in writing, not completed, with the requisite certification of the health care provider or received by Southland more than 365 days following the claim occurrence;

13. Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

**Coordination of Vision Benefits**

If an enrolled member is covered under more than one group vision plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the covered expenses. SEIB benefits will be secondary to all other coverages available to a claimant.

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