

# **Optional Coverage Plan**

**State Employees' Insurance Board**

**Southland Benefit Administrators**

**Revised 2009**



## INTRODUCTION

The State Employees' Health Insurance Plan (SEHIP) was established under provisions of Act 65-833 of the 1965 Alabama Legislature. The Act created the State Employees' Insurance Board (SEIB). The SEIB established a uniform plan of health insurance for employees.

In November of 2004, the Alabama Legislature enacted a new law (Act No: 2004-647) that gave the SEIB the authority to offer supplemental policies to active and retired State employees.

This summary of health care benefits available to you through the State Employees' Insurance Board Optional Insurance 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 National Insurance Corporation (Southland) 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 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 SEIB Optional Insurance Plan offers a package of four plans of insurance (Dental - Cancer - Hospital Indemnity - Vision) that are administered by Southland National Insurance Corporation (Southland) at no cost to the employee.

Plan Year will begin on January 1 and run 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.**



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## GENERAL INFORMATION

### **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 and County Soil & Water Conservation Districts are to be eligible for coverage under this plan.
2. Members of the Legislature and the Lieutenant Governor are eligible during their term of office.

**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.

### **Eligible Retired State Employee**

A retired employee with at least ten 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 System.

### **Eligible Dependents**

The term “dependent” includes the following individuals subject to appropriate documentation (marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (an ex-spouse cannot be covered).
2. An unmarried child under age 19, only if the child is:
  - a. your son or daughter
  - b. a child legally adopted by you (including any probationary period during which the child is required to live with you)
  - c. your stepchild
3. An unmarried grandchild, niece or nephew, under age 19, only if:
  - a. the court has granted you custody, and
  - b. she/he is not eligible for other group health insurance.

4. Children ages 19 through 25 who are full-time unmarried students attending an accredited institution. Annual student verification from the institution must be filed with the SEIB.
5. An incapacitated dependent will be considered for coverage to any age provided dependent
  - a. is unmarried,
  - b. is permanently mentally or physically disabled or incapacitated,
  - c. is so incapacitated as to be incapable of self-sustaining employment,
  - d. is dependent upon the subscriber for 50% or more support,
  - e. is otherwise eligible for coverage as a dependent except for age, and
  - f. the condition must have occurred prior to the dependent's 19<sup>th</sup> birthday (unless already covered by the SEIB as a student, in which case the condition must have occurred prior to the dependent's 26<sup>th</sup> birthday).

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

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.

**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 SEIB Optional Insurance 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 SEIB Optional Insurance 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 SEIB Optional Insurance Plan for at least twelve 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 to 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 the SEIB receives and approves the enrollment within 60 days following date of marriage, birth, adoption, etc., the effective date will be the date of the coverage event. If the SEIB receives the enrollment more than 60 days after the person becomes a dependent, coverage of such person may not commence until the first day of the month following date of approval.

**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 SEIB Optional Insurance Plan for the time period required under the SEIB rules and procedures, he or she may terminate coverage in the SEIB Optional Insurance Plan and re-enroll in the SEHIP during the SEHIP's Open Enrollment period.

**Special Enrollment Back into 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 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 requests enrollment in 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 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 plan'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**

Southland, and other business associates of this plan, has an agreement with the plan 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 plan, you agree that the Plan, and its business associates, may obtain, use, and release all records about you and your minor dependents needed to administer the 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.

### **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 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 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 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. And 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 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**

Will be provided by Southland.

## **Claim Forms**

Claim forms may be obtained from Southland or the SEIB and may also be downloaded from the SEIB website at <http://www.alseib.org>.

## **Claims Administrator**

The Claims Administrator for the SEIB Optional Insurance Plan is Southland National Insurance Corporation - PO Box 1250, Tuscaloosa, Alabama 35403. (1-800-476-0677)

## **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 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 the 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 SEIB Optional Insurance Plan related to the false or misleading information, plus interest.

**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 7:45 a.m. - 4:30 p.m. Monday through Thursday and 7:45 a.m. - 1:00 p.m. on Friday. The phone number is: **1-866-327-6674**.

# **APPEAL PROCESS**

## **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 SEIB Optional Insurance 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, Southland.

**Informal Review:** If you still 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 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 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 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. A copy of the decision of the claims 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 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 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 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:

- Investigative 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 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 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?**

COBRA Continuation Coverage is a continuation of coverage under the SEIB Optional Insurance 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 SEIB Optional Insurance Plan is lost because of a qualifying event. Under the SEIB Optional Insurance Plan, 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 SEIB Optional Insurance 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.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the SEIB Optional Insurance 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.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the SEIB Optional Insurance 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 SEIB Optional Insurance 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 Parts A, B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the SEIB Optional Insurance Plan 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 plan 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 SEIB Optional Insurance 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.

## **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 SEIB Optional Insurance 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 anyone in your family covered under SEIB Optional Insurance Plan 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:

1. Employee or former employee dies,
2. Employee or former employee gets divorced or legally separated, or
3. If dependent child loses eligibility as a “dependent child” under SEIB Optional Insurance Plan.

For the extension to apply, the above listed events must have caused the spouse or dependent child to lose coverage under the SEIB Optional Insurance Plan 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 pre-existing 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 plan. 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.

### **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](http://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  
201 South Union Street, Suite 200  
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 1-866-833-3375.

## DENTAL BENEFITS PROGRAM

### Plan Summary and Dental Benefit Schedule

	Plan I (Employee Only)	Plan II (Employee & Full Family)
Maximum benefits applicable per person per plan year:	\$1,250.00	\$1,000.00

#### Diagnostic & Preventive Services: Based on Reasonable & Customary Charges

	Plan I (Employee Only)	Plan II (Employee & Full Family)
Deductible	None	None
Oral Examinations	100%	100%
Cleaning of Teeth	100%	100%
Fluoride Applications for children	None	100%
Space Maintainers for children <sup>1</sup>	None	Limited
X-Rays	100%	100%
Emergency Office Visits	100%	100%
Sealants	None	100%

#### Basic & Major Services: Based on Reasonable & Customary Charges

	Plan I (Employee Only)	Plan II (Employee & Full Family)
Deductible <sup>2</sup>	None	\$25.00
Fillings	80%	60%
General Anesthetics	80%	60%
Oral Surgery <sup>3</sup>	80%	60%
Periodontics	80%	60%
Endodontics	80%	60%
Dentures	80%	60%
Bridgework <sup>4</sup>	80%	60%
Crowns	80%	60%

### NO ORTHODONTIC BENEFITS

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

### Covered Dental Expenses

Charges of a dentist or medical doctor which an employee is required to pay for services which 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 term “reasonable and customary charges” means 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 One Hundred Twenty-Five (\$125.00) Dollars 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 nineteen (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 Benefits Schedule for the following:

**Restorations.** (includes fillings, inlays, onlays, and crowns) 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 (5) 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 recementing 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 (5) 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 benefits 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 benefits 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 Benefits procedure is 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 Benefits**

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 National 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. 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 appliances.
19. Services 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 Workmen'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. Services of a dentist who is related to the member by blood or marriage or who regularly resides in the same household.
39. Hospital expenses for dental work performed in the hospital.

## CANCER PROGRAM

### Coverage Outline

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

In-Hospital Benefits (per day) under this plan do not cover charges for outpatient or same-day surgery UNLESS you are admitted on an in-patient basis where you are charged for a private or semi-private room. Emergency Room, Out-patient 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. No lifetime maximum for Leukemia.
- 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 for 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.

<b>ABDOMEN</b>		<b>BLADDER</b>	
Paracentesis	100.00	Cystoscopy	150.00
Exploratory laporatomy	600.00	Cystectomy (Partial)	1,000.00
Cholecystectomy	800.00	Cystectomy (Complete)	1,800.00
		TUR bladder tumors	600.00
<b>BRAIN</b>		<b>BREAST</b>	
Exploratory Craniotomy	1,200.00	Needle Biopsy	150.00
Burr holes not followed by surgery	300.00	Cutting Operation Biopsy	300.00
Excision brain tumor	2,400.00	Mastectomy (Simple)	800.00
		Mastectomy (Radical)	1,200.00
		Lumpectomy	400.00
<b>CERVIX</b>		<b>CHEST</b>	
D&C	200.00	Thoracentesis	100.00
Colposcopy	200.00	Bronchoscopy	300.00
Abdominal and Vaginal hysterectomy/uterus only	800.00	Mediastinoscopy	300.00
Uterus, tubes, & ovaries	1,200.00	Thoracostomy	800.00
		Pneumonectomy	1,600.00
		Wedge Resection	1,200.00
		Lobectomy	1,400.00
<b>ESOPHAGUS</b>		<b>EYE</b>	
Esophagoscopy	300.00	Enucleation	400.00
Resection of Esophagus	1,600.00	P32 uptake	200.00
Esophagogastrectomy	1,400.00		

- Schedule continued on next page –

## SCHEDULE OF OPERATIONS – Continued

(Maximum Amounts Payable)

<b>INTESTINES</b>		<b>KIDNEY</b>	
Sigmoidoscopy	150.00	Nephrectomy	2,000.00
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 intestine	2,000.00		
<b>LIVER</b>		<b>LYMPHATIC</b>	
Needle Biopsy	150.00	Excision of lymph node	200.00
Wedge Biopsy	300.00	Splenectomy	800.00
Resection of liver	1,000.00	Axillary node dissection	800.00
		Lymphadenectomy (Unilateral)	800.00
		Lymphadenectomy (Bilateral)	1,000.00
<b>MANDIBLE</b>		<b>MISCELLANEOUS</b>	
Mandibulectomy	1,600.00	Bone Marrow Biopsy or Aspiration	150.00
		Pathological Fracture Hip	1,000.00
<b>MOUTH</b>		<b>PANCREAS</b>	
Hemiglossectomy	400.00	Jejunostomy	1,000.00
Glossectomy	800.00	Pancreatactomy	2,400.00
Resection of Palate	800.00	Whipple Procedure	2,400.00
Tonsil/Mucous membrane	600.00		
<b>PENIS</b>		<b>PROSTATE</b>	
Amputation (Partial)	300.00	Cystoscopy	150.00
Amputation (Complete)	600.00	TUR Prostate	600.00
Amputation (Radical)	800.00	Radial Prostatectomy	1,400.00
<b>SALIVARY GLANDS</b>		<b>SKIN</b>	
Biopsy	400.00	Excision of lesion of skin	150.00
Parotidectomy	800.00	With flap or graft	400.00
Radial Neck Dissection	1,600.00		

- Schedule continued on next page -

## SCHEDULE OF OPERATIONS – Continued

(Maximum Amounts Payable)

<b>SPINE</b>		<b>STOMACH</b>	
Laminectomy	1,000.00	Gastroscope	300.00
Cordotomy	600.00	Partial Gastrectomy	1,000.00
		Gastrectomy	1,400.00
		Gastrojejunostomy	1,000.00
<b>TESTIS</b>		<b>THROAT</b>	
Orchiectomy	400.00	Laryngoscopy	300.00
		Laryngectomy (Without neck dissection)	800.00
		Laryngectomy (With neck dissection)	1,600.00
		Tracheostomy	300.00
<b>THYROID</b>		<b>VULVA</b>	
Thyroidectomy		(Partial)	600.00
Partial (one lobe)	600.00	(Radical)	1,200.00
Total (both lobes)	800.00		

### 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:
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 reconstructive surgery. However, there are limited benefits available for a surgically implanted prosthetic device, 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 premise 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 patient's written history and medical records must be kept on the premises. 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**

	<b>Plan I (Employee Only)</b>	<b>Plan II (Employee and Full Family)</b>
* In-Hospital Benefit (Per Day) <sup>1</sup>	150.00	75.00
* Maternity Benefit (Per Day)	150.00	75.00
* Intensive Care Benefit (Per Day)	300.00	75.00
* Convalescent or Long Term Care/ Rehabilitation (Per Day) <sup>2</sup>	150.00	75.00
Supplemental Accident <sup>3</sup>	1,000.00	1,000.00
Ambulance Benefit <sup>4</sup>	100.00	100.00
* In-hospital, maternity, intensive care and convalescent or long term care benefits are exclusive and non-duplicating.		
<sup>1</sup> In-hospital benefits 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.		
<sup>2</sup> Limited to 90 days, lifetime maximum		
<sup>3</sup> Limited to \$1,000 per plan participant and/or dependent, per plan year.		
<sup>4</sup> 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 benefits 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 twenty-four (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 patient's written history and medical records must be kept on the premises. 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 Benefits (per day) under this plan do not cover charges for outpatient or same-day surgery UNLESS you are admitted on an in-patient basis where you are charged for a private or semi-private room. Emergency Room, Out-patient 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 in-patient per plan year. This benefit is further limited to a lifetime maximum of two (2) admissions of not more than 14 days per admission for the treatment of substance abuse.**

**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.**

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

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

<b>VISION PROGRAM</b>
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**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 contacts 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 payment will be made based on the date the claims 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 findings and recommendations
- ❖ prescribing corrective lenses, if needed

## DEFINITIONS

**Bifocal Lenses:** Lenses containing 2 foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

**Trifocal Lenses:** Lenses containing 3 foci, usually arranged with the focus for distance above, for intermediate distance in the middle, and for near vision below.

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

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

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

**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.

**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.

**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.

**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.

## 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 Public Education Employees' Health 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. Sunglasses, 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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