

STATE EMPLOYEES' SUPPLEMENTAL COVERAGE PLAN

State of Alabama
Revised October 1, 2008

Blue Cross Blue Shield of Alabama
An Independent Licensee of the Blue Cross Blue Shield Association

INTRODUCTION

This summary of health care benefits available to you through the State Employees' Supplemental Coverage 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 State Employees Insurance Board (SEIB) and Blue Cross Blue Shield of Alabama or other third party administrators that the SEIB may contract with that it deems is necessary to carry out its statutory obligations. Copies of all contracts are kept on file at the SEIB office and are available for review. The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the plan and reserves the right to change the terms and conditions and/or end the plan at any time and for any reason.

This plan is established and maintained pursuant to Section 36-29-19.2 of the Code of Alabama. Except for members with no primary dental plan, it is designed for the express and limited purpose of providing supplemental benefits to eligible employees and non-Medicare retirees who are able to obtain group health coverage through a plan maintained by another employer (generally referred to throughout the remainder of this booklet as the "primary plan").

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

By electing to participate in this plan, you are electing not to participate in the SEIB's comprehensive health plan (the State Employees' Health Insurance Plan). Instead, you are electing to participate in a plan that supplements coverage under the primary plan. You and your family members should look to the primary plan as the principle source of health care benefits. Only after benefits have been determined under the primary plan, will this plan determine the level of supplemental benefits that are due to be paid.

If you have no primary dental plan, you may elect to participate in the SEIB Preferred Dental Program as your primary dental plan. The supplemental provisions of the State Employees' Supplemental Coverage Plan will not apply to your dental benefits if you elect the SEIB Preferred Dental Program.

As you read this booklet, it is important for you to pay attention to terms that have defined meanings. In order to make the booklet more readable, the initial letters of defined terms are not capitalized. You are encouraged to begin your review of this booklet by going first to the definitions section and familiarizing yourself with the meaning of the terms used. For further information, contact one of the following:

State Employees' Insurance Board
201 South Union Street, Suite 200
Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: 334-263-8341
Toll Free: 1-866-836-9737
Retiree Accounts: 334-263-8359
COBRA Information: 334-263-8357
Website: www.alseib.org

or

Blue Cross Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244
Customer Service: 1-800-824-0435
Rapid Response: 1-800-248-5123
Fraud Hot Line: 1-800-824-4391
Website: www.bcbsal.com

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ELIGIBILITY AND ENROLLMENT

Please visit our web page at www.alseib.org to download forms.

Eligible Employees

The term "employee" includes only:

1. Full-time State employees and employees of County Health Departments, who are paid by the State Comptroller, the State Department of Mental Health, Historic Blakeley, Ft. Payne Improvement Authority, Historic Ironworks Commission, Bear Creek Development Authority, International Motor Sports Hall of Fame, Space and Rocket Center, the Sports Hall of Fame, the State Docks, St. Stephens Historical Commission, USS Alabama Battleship Commission 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 seasonal, temporary, intermittent, emergency, or contract basis.

Eligible Dependent

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 19th birthday (unless already covered by the SEIB as a student, in which case the condition must have occurred prior to the dependent's 26th 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.

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

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

Enrollment & Commencement

Before an employee can enroll in the State Employees' Supplemental Coverage Plan, he or she must decline coverage in the State Employees' Health Insurance Plan.

Employees and dependents can enroll and coverage commences as stated.

Employee

Current employees may enroll at any time and coverage will be effective no later than first day of the second month following receipt and approval by the SEIB of an enrollment form. New employees may be enrolled as of the effective date of employment, subject to SEIB rules and procedures. An SEIB enrollment form must be completed by the employee and his/her employer and submitted to the SEIB.

Dependents

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

New employees may elect to have dependent coverage begin on the date their coverage begins or on the first day of any subsequent month following their effective date of coverage.

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

New employees may enroll incapacitated dependents, as approved by the SEIB, over the age of 19 provided the child was incapacitated prior to age 19. Requests for incapacitation status shall be submitted to the SEIB within 60 days of employment.

If the SEIB is notified of a new dependent after the 60-day grace period, the effective date of coverage will be the first day of the month following the date of notification.

Re-enrollment into the State Employees' Health Insurance Plan

Employees may re-enroll in the State Employees' Health Insurance Plan at any time. Coverage will be effective no later than the first day of the second month following receipt and approval of an enrollment form by the SEIB.

Active Employees Over 65

Active employees and their dependents over age 65 are covered under the same conditions as any employee under age 65.

Notice

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

Status Changes

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

Address Changes

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

Employee Name Changes

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

RETIREE ELIGIBILITY AND ENROLLMENT

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 and is not entitled to Medicare.

Note: Dependents of retirees are not eligible for the State Employees' Supplemental Coverage Plan if they are entitled to Medicare.

Eligible Dependent - (see page 3)

Enrollment/Continuation

Before a retiree can enroll in the State Employees' Supplemental Coverage Plan, he or she must decline coverage in the State Employees' Health Insurance Plan.

A retiree may enroll at any time and coverage will be effective no later than the first day of the second month following receipt and approval by the SEIB of an enrollment form.

Re-enrollment in the State Employees' Health Insurance Plan

Retirees may re-enroll in the State Employees' Health Insurance Plan at any time. Coverage will be effective no later than the first day of the second month following receipt and approval of an enrollment form by the SEIB.

Survivor Enrollment

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

TERMINATION OF COVERAGE

Coverage under this plan will terminate:

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

Coverage under this plan will also terminate for a dependent:

1. On the first day of the following month in which such person ceased to be an eligible dependent.
2. If the dependent becomes covered as an employee.

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

Family & Medical Leave Act

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

Employees on Leave Without Pay (LWOP)

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

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

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.

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.***

Important note: Since this plan pays secondary benefits only, except when benefits are filed for primary consideration under the SEIB Preferred Dental Program, you should make sure that you have primary coverage through another group health plan or policy before buying COBRA coverage under this plan. If you do not have such primary coverage, then this plan will pay no benefits – notwithstanding your payment of COBRA premiums. In addition, you should note that coverage under this plan is not “creditable coverage” under HIPAA. Therefore, in order to prevent having a 63-day break in service, you will need to maintain primary coverage elsewhere.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under this 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 this plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Note that your COBRA coverage will be identical to the coverage that you were receiving immediately before the qualifying event. Your COBRA coverage will, like coverage for active employees participating in this plan, pay supplemental benefits only, except when enrolled for primary coverage under the SEIB Preferred Dental Program.

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 this 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 this 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 this 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 this 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 this plan as a “dependent child.”

Coverage Available

If you choose continuation coverage, this plan 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. As previously noted, this coverage is limited in scope, and intended to supplement group coverage through another, primary, plan.

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
- 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 this 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 this 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 this 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:
- Employee or former employee dies,
- Employee or former employee gets divorced or legally separated, or
- If dependent child loses eligibility as a “dependent child” under this plan.

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

NOTE: Since the sole purpose of this plan is to supplement coverage under a primary plan, if you cease to be covered under the primary plan no benefits will be payable under this plan.

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.

Termination of Continuation Coverage

COBRA continuation coverage may be terminated for any of the following reasons:

1. You are no longer covered under a primary plan.
2. SEIB no longer provides group health coverage.
3. The premium for your continuation coverage is not paid on time.
4. You become covered after the date of the qualifying event by another group plan, unless the plan contains any exclusions or limitations with respect to any preexisting condition you or your covered dependents may have.
5. You become entitled to Medicare.
6. 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 1-334-263.8341 or 1-866-836-9737 or by mail at the contact listed below. For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

SEIB Contact Information

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

State Employees' Insurance Board
COBRA Section
Post Office Box 304900
Montgomery, AL 36130-4900

BENEFITS - SUPPLEMENTAL HEALTH AND DENTAL PLAN

Benefit Conditions

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

- They must be furnished after your coverage becomes effective;
- They must be covered for you and any of your dependents under a primary plan and you must have enrolled for coverage under that plan;
- Claims for services or supplies must have been filed with the primary plan, and the primary plan must have made its coverage and determinations and notified you of them;
- The primary plan must have determined that the services or supplies were covered, medically or dentally necessary, not excluded, and in accordance with the primary plan's utilization review or similar guidelines;
- The primary plan must have made a benefit determination (that is, the primary plan has determined what it will pay), and Blue Cross must have been provided with a copy of that benefit determination;
- The service or supplies must have been furnished while coverage under the primary plan and this plan was in effect. If coverage ceases to be in effect under the primary plan, no benefits will be provided under this plan unless you have purchased and are maintaining COBRA coverage through the primary plan, in which case this plan will continue to pay secondary benefits.

Inpatient Hospital Benefits

In General

If you are admitted as a hospital inpatient and if the inpatient admission is covered under the primary plan and meets all medical necessity and utilization review criteria of the primary plan, this plan will pay a benefit equal to the smaller amounts of:

1. The sum of any coinsurance, deductibles, and/or copayments you owe under the primary plan with respect to such admission.
2. \$300 per day for days 1-10 of the inpatient hospital admission and \$150 per day for days 11-90 of the hospital admission.
3. The allowed amount for the admission in question (the term allowed amount is defined and explained in the Glossary Section).

For this purpose, an inpatient hospital admission means a continuous stay as an inpatient in a hospital not broken by more than the number of days specified by the primary plan for determining the length of a hospital admission.

Admissions for Mental and Nervous Disorders and Substance Abuse

If you are admitted as a hospital inpatient for treatment of a mental and nervous disorder or substance abuse and if the inpatient admission is covered under the primary plan and meets all medical necessity and utilization review criteria of the primary plan, this plan will pay a benefit equal to the smaller of the amounts of:

1. The sum of any coinsurance, deductibles, and/or copayments you owe under the primary plan with respect to such admission.
2. \$150 per day for days 1-10 of the inpatient hospital admission and \$75 per day for days 11-90 of the hospital admission.
3. The allowed amount for the admission in question (the term "allowed amount" is defined and explained in the Glossary Section).

Plan Year Maximums for Inpatient Hospital Benefits

During any one plan year, the plan will not pay benefits for more than 90 days of inpatient hospital care - regardless of whether the inpatient days relate to more than one admission or different types of admissions. In other words, the 90-day limitation is a combined limitation for medical, mental and nervous, and substance abuse admissions.

Exclusions

The plan will not pay benefits in the following circumstances, even if the service or supply would otherwise be covered under the plan and has been provided to a member by a licensed medical provider acting within the scope of his or her license.

- Services or supplies that are not covered under the primary plan.
- Services or supplies that are excluded under the primary plan. Included within this are services or supplies that are excluded under the primary plan as a result of the application of a pre-existing condition exclusion clause or waiting period.
- Any liabilities that the patient is responsible for paying as a result of any penalties under the primary plan for failure to comply with the primary plan's medical necessity, utilization review, precertification, or other similar requirements. This applies regardless of whether the provider waives collection of the penalty.
- Any liabilities or penalties that the patient is responsible for paying because he or she received services or supplies outside the primary plan's provider network.
- Services or supplies in excess of any benefit limits or maximums under the primary plan.

Other Covered Services

If you receive any other medical or dental services or supplies and if the primary plan covers and makes payment for the services or supplies in question, this plan will pay a benefit equal to the smaller of :

1. The sum of any copayments, deductibles, or coinsurance that you are required to pay with respect to the covered services or supplies.
2. The allowed amount for the service or supply in question (the term allowed amount is defined and explained in the Glossary Section.)

If your primary plan **does not** include dental services, SEIB's Preferred Dental Program will apply.

SEIB PREFERRED DENTAL PROGRAM

This section contains information which is applicable when the SEIB Preferred Dental Program is the primary dental plan.

Dental Benefits

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

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

Maximum Dental Benefits

Covered dental expenses are provided up to a maximum dollar amount of **\$1,000 for each member** during each calendar year.

Dental Benefit Period

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

Dental Deductible

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

Diagnostic and Preventive Expenses

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

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

Emergency Office Visits

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

Sealants

A substance placed on the occlusal surface of permanent teeth to prevent decay. This service is only covered when rendered to a member under age 19.

Basic and Major Services

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

- Fillings of amalgam, silicate, acrylic, synthetic porcelain and composite fillings to restore diseased or accidentally broken teeth.
- General Anesthesia - covered when medically necessary and administered in connection with oral surgery.
- Oral Surgery - surgical procedures performed in or about the mouth that involve but are not limited to the incision and excision procedures for the correction of diseases, injury or preparation of the mouth for dentures. Dental surgery includes charges for removal of teeth.
- Periodontics - treatment of the gum and tissues supporting the teeth; management of periodontal disease; gingivectomy and gingivoplasty (removal of diseased gum tissue and reconstructing gums); osseous/surgery (removal of diseased bone); mucogingivoplastic surgery (reconstruction of gums and mucous membranes by surgery); and management of acute infection and oral lesions.

- Endodontics - treatment of disease of the dental pulp and the surrounding structures, including pulpotomy, direct pulp capping and root canal treatment.
- Prosthodontics (dentures, bridgework and crowns); initial installation of fixed bridgework including inlays, veneers and crowns to form abutments; initial installation of partial or full removal dentures including adjustments during the six-month period following installation; addition of a tooth or teeth to an existing partial removable denture or to bridgework; installation of a permanent full denture that replaces and is installed within 12 months of a temporary denture; repair or recementation of inlays, veneers, crowns, bridgework, dentures, or relining of dentures; the replacement of an existing partial denture, full removable denture, crown or fixed bridgework is covered providing the existing denture, crown or bridgework cannot be made serviceable and was installed at least five years before its replacement; however, should additional extractions require the replacement of dentures or bridgework, the five-year requirement is waived.
- Orthodontic benefits are provided for the initial and subsequent treatment and installation of orthodontic equipment for dependent children up to age 19. Benefits are provided at 50% of the allowable amount and are subject to a separate lifetime limit of \$1,000 per member.
 - The need for orthodontic services must be diagnosed and a treatment plan submitted by the dentist. The diagnosis must indicate that the orthodontic condition consists of handicapping malocclusion that is abnormal and is correctable.
 - Blue Cross Blue Shield reserves the right to review the member's dental records, including necessary X-rays, photographs, and models, to determine whether orthodontic needs and treatment are within the limitations and exclusions of the contract.
 - If orthodontic treatment is terminated for any reason before completion, benefits will not be paid after the date the treatment was terminated. If services are resumed, benefits will be resumed to the extent of the remaining maximums applicable to the individual.
 - The benefit payment for orthodontic services shall be only for months that coverage is in force. Benefits are not provided for treatment received prior to commencement of coverage. Claims for a course of treatment that was started prior to commencement of coverage but completed while coverage is in force will be investigated to determine the amount of the entire fee that should be allocated to the treatment that was actually received while covered.
 - Any charge for the replacement and/or repair of any appliance furnished under the treatment plan shall not be paid.

Treatment Plan

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

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

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

Pre-Determination of Benefits

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

Benefit Conditions

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

- Must be furnished after your coverage becomes effective;
- Blue Cross Blue Shield must determine before, during, or after services and supplies are furnished that they are dentally necessary;
- PPO and Preferred Dentist benefits must be furnished while you are covered by this plan and the provider must be a PPO provider or a Preferred Dentist when the services are furnished to you;
- Services and supplies must be furnished when the plan and your coverage are both in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition that began before the plan or your coverage ends.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is a provision designed to help manage the cost of health care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary.

A primary plan is one whose benefits for a person's health care coverage must be determined first without taking the existence of any other plan into consideration.

A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan.

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

1. If the other plan has no COB provision, it is primary.
2. Employee/Dependent: The plan covering a patient as an employee, member, or subscriber (that is other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require that the order of payment be reversed. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.
3. Dependent Child-Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. If the other plan does not use this "birthday rule" the other plan's rule will be used.
4. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:
 - a. first, the plan of the parent with custody;
 - b. second, the plan of the spouse of the parent with custody;
 - c. third, the plan of the parent without custody; and
 - d. last, the plan of the spouse of the parent without custody.

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

If there is a court order that specifically states that one parent must provide for the child's health expenses or provide health insurance coverage for the child, benefits are determined in this order:

- a. first, the plan of the court-ordered parent;
 - b. second, the plan of the spouse of the court-ordered parent;
 - c. third, the plan of the non-court-ordered parent; and,
 - d. last, the plan of the spouse of the non-court-ordered parent.
5. **Active/Inactive Employee:** When a patient is covered under one plan as a active employee and under another plan as a retired or inactive employee (e.g., a former employee receiving COBRA benefits), the plan which covers the patient as an active employee is the primary over a plan which covers the patient as a laid-off or retired employee. This applies to the employee's dependents as well unless the dependents have other coverage due to their own current or former employment status.
6. **Longer/Shorter Length of Coverage:** If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

If our records indicate this plan is secondary, Blue Cross will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination. If this plan is secondary according to the above rules, it will calculate benefits as if it were the primary plan, applying all applicable cost-sharing provisions. This plan will then reduce, on a dollar for dollar basis, any benefits that it would have paid by the benefits paid pursuant to the primary plan. In many cases, this will result in no payment of benefits under this plan.

Dental Benefit Limitations

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

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

Dental Exclusions

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

Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, trustee or similar person or group.

Dental services for which the member incurs no charge.

Dental services for which coverage is available to the member, in whole or in part, under any Worker's Compensation Law or similar legislation whether or not the member claims compensation or receives benefits there under.

Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.

Dental services provided or available to a member in whole or in part under the laws of the United States, or any state, or political subdivision thereof, or for which the member would have no legal obligation to pay in the absence of this or any similar coverage.

Dental services, to the extent coverage is available to the member under any other Blue Cross Blue Shield contract.

Charges for dental care or treatment by a person other than a dentist unless the treatment is rendered under the direct supervision of a dentist.

Gold foil restorations.

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

Service or expenses of any kind covered by Medicare.

Services rendered or provided in any setting other than the dentist's office. Such settings include, but are not limited to, ambulatory surgical facility, outpatient department of a hospital, a hospital or any other type of facility. Services, care or treatment that Blue Cross Blue Shield of Alabama determines not to have been medically necessary.

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

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

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: Blue Cross Blue Shield of Alabama, and other business associates of this plan, have 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.

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

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

Incorrect Benefit Payments

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

Responsibility for Actions of Providers of Services

Blue Cross Blue Shield and the State Employees' Insurance Board (SEIB) will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. Blue Cross Blue Shield 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. Blue Cross Blue Shield and SEIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

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

Obtaining, Use and Release of Information

By submitting your application for coverage or any claims for benefits you authorize Blue Cross Blue Shield 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 Blue Cross Blue Shield any such records or information it requests. And you authorize Blue Cross Blue Shield to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither Blue Cross Blue Shield 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 Blue Cross Blue Shield.

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 Blue Cross Blue Shield 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 Blue Cross Blue Shield requests.

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

Providers of Services Subject to Contract Provisions

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

Benefit Decisions

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

Applicable State Law

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

Plan Changes

Any or all of the provisions of this Plan may be amended by the State Employees' Insurance Board at any time by an instrument in writing.

No representative or employee of Blue Cross Blue Shield of Alabama is authorized to amend or vary the terms and conditions of this Plan, make any agreement or promise, not specifically contained in the Plan, or waive any provision of the Plan.

SUBROGATION

Right of Subrogation

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

Right of Reimbursement

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

Right to Recovery

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

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

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

CLAIMS AND APPEALS

The following explains the rules under this plan for filing claims and appeals with Blue Cross and for filing voluntary appeals with the SEIB.

Filing of Claims Required

In order to file a claim with us (Blue Cross) you must first file your claim with the primary plan, except when filing for primary consideration for benefits under the SEIB Preferred Dental Program, and the primary plan must determine the amount of any deductible, copayment, or coinsurance. Only after the primary plan has made this determination, may you then submit a claim under this plan. You must submit sufficient information to us to confirm that covered services or supplies were rendered, that the primary plan made a benefit determination, and that the primary plan calculated and applied against its benefit payment a deductible, copayment, or coinsurance. Once we have received this information, we will then process your claim under this plan, and pay benefits as previously indicated.

When filing for primary consideration of benefits under the SEIB Preferred Dental Program, a claim prepared and submitted to Blue Cross must be received by Blue Cross before any payment of benefits for services or supplies can be considered.

Who Files Claims

As a general rule, you must file claims under this plan. In some cases, we have contracts with providers who will file claims with us on your behalf. When filing claims for consideration as primary benefits under the SEIB Preferred Dental Program, payment will be made to the provider, if the provider is a preferred dental provider.

Who Receives Payment

If you file the claims, we will pay you. If your provider files the claim, we will pay the provider.

When Claims Must Be Submitted

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

Processing of Claims

From time to time we might need additional information in order to determine whether your claim is payable. If additional information is needed, Blue Cross will ask you to furnish it, and will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to Blue Cross. To expedite receipt of the information Blue Cross may request it directly from your provider. Blue Cross will send you a copy of its request. However, you will remain responsible for seeing that Blue Cross gets the information on time.

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

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

Member Satisfaction

If you are dissatisfied with the handling of a claim by Blue Cross or have any questions or complaints, you may do one or more of the following:

- You may call or write the Blue Cross Customer Service Department. They will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
- You may file an appeal if you have received an adverse benefit determination.

Customer Service

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

1-800-824-0435

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

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

Blue Cross also has a special 24 hour-a-day, 7 days a week, Customer Service request line, called Rapid Response, for you to use when you need claim forms and other printed materials relevant to your benefits. Rapid Response is quick and easy to use, so we encourage you to use it when you need materials such as:

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

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

The numbers for Rapid Response are:

(205) 988-5401 in Birmingham or 1-800-248-5123 toll-free.

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

Blue Cross Blue Shield Appeals

In General

The rules in this section of the summary allow you or your authorized representative to appeal any adverse benefit determination by Blue Cross. An adverse benefit determination means that Blue Cross has denied some or your entire claim for benefits.

You have 180 days following an adverse benefit determination by Blue Cross within which to submit an appeal.

How to Appeal Adverse Benefit Determinations

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

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

- the patient's name;
- the patient's contract number;
- sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
- a statement that you are filing an appeal.

You must send your appeal to the following address:

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

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

Conduct of Appeal

Blue Cross will assign your appeal to one or more persons within the organization who are neither the persons who made the initial determination nor subordinates of those persons.

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

Blue Cross will consider your appeal fully and fairly.

Time Limits for Blue Cross Consideration of Your Appeal

Blue Cross will notify you of its decision within 60 days of the date on which you filed your appeal.

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

If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies

If you have filed an appeal and are dissatisfied with the response, you may do one or more of the following:

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

SEIB APPEALS PROCESS

General Information

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

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 sixty (60) days. The Administrative Review Committee shall issue a decision in writing to all parties involved in the grievance.

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

Formal Appeal

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

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

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

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

- Investigational Related Services
- Custodial Care
- Allowed Amounts

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

GLOSSARY

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

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

- 1. Preferred Providers:** Blue Cross and Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the preferred provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered services or care. The negotiated price applies only to services that are covered under the Plan and also covered under the contract that has been signed with the preferred provider. Please be aware that not all participating or contracting providers are preferred providers. Each local Blue Cross and/or Blue Shield plan determines which of its participating or contracting providers will be considered preferred providers.
- 2. Non-Preferred Providers:** The allowed amount for care for non-preferred providers or for services or supplies not included in a preferred provider's contract is normally determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to preferred providers, or may be based on the average or anticipated charge or discount for care in the area or state, or for care from that particular type of provider. When the local Blue Cross and/or Blue Shield plan does not provide appropriate pricing data or when Blue Cross and Blue Shield of Alabama is determining the allowed amount for services or supplies by a non-preferred provider (or for services and supplies not included in the contract with the provider), Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

The charge for the same or a similar service;

The relative complexity of the service;

The preferred provider allowance for the same or a similar service;

The average expected or estimated provider discount for the type of provider in the service area, as reported by the Blue Cross and Blue Shield Association from time to time;

Applicable state health care factors;

The rate of inflation using a recognized measure; and,

Other reasonable limits, as required with respect to outpatient prescription drug costs.

Non-preferred providers include providers that have not signed a contract with the Blue Cross and/or Blue Shield plan where services are rendered as well as participating or contracting providers who have not been designated by the local Blue Cross and/or Blue Shield plan as preferred providers. In this situation the provider may bill the member for charges in excess of the allowed amount. The allowed amount will not exceed the amount of the provider's charge.

Inpatient Hospital Admissions: The allowed amount for inpatient hospital admissions is the sum of the interim per-diem payment that we would make to that hospital for each day of the inpatient stay. Our determination of the allowed amount – when made – is final; we will not recalculate the allowed amount if, at a later date, the interim per-diem is changed.

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

Blue Cross Blue Shield of Alabama: The Company chosen by the State Employees' Insurance Board, through competitive bid, to process benefit claims filed by members (also referred to as Blue Cross).

Claims Administrator: The Company chosen by the State Employees' Insurance Board, through competitive bid, to process benefit claims filed by members. The Claims Administrator is Blue Cross Blue Shield of Alabama.

Coinsurance: The amount (normally expressed as a percentage of the allowed amount) that you are required to pay in conjunction with the benefits paid under the primary plan. A common example is an 80/20 plan, where the plan pays 80% of the provider's allowable charges and you pay the remaining 20%.

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

Copayment: An up-front payment (normally a fixed dollar amount) that you are required to make under the primary plan in order to receive covered services or supplies. A common example is a \$25 copayment that you are required to make at the time you receive services from a physician during an office visit.

Deductible: The portion of the primary plan's eligible benefits that you are required to pay before the primary plan makes a payment.

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

Dental Necessity: Services or supplies necessary to treat your illness, injury, or symptom. To be dentally necessary, services or supplies must be determined by Blue Cross to be:

- appropriate and necessary for the symptoms, diagnosis, or treatment of your dental condition;
- provided for the diagnosis or direct care and treatment of your dental condition;
- in accordance with standards of direct care and treatment of your dental condition;
- in accordance with standards of good dental practice accepted by the organized dental community;
- not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- is not "investigational;"

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

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

Employee: See the "Eligibility and Enrollment" section.

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

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

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

Inpatient: A registered bed patient in a hospital.

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

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

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

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

Member: An active/retired State Employee or eligible dependent who has coverage under the Plan and whose application for coverage under the contract is made and accepted by the State Employees' Insurance Board. A member also is a former dependent and/or employee eligible for and covered under COBRA.

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

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those classified or classifiable under standards of the American Hospital Association as "special" hospitals, such as those classified as for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease, or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

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

Plan Year: The initial Plan Year will be June 1, 2005 through December 31, 2005. Subsequent Plan Years will be January 1 through December 31.

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

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

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

Preferred Dentist: A dentist who has an agreement with Blue Cross Blue Shield of Alabama to provide dental services to members entitled to benefits under the Preferred Dental Program.

Preferred/Participating Provider: Any provider of health care services or supplies when licensed and acting within the scope of that license at the time and place you are treated and receive services (such as a Preferred/Participating Physician, Preferred/Participating Dentist, Preferred/Participating Medical Laboratory, Preferred/Participating Outpatient Facility, or Preferred/Participating Nurse Practitioner Provider) who has an agreement to furnish services or supplies to members entitled to benefits under preferred or participating care programs.

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

Retired Employee: A former employee who receives a monthly benefit check from the State of Alabama and is not entitled to Medicare.

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

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

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

State Employees' Supplemental Coverage Plan (SESCP): A self-insured supplemental coverage plan administered by the State Employees' Insurance Board.

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

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

STATE EMPLOYEES' INSURANCE BOARD

Post Office Box 304900
Montgomery, Alabama 36130-4900
Phone: 334-263-8341
Toll Free: 1-866-836-9737
Retiree Accounts: 334-263-8359
Continuation Coverage (COBRA) Information: 334-263-8357
Website: www.alseib.org

**Claims Administrator
Blue Cross Blue Shield of Alabama**

450 Riverchase Parkway East
Birmingham, Alabama 35244
Customer Service: 1-800-824-0435
Rapid Response: 1-800-248-5123
Fraud Hot Line: 1-800-824-4391
Website: www.bcbsal.com

Group # 60913
10/08