

State of Alabama
State Employees' Supplemental Coverage Plan
Group 60913

Important Information Regarding Your SEIB Supplemental Coverage Plan:

- The SEIB Supplemental Coverage Plan only **supplements** your primary insurance plan by covering the copay, deductible and/or coinsurance of your primary insurance plan **or** the preferred/participating allowance, whichever is less.
- To be eligible for reimbursement under the SEIB Supplemental Coverage Plan, the primary insurance plan must have either **1)** applied the eligible charges to the deductible, or **2)** made primary payment for the services rendered.
- For hospital admissions, a daily copay may be required under the SEIB Supplemental Coverage Plan and there is a combined maximum allowance (Medical, Mental Health and Substance Abuse) of 90 days each benefit period.
- The SEIB Supplemental Coverage Plan will not pay for amounts in excess of the allowed amount for services rendered by a non-preferred provider, amounts in excess of the maximums provided under the primary insurance plan, any services denied by the primary insurance plan, or any penalties or sanctions imposed by the primary insurance plan.
- When services are rendered by a Blue Cross and Blue Shield preferred provider in Alabama, the provider should file the claim for you and payment will be made to the provider. If your primary insurance plan requires an office copay, this means the SEIB Supplemental Coverage Plan will reimburse that office copay to the preferred provider.
- In some cases, when a non-preferred Blue Cross and Blue Shield provider in Alabama is used, the subscriber may be required to file the claim. For claims filed by subscribers, an Explanation of Benefits (EOB) from the primary insurance plan must be submitted along with your claim for consideration of benefits under the SEIB Supplemental Coverage Plan.
- Remember to show your health care provider **both** your primary insurance plan ID card and your SEIB Supplemental Coverage Plan ID card so that they can verify your benefits and make a copy of your ID cards for their office file.
- If you have questions regarding your SEIB Supplemental Coverage Plan benefits, please call **1 800 824-0435**.
- If your health care provider needs to verify your SEIB Supplemental Coverage Plan benefits, they should call **1 800 517-6425**.

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Health

SERVICES	BENEFIT
Inpatient Facility Charges for Medical Services	The coinsurance, deductible and/or copays of the primary insurance or the preferred/participating allowance, whichever is less; limited to \$300 per day for days 1 – 10 and \$150 per day for days 11 – 90*
Inpatient Facility Charges for Mental Health and Substance Abuse Services	The coinsurance, deductible and/or copays of the primary insurance or the preferred/participating allowance, whichever is less; limited to \$150 per day for days 1 – 10 and \$75 per day for days 11 – 90*
All Other Covered Services (inpatient physician visits, outpatient facility charges, office visits, laboratory expenses, drugs, etc.)	The coinsurance, deductible and/or copays of the primary insurance or the preferred/participating allowance, whichever is less

*There is a combined 90 day inpatient facility maximum for medical and mental health/substance abuse every 365 days

Dental

SERVICES	BENEFIT
All Covered Dental Services (including orthodontics)	The coinsurance, deductible and/or copays of the primary insurance or the preferred/participating allowance, whichever is less

SEIB's Preferred Dental Program below will apply if your primary insurance **does not** cover dental services.

DENTAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Deductible	\$25 per person each calendar year; maximum of three deductibles per family, subject to \$1,000 maximum per person per calendar year.	\$25 per person each calendar year; maximum of three deductibles per family, subject to \$1,000 maximum per person per calendar year.
Diagnostic & Preventive Services	Covered at 100% of the Preferred Dental Fee Schedule with no deductible.	Covered at 100% of the Preferred Dental Fee Schedule with no deductible.
Basic and Major Services (Fillings, Oral Surgery, etc.)	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible.	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible.
Orthodontic Services	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible and a separate lifetime maximum of \$1,000 per person.	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible and a separate lifetime maximum of \$1,000 per person.

Note: Member is responsible for any difference between billed charges and the fee schedule when using a non-participating provider.

All benefit payments are based on the amount of the provider's charge that Blue Cross recognizes for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.

The actual payment under the plan will be limited to the lesser of the plan benefit or allowed amount.

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.