Local Government Health Benefit Plan

Local Government Plan

Effective January 1, 2016

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

INTRODUCTION

This summary of health care benefits of the Local Government Health Insurance Plan (LGHIP) is designed to help you understand your coverage. This booklet replaces any previously issued information. All terms, conditions and limitations are not covered here. All benefits are subject to the terms, conditions and limitations of the contract or contracts between the Local Government Health Insurance Board (LGHIB) and Blue Cross Blue Shield of Alabama (BCBS) or other third party administrators that the LGHIB may contract with that it deems is necessary to carry out its statutory obligations. Copies of all contracts are kept on file at the LGHIB office and are available for review.

The LGHIB shall have absolute discretion and authority to interpret the terms and conditions of the LGHIP and reserves the right to change the terms and conditions and/or end the LGHIP at any time and for any reason.

The following provisions of this booklet contain a summary, in English, of your rights and benefits under the LGHIP. If you have questions about your benefits, please contact Customer Service at 1-800-321-4391. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favorEste folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-877-255-7250. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

Local Government Health Insurance Plan

Administered By:

Local Government Health Insurance Board
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Toll-Free: 1.866.836.9137
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LOCAL GOVERNMENT JANUARY 1, 2016

This table is a summary of benefits and is subject to all other terms and conditions of the Plan.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard® Preferred Provider Organization (PPO) Program. To find out if your provider is a PPO member, call 1-800-810-BLUE (2583) or access the Blue Cross website, www.bcbs.com. Please be aware that not all providers participating in the BlueCard® PPO Program will be recognized by Blue Cross as approved providers for the type of service being furnished as explained more fully in "Benefit Conditions."

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Precertification is required for inpatient admissions (except medical emergency and maternity); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 for precertification.		
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance, subject to a $200 per admission deductible and $50 co-pay per day for days 2-5	Covered at 80% of the allowance, subject to a $200 per admission deductible and $50 co-pay per day for days 2-5.
OUTPATIENT HOSPITAL BENEFITS		
Precertification is required for certain outpatient hospital benefits, including radiology services, and a select group of physician-administered drugs; visit AlabamaBlue.com and the benefit booklet. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.		
Surgery	Covered at 100% of the allowance, subject to the $100 facility co-pay. Certain outpatient surgeries require pre-certification, call **1-800-248-2342**.	Covered at 80% of the allowance, subject to the calendar year deductible. Certain outpatient surgeries require pre-certification, call **1-800-248-2342**.
Medical Emergency	Covered at 100% of the allowance, subject to the $200 facility co-pay.	Covered at 100% of the allowance, subject to the $200 facility co-pay.
Accidental Injury **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **(Medical Emergency)** above.	Covered at 100% of the allowance with no deductible or co-pay required if services are provided within 72 hours of the accident.	Covered at 100% of the allowance with no deductible or co-pay required if services are provided within 72 hours of the accident. Thereafter, and when not a medical emergency as defined by the plan, covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Tests	Covered at 100% of the allowance, subject to the $100 facility co-pay per visit or cost of service, whichever is less.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic Lab & Pathology	Covered at 100% of the allowance, subject to a $3 co-pay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Note: In Alabama, inpatient and outpatient benefits for non-member hospitals are available only in cases of accidental injury or medical emergency and covered as an out-of-network hospital.		
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Precertification is required for a select group of physician-administered drugs; visit AlabamaBlue.com/DrugList. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.		
Physician Office Visits, Office Surgery & Outpatient In-Person Consultations	Covered at 100% of the allowance, subject to the $40 office visit co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Nurse Practitioners / Nurse Midwives, Physician Assistant Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $20 office visit co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Telephone and Online Video Consultations Program A telephone and online video consultation service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations (where available) are offered 7 days a week, 7 am to 9 pm. To enroll, go to Teladoc.com/Alabama or call 1-855-477-4549.	Covered at 100% of the allowance.	Not covered.
Emergency Room	Covered at 100% of the allowance, subject to the office visit co-pay.	Covered at 100% of the allowance, subject to the office visit co-pay.
Inpatient Visits	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Maternity	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
Lab & Pathology Exams	Covered at 100% of the allowance, subject to a $3 co-pay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Tests	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
ROUTINE PREVENTIVE CARE		
Routine Immunizations and Preventive Services	Covered at 100% of the allowance with no deductible or copay. See **AlabamaBlue.com/preventiveservices** for a listing of the specific immunizations and preventive services.	Covered at 80% of the allowance subject to the calendar year deductible. See **AlabamaBlue.com/preventiveservices** for a listing of the specific immunizations and preventive services.
Additional Routine Preventive Services	Covered at 100% of the allowance with no deductible or copay. In addition to the standard, the following will apply: • Urinalysis (once by age 5, then once between ages 12-17) • CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) • Glucose testing (once every calendar year age 18 and over) • Cholesterol testing (once every calendar year age 18 and over) • TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)	Covered at 80% of the allowance subject to the calendar year deductible. In addition to the standard, the following will apply: • Urinalysis (once by age 5, then once between ages 12-17) • CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) • Glucose testing (once every calendar year age 18 and over) • Cholesterol testing (once every calendar year age 18 and over) • TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)
MENTAL HEALTH SERVICES		
Inpatient Facility Services	Covered at 80% of the participating allowance, subject to a $200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.
Inpatient Physician Services	Covered at 80% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
LGHIB Approved Outpatient Provider Services	Covered at 100% of the allowance, subject to a $14 co-pay per visit; limited to 20 visits per person per calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 20 visits per person per calendar year.
SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.
Inpatient Physician Services	Covered at 80% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
LGHIB Approved Outpatient Provider Services	Covered at 100% of the allowance, subject to a $14 co-pay per visit; limited to 20 visits per person per calendar year. (Other co-pays may apply based on services rendered.)	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 20 visits per person each calendar year.
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar Year Deductible	$200 per person each calendar year; maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$6,250 individual annual out-of-pocket maximum; $12,500 aggregate family maximum. **In-Network Services:** Deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum, including prescription drugs (excludes Medicare Blue Rx plan). For members up to age 19, deductibles and coinsurance for in-network dental services under the group dental benefits apply to the out-of-pocket maximum. **Out-of-Network Services:** Do not apply to the out-of-pocket maximum.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MAJOR MEDICAL SERVICES		
Precertification is required for certain major medical services; please see benefit booklet. Call 1-800-248-2342 for precertification. If no precertification is obtained, no benefits are available.		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th visit.	**Non-Participating:** Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 18th visit.
Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. *Preauthorization* is required after the 15th visit to determine the medical necessity for continued therapy. **Call 1-800-248-2342 for precertification.** If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	
Allergy Testing & Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Participating Home Health Services	Covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency; Precertification is required; call **1-800-248-2342**. **NOTE:** No coverage for services rendered by a non-participating Home Health agency.	
Diabetic Education	Covered at 100% of the allowance with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call **1-800-248-2342**.	
PRESCRIPTION DRUGS – ACTIVE AND NON-MEDICARE RETIREES		
Prescription Drug Card Program for Tier 1 Drugs	**Participating Pharmacy:** Tier 1 drugs covered at 100% of the allowance subject to a $10 co-pay per prescription; 60-day supply on maintenance drugs for one co-pay.	**Non-Participating Pharmacy:** No benefits are available for prescriptions purchased at a non-Participating Pharmacy.
Point-of-Sale Drug Program for Tier 2 and Tier 3 Drugs	**Participating Pharmacy:** Tiers 2 & 3 drugs are covered at 80% of the allowance, subject to the calendar year deductible. ***Claims Authorization Number is required.***	**Non-Participating Pharmacy:** No benefits are available for prescriptions purchased at a non-Participating Pharmacy.
PRESCRIPTION DRUGS – MEDICARE RETIREES AND MEDICARE DEPENDENTS OF RETIREES–LGHIP's EMPLOYER GROUP WAIVER PLAN (EGWP)		
Prescription Drug Card Program for Tier 1 Drugs	**Preferred/Extended Supply Network Pharmacies** $10 co-pay for 30-day supply $20 co-pay for 60-day supply $20 co-pay for 90-day supply **Non-Preferred Pharmacies** $10 co-pay for 30-day supply $20 co-pay for 60-day supply $30 co-pay for 90-day supply	**Non-Participating Pharmacy:** In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Please call BCBS Customer Service if you have any additional questions at 1-800- 321-4391.
Point-of-Sale Drug Program for Tier 2, Tier 3, and Tier 4 Drugs	**Retail & Extended Supply Network Pharmacies** 20% coinsurance after the $100 drug deductible is met. Deductible applies only to Medicare covered Part D Drugs.	**Non-Participating Pharmacy:** In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Please call BCBS Customer Service if you have any additional questions at 1-800- 321-4391.
LGHIB DISCOUNTED VISION CARE PROGRAM (Note: This is a LGHIB administered benefit. No claims should be filed to Blue Cross and Blue Shield of Alabama.)		
Routine Eye Exam	Routine examinations are limited to one per year for a $40 fee when a participating provider is used. Please see benefit booklet for additional program provisions. LGHIP's vision network is on our website at **www.lghip.org**	Not covered.

For precertification call 1-800-248-2342. Call Blue Cross and Blue Shield of Alabama at 1-800-321-4391. Visit Local Government's website at www.lghip.org.

This is not a contract, benefit booklet, or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract. Check your benefit booklet for more detailed coverage information. Please visit our website, AlabamaBlue.com.

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OVERVIEW OF THE PLAN

Purpose of the Plan

The LGHIP is intended to help you and your covered dependents pay for the costs of medical care. The LGHIP does not pay for all of your medical care. For example, you may be required to pay deductibles, copayments, and coinsurance.

Using *my*BlueCross to Get More Information

By being a member of the LGHIP, you get exclusive access to ***my*BlueCross** – an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at www.AlabamaBlue.com/register. With ***my*BlueCross**, you have 24-hour access to personalized healthcare information, PLUS easy-to-use online tools that can help you save time and efficiently manage your healthcare:

- Download and print your benefit booklet or Summary of Benefits and Coverage.
- Request replacement or additional ID cards.
- View all your claim reports in one convenient place.
- Find a doctor.
- Track your health progress.
- Take a health assessment quiz.
- Get fitness, nutrition, and wellness tips.
- Get prescription drug information.

Definitions

Near the end of this booklet you will find a "Definitions" section that identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with these definitions so that you will understand your benefits.

Receipt of Medical Care

Even if the plan does not cover benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Generally, after-hours care is provided by your physician. They may have a variety of ways of addressing your needs. You should call your physician for instructions on how to receive medical care after the physician's normal business hours, on weekends and holidays, or to receive non-emergency care for a condition that is not life threatening, but requires medical attention.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room. Having a primary care physician is a good decision:

Although you are not required to have a primary care physician, it is a good idea to establish a relationship with one. Having a primary care physician has many benefits, including:

- Seeing a physician who knows you and understands your medical history.
- Having someone you can count on as a key resource for your healthcare questions.
- Help when you need to coordinate care with specialists and other providers.

Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics. Find a physician in your area by visiting AlabamaBlue.com and choosing Find a Doctor.

Seeing a specialist or behavior health provider is easy: If you need to see a specialist or behavioral health provider, you can contact their office directly to make an appointment. If you choose to see a specialist or Blue Choice Behavioral Health provider, you will have the maximum benefits available for services covered under the plan. If you choose to see an out-of-network specialist or non-Blue Choice behavioral health provider, your benefits could be lower.

Beginning of Coverage

The section of this booklet called "Eligibility" will tell you what is required for you to be covered under the LGHIP and when your coverage begins.

Limitations and Exclusions

In order to maintain the cost of the LGHIP at an overall level that is reasonable to all plan members, the LGHIP contains a number of provisions that limit benefits. There are also exclusions that you need to pay particular attention to as well. These provisions are found through the remainder of this booklet. You need to be aware of these limits and exclusions in order to take maximum advantage of the LGHIP.

Medical Necessity and Precertification

The LGHIP will only pay for care that is medically necessary and not investigational, as determined by BCBS. BCBS developed medical necessity standards to aid BCBS when it makes medical necessity determinations. BCBS publishes these standards on the Internet at www.AlabameBlue.com/providers/policies. The definition of medical necessity is found in the "Definitions" section of this booklet.

In some cases, the LGHIP requires that you or your treating provider precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Later sections tell you when precertification is required and how to obtain precertification.

In-Network Benefits

One way in which the LGHIP tries to manage healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of in-network provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. For example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the LGHIP. Additionally, out-of-network providers have not contracted with BCBS or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the LGHIP.

In-network providers are hospitals, physicians, pharmacies, and other healthcare providers or suppliers that contract with BCBS or any Blue Cross and/or Blue Shield plans (directly or indirectly through, for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced price. Examples of the plan's Alabama in-network providers are:

- BlueCard PPO
- Participating Hospitals
- Preferred Outpatient Facilities

- Participating Ambulatory Surgical Centers
- Participating Renal Dialysis Providers
- Preferred Medical Doctors (PMD)
- Specialty Pharmacy Network

To locate Alabama in-network providers, go to www.AlabamaBlue.com.

1. Click “Find a Doctor.”
2. Select a healthcare provider type: doctor, hospital, dentist, pharmacy, other healthcare provider, or other facility or supplier.
3. Enter a search location by using the zip code for the area you would like to search or by selecting a state.
4. Use the drop-down menu in the Network and Plans filter to select a specific provider network (as noted above).

Search tip: If your search returns zero results, try expanding the number in the Maximum miles for search drop-down.

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder website at http://AlabamaBlue.com. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross plan where services are rendered. The local Blue Cross plan will then forward the claims to BCBS for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the LGHIP or is not covered under the contract between the provider and the local Blue Cross plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the LGHIP, such as “Other Covered Services.”

Relationship between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association

BCBS is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits BCBS to use the Blue Cross and Blue Shield service marks in the state of Alabama. BCBS is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than BCBS and the Local Government Health Insurance Board will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of BCBS not created under the original agreement.

Claims and Appeals

When you receive services from an in-network provider, your provider will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with BCBS for reimbursement under the terms of the LGHIP. If BCBS denies a claim in whole or in part, you may file an appeal with BCBS. BCBS will give you a full and fair review. Thereafter, you may have the right to an independent external review. The provisions of the plan dealing with claims or appeals are found further on in this booklet.

Termination of Coverage

The following chapter, “Eligibility and Enrollment” tells you when coverage may be declined, canceled or terminated under the LGHIP. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the LGHIP or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your LGHIP coverage terminates. COBRA coverage is explained in detail later in this booklet.

Your Rights

As a member of the plan, you have the right to:

- Receive information about services, in-network providers, and your rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the plan provides.
- Make recommendations regarding member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service Department number on the back of your ID card.

Your Responsibilities

As a member of the plan, you have the responsibility to:

- Supply information (to the extent possible) that is needed for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ELIGIBILITY AND ENROLLMENT

Minimum Employee Participation

All current and future eligible active employees, and elected officials if covered by the unit, must be enrolled in the LGHIP unless proof of other group insurance is provided. All employees who decline coverage must sign a "Declination of Coverage" form and submit acceptable proof of other group coverage.

All eligible employees must be enrolled at all times during their employment with the unit except for any time(s) that the employee is covered by other group coverage. If an eligible employee is covered by other group coverage, that employee must provide a “Declination of Coverage” form to the LGHIB with proof of other group coverage. If an employee has declined coverage in the LGHIP and later loses their other group coverage, that eligible employee must immediately notify the LGHIB and enroll in the LGHIP. If the eligible employee does not notify the LGHIB and does not enroll in the LGHIP, both the eligible employee and the unit will be liable and will be back-billed to the date the eligible employee should have been enrolled. If the premiums for the back-billing are not paid, the unit may be cancelled from participation in the LGHIP.

If the unit elects to provide insurance coverage for its retirees, such coverage must be offered to all current and future retirees. The LGHIB may periodically require and verify an employment census.

Eligible Participants

Employee - a permanent active full-time employee in a bona fide employer-employee relationship, working 30 hours (minimum) per week, who is not on layoff or leave of absence. Temporary, part-time, seasonal, intermittent, emergency, and contract employees are not eligible for coverage unless you work an average of 30 hours per week during a designated measurement period as stipulated under the Affordable Care Act. Note: Employees classified as “part-time” by a unit must average less than 30 hours of service per week.

Elected officials – Elected officials of a local government unit are also eligible while in office. Elected officials will be classified for insurance purposes as active employees.

Retiree – the following rules apply to retiring employees:

1. Employees who enrolled in the LGHIP prior to January 1, 2005 may elect to continue coverage as a retiree under the LGHIP if:
   - employee has 25 years of creditable service, regardless of age, or
   - employee has 10 years of service and:
     - is 60 years old or
     - is determined to be disabled by the Social Security Administration or the Retirement Systems of Alabama

2. Employees enrolling in the LGHIP after January 1, 2005 may elect to continue coverage as a retiree under the LGHIP if:
   - employee has 25 years of creditable service, regardless of age, or
   - employee has 10 years of service, and
     - is 60 years old, or
     - is determined to be disabled by the Social Security Administration or the Retirement Systems of Alabama, and
   - employee has been enrolled in the local government health plan for 10 years prior to the date of retirement, or
   - if unit has been enrolled less than 10 years, the employee must have been enrolled continuously from the date the unit joined the LGHIP.

   Any retired employee who does not meet the above requirements will be considered a termination.

3. Elected Officials - An elected official retiring from a unit that offers health insurance coverage to its retirees, but who is not eligible to receive the same pension benefits from the unit due to local, state or federal law as full-time employees may be eligible to elect to continue coverage under a plan designated by the LGHIB if the retired official:
   - has at least 25 years of service with the unit he or she is retiring from, regardless of age, and
   - has been enrolled in the LGHIP for at least 10 years prior to the date of retirement. (If unit has been enrolled in the LGHIP less than 10 years, the elected official must have been enrolled from the date the unit joined the LGHIP.)

   Before the LGHIB will consider coverage for a retired elected official, the unit must submit an elected official retiree enrollment form, which will include references to the local state or federal law that prohibits pension benefits and certify that no local, state or federal law will be violated by continuing the retired elected official's health insurance coverage.

   The local government unit makes the determination of allowing eligible retirees to continue on the Program. The unit also makes the determination to continue retiree coverage until Medicare eligible or indefinitely.

Eligible Dependents

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.):

1. Your spouse (excludes a divorced spouse)
2. A child under age 26, only if the child is:
   a. Your son or daughter (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
   b. A child legally adopted by you
   c. Your stepchild
   d. Your grandchild, niece or nephew for whom the court has granted custody to you or your spouse.
3. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent upon the subscriber for 50% or more support,
   e. is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group insurance benefits, including Medicare and Medicaid.

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 LGHIB 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 LGHIB within 60 days from the date the child would otherwise cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who meets the eligibility requirements except for age:

- when a new employee requests coverage for an incapacitated dependent within 60 days of employment, or
- 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 LGHIB within 30 days of the incapacitated dependent's loss of other coverage, and
- Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the final decision as to whether an application for incapacitated status will be accepted. NOTE: The LGHIB reserves the right to periodically recertify incapacitation.

Exclusion: You may not cover your spouse or other dependents if they are insured or if they are eligible to be insured as an active employee in the LGHIP.

Qualified Medical Child Support Orders

If the LGHIB receives an order from a court or administrative agency directing the LGHIP to cover a child, the LGHIB will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The LGHIB has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting the LGHIB.

The LGHIP will cover an employee's child if required to do so by a QMCSO. If the LGHIB determines that an order is a QMCSO, the child will be enrolled for coverage effective as of a date specified by the LGHIB, but not earlier than the first day of the month following the LGHIB's determination that the order is a QMCSO.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the LGHIB will charge the unit for that coverage. During the period the child is covered under the LGHIP as a result of a QMCSO, all LGHIP provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the QMCSO is in effect the LGHIP will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. The LGHIB will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the LGHIP. The LGHIB will also send claims reports directly to the child's custodial parent or legal guardian.

Initial Employee Enrollment

Eligible employees, elected officials, retirees and dependents who make application on or before the effective date of the Group Contract will be enrolled for coverage as of the effective date of the Group Contract. All eligible employees, elected officials and retirees must either elect or decline coverage.

Employees eligible for coverage as a result of averaging 30 or more hours per week or 130 or more hours per month during a designated measurement period will be enrolled as of the first day of a corresponding designated stability period (unless the employee provides a declination of coverage form).

Eligible retirees must enroll on the date they first become eligible for retiree health benefits. If coverage is declined, enrollment will not be allowed after the retirement date. Retirees who do not elect coverage will not be allowed to enroll at a later date.

Family Coverage Enrollment

A participating employee, elected official or retiree in the LGHIP may apply for family coverage either upon their initial enrollment (enrollment form), or by acquiring a new dependent (dependent change form), or annual open enrollment (dependent change form) or dependent special enrollment (dependent change form).

Appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) must be submitted to the LGHIB. **Note**: to ensure that enrollment deadlines are met, change forms should be submitted to the LGHIB even if all the required documentation is not available.

If the required documentation is not submitted with an Enrollment Form or Change Form, the LGHIB will send a notice to the employee that the required documentation must be submitted within 60 days of the date of the letter. If documentation is not submitted to the LGHIB office within those 60 days, the request to add dependent coverage will be denied.

Initial Enrollment/New Employees
New employees may elect to have dependent coverage begin on the date their coverage begins.

Acquiring New Dependent
A newly acquired dependent may be enrolled if the LGHIB is notified within 60 days of acquiring the new dependent through marriage, birth, adoption, or custody of a grandchild, niece or nephew.

The effective date of coverage will be:
- in the case of a birth - the date of birth;
- in the case of marriage – the date of marriage;
- in an adoption – the date of the Interlocutory Decree or other temporary Order granting the employee custody of the adoptee entered by a court in which the adoption proceeding has been filed;
- custody of a grandchild, niece or nephew – the date of the judge's order granting custody.

If the LGHIB is notified of a new dependent after 60 days, the eligible participant will not be allowed to enroll the newly acquired dependent at that time and will need to reapply during the annual open enrollment.

Annual Open Enrollment
A participating employee, elected official or retiree may apply to add a dependent or apply for family coverage during the month of November for a January 1 effective date. The effective date indicated on the form should be January 1.

Dependent Special Enrollment
If a dependent loses their other group coverage, the subscriber may apply for Dependent Special Open Enrollment. The effective date of coverage will be the date the other group coverage ceased. See "Special Enrollment Period, Dependents." The only dependents eligible are those who experienced a "qualifying event."

Open Enrollment

Subsequent to the effective date of the Group's Contract, there shall be an Annual Open Enrollment held November 1 thru November 30 (for coverage to be effective January 1) of each year during which:
- Active eligible employees not currently participating in the insurance may enroll.
- Eligible participants may add dependents or family coverage. If an employee wishes to add dependents or add family coverage during open enrollment, a dependent change form must be filled out and submitted to the LGHIB.
- Eligible participants are permitted to change insurance carriers/plans.
- Employees who have previously declined coverage may submit an updated "Declination of Coverage" form with acceptable proof.

Forms shall be completed and signed in November with an effective date of January 1 indicated on the form and submitted to the LGHIB office by November 30. If an employee does not want to change plans or add/drop family coverage during open enrollment, no paperwork is necessary.

Special Enrollment Period

Employees

Under the Health Insurance Portability and Accountability Act, the LGHIP must offer a special enrollment period in addition to open enrollment for those employees who experience a qualifying event such as loss of

their other employer group coverage or the addition of a dependent. However, since the LGHIP already requires that an employee enroll in the plan when they lose other employer group coverage, special enrollment will only apply to the following qualifying events not related to loss of coverage:

- the addition of a new dependent through birth, adoption or marriage or
- a substantial change in their other employer group coverage or
- a substantial change in the cost of their other employer group coverage.

To be eligible for special enrollment an employee must have a declination of coverage form with proof of other employer group coverage on file. Employees requesting special enrollment must notify the LGHIB in writing within the 30 days of a qualifying event. Notification must include:

1. a letter requesting participation in the special enrollment; and
2. a completed enrollment form; and
3. if proof of the qualifying event is not submitted with the letter requesting special enrollment and the completed enrollment form, the proof listing the reason and date of loss for all individuals affected by loss of coverage (e.g., employment termination on company letterhead) must be submitted within 60 days of the qualifying event.

All employees who lose their other employer group coverage, whether voluntarily or involuntarily must submit an enrollment form to the LGHIB with coverage effective as of the date coverage is lost.

Dependents

To be eligible for dependent special enrollment, an employee must submit a dependent change form with proof of loss of other employer group coverage. Employees requesting dependent special enrollment must notify the LGHIB in writing within 30 days of the qualifying event. Notification must include:

1. a letter requesting participation in the special enrollment; and
2. a completed dependent change form; and
3. if proof of the qualifying event is not submitted with the letter requesting special enrollment and the completed dependent change form, the proof listing the reason and date of loss for all individuals affected by loss of coverage (e.g., employment termination on company letterhead) must be submitted within 60 days of the qualifying event.

The only dependents eligible are those who experienced a “qualifying event.” If approved, the effective date of coverage will be the date other group coverage ceased.

When Coverage Commences

Coverage commences as of the effective date of the employee's insurance contract.

Cancellation of Family Coverage

An employee may drop family coverage at any time. The earliest effective date of cancellation will be the first day of the month following the LGHIB’s receipt of written notification by the LGHIB office. The LGHIB requires proof of divorce (divorce decree) when dropping a former spouse due to divorce.

Transfers

Only new employees meeting the following criteria will be considered as transfers under the LGHIP:

1. new hire, previously covered by the LGHIP, and
2. new hire, terminated employment with another local government unit covered by the LGHIP, who became employed with a local government unit during the same calendar month of termination.

Notice

Notice of any enrollment changes is the responsibility of the subscriber (for example, additions or deletions of dependents or address changes).

In addition, it is the responsibility of the subscriber to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible from coverage) of the subscriber results in or contributes to the payment of claims by the LGHIP for persons ineligible for coverage, the subscriber will be personally responsible for all such overpayments and shall be subject to disciplinary action including termination of coverage. (Note: an ex-spouse is ineligible for coverage and cannot be maintained as a dependent under family coverage regardless of a judgment or divorce decree requiring the subscriber to provide health care for an ex-spouse. However, an ex-spouse may be eligible for COBRA continuation coverage.)

Declination of Coverage

Employees may decline coverage at any time. The earliest effective date of cancellation will be the first day of the month following receipt of **both the Declination of Coverage and acceptable proof of group coverage with another employer**. Acceptable proof is a current letter from employer/insurance carrier verifying current coverage.

Premium Payments

The LGHIB bills in advance for the following month's coverage. To be eligible for coverage members must comply with the LGHIP's enrollment and eligibility rules. Acceptance of premium payment does not guarantee coverage.

Supernumeraries

Supernumeraries will be classified for insurance purposes as retired employees.

PROVISION FOR MEDICARE ELIGIBLES

Active Employees

The LGHIB provides active employees, over age 65, coverage under the LGHIP under the same conditions as any employee under age 65. Medicare is secondary to benefits payable under the LGHIP for employees over age 65 and their spouses over age 65. If the service is also covered by Medicare, the claim can be submitted to Medicare who may pay all or a portion of the unpaid balance of the claim subject to Medicare limitations.

The LGHIB will not provide an active employee or his/her spouse with benefits that supplement Medicare. The employee has the right to elect coverage under the LGHIP on the same basis as any other employee.

The LGHIP will be the primary payer for those items and services covered by Medicare. (Note that Medicare covers hospitalization, post-hospital nursing home care, and home health services.) This means that the LGHIP will pay the covered claims and those of the employee's Medicare-entitled spouse first, up to the limits contained in the LGHIP, and Medicare may pay all or a portion of the unpaid balance of the claims, if any, subject to Medicare limitations. If the employee's spouse is not eligible for Medicare, the LGHIP will be the sole source of payment of the spouse's claims.

Since the LGHIP also covers items and services not covered by Medicare, the LGHIP will be the sole source of payment of medical claims for these services.

Retired Employees

Health benefits will be modified when you or your dependent becomes entitled to Medicare. Coverage under the LGHIP plan will be reduced by those benefits payable under Medicare, Parts A and B. If a retiree or dependent becomes entitled to Medicare because of a disability before age 65, the retiree must notify the LGHIB to be eligible for the reduced premiums and to ensure that claims are paid properly. A copy of the retiree's or their dependent's Medicare card and a Change Form that indicates the rate change must be submitted if the unit covers Medicare retirees.

The LGHIP remains primary for retirees until the retiree is entitled to Medicare. Upon Medicare entitlement, the retiree's coverage under the LGHIP will complement his/her Medicare Parts A and B coverages. Medicare will be the primary payer and the LGHIP will be the secondary payer. **A Medicare retiree and/or Medicare dependent should have both Medicare Parts A and B to have adequate coverage with the LGHIP.**

Medicare Part B premiums are the retiree's responsibility. These premiums are deducted from the retiree's Social Security check.

Medicare Part D Prescription Drug Coverage

Medicare retirees and retiree Medicare dependents are enrolled in the LGHIP's prescription drug Employer Group Waiver Plan (EGWP). The LGHIP EGWP is a Medicare Part D prescription drug plan that is in addition to the coverage under Medicare Part A or Part B.

It is the retiree's responsibility to inform the LGHIB if they are enrolled in another Medicare prescription drug plan. Retirees can only be enrolled in one Medicare prescription drug plan at a time. Retirees are not required to be enrolled in the LGHIP EGWP, but if they elect to opt out, they must complete an EGWP Opt-Out Form and return it to the LGHIB. Opt-out forms are available on the website.

If a Medicare retiree opts out of the LGHIP EGWP, **the retiree will have no prescription drug coverage from the LGHIP**. Retirees will, however, still have the LGHIP secondary Medicare Part A and B coverage if they opt-out of the LGHIP EGWP and can also decide to join a different Medicare Part D prescription drug plan. Retirees can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for help in learning how to enroll in another Medicare Part D prescription drug plan. (TTY users should call 1-877-486-2048.)

Retirees should keep in mind that if they leave the LGHIP plan and do not have or do not enroll in another prescription drug plan, there may be a late enrollment penalty in addition to their premium for Medicare prescription drug coverage in the future.

Medicare limits when changes can be made to coverage. Retirees may leave this plan only at certain times of the year or under certain special circumstances. Generally, there is an open enrollment period at the end of each year when changes can be made to Medicare Part D prescription drug plans for coverage that will be effective January 1 of the following year. To request to leave the LGHIP EGWP, please submit the EGWP Opt-Out Form to:

Local Government Health Insurance Board
PO Box 304900
Montgomery, AL 36130-4900.

Once enrolled in the LGHIP EGWP, a retiree has the right to appeal plan decisions about payment of services if they disagree. Read EGWP plan documents to know the rules that must be followed to receive coverage with this Medicare prescription drug plan.

TERMINATION OF COVERAGE

When Coverage Terminates

The member's coverage will terminate:

1. On the last day of the month in which the member's employment terminates.
2. When the LGHIP is discontinued.
3. When premium payments cease.
4. When the unit withdraws from the LGHIP.
5. In addition to the above, the coverage terminates for a dependent:
   a. on the last day of the month in which such person ceases to be an eligible dependent, or
   b. if the dependent becomes eligible to be insured as an employee in the LGHIP.
6. In the case of an employee who is eligible and receives insurance pursuant to the provisions of the Affordable Care Act on the basis of working an average of 30 or more hours per week or 130 or more hours per month during a measurement period, coverage terminates on the first day after the applicable stability period if the employee does not average 30/130 or more hours per week/month during a subsequent measurement period.

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 and Medical Leave Act

The LGHIB will adhere to the provisions of the Family and Medical Leave Act.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

Introduction

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

This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of this law. **You and your spouse should take the time to read this carefully.**

What is COBRA Continuation Coverage?

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

Who is a Qualified Beneficiary?

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under the LGHIP 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. (An increase in the cost of retiree coverage relative to active employee coverage is also considered a loss of coverage for COBRA purposes.) In addition, a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the LGHIP because either one of the following qualifying events occurs:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

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

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform the LGHIB that you do not intend to return to work, whichever occurs first.

COBRA Rights for a Covered Spouse and Dependent Children

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the LGHIP because one of the following qualifying events occurs:

- 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 LGHIP because any of the following qualifying events occurs:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the LGHIP as a "dependent child."

What Coverage is Available?

If you choose continuation coverage, the LGHIB is required to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the LGHIP to similarly situated employees or family members.

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the LGHIB has been notified that a qualifying event has occurred.

When Your Employer Should Notify the LGHIB

COBRA continuation coverage will be offered to qualified beneficiaries only after the LGHIB has been notified that a qualifying event has occurred. Your employer is responsible for notifying the LGHIB of the following qualifying events:

- End of employment,
- Reduction of hours of employment, or
- Death of an employee.

When You Should Notify the LGHIIB

The employee or a family member has the responsibility to inform the LGHIB of the following qualifying events:

- A divorce,
- A legal separation, or
- A child losing dependent status.

Written notice must be given to the LGHIB within 60 days of the date of the qualifying event or the date in which coverage would end under the LGHIP because of the qualifying event, whichever is later. All notices should be sent to the address listed under "LGHIB Contact Information" at the end of this section.

How is COBRA Coverage Provided?

When the LGHIB is notified that a qualifying event has happened, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. In addition, a covered employee may elect COBRA continuation coverage on behalf of his or her spouse and either covered parent may elect COBRA continuation coverage on behalf of their children. If you do not choose continuation coverage, your group health insurance will end.

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

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the LGHIP, or (2) the date on which the LGHIB notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date the election notice is sent back to the LGHIB.

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

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

What Will Be the Length of COBRA Coverage?

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage will last for up to a total of 36 months when one of the following qualifying events occurs:

- Death of the employee,
- Divorce or legal separation, or
- Dependent child loses eligibility as a "dependent child" under LGHIP.

COBRA continuation coverage will last for up to a total of 18 months when one of the following qualifying events occurs:

- End of employment or
- Reduction in the hours of employment.

There are only two ways to extend the 18-month COBRA continuation coverage period:

- **Disability** – If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the LGHIB, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

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

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

  For this disability extension of COBRA coverage to apply, you must give the LGHIB timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the LGHIB within 30 days of any revocation of Social Security disability benefits.

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

  This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, gets divorced, or if the child stops being eligible under the plan as a dependent child, *but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.* For example, if a covered employee is terminated

from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

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

Can New Dependents Be Added to COBRA Coverage?

You may add new dependents to your COBRA coverage under the circumstances permitted under the LGHIP. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

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

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

How Does the Family and Medical Leave Act Affect COBRA Coverage?

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.

How Much is COBRA Coverage Premium?

If you qualify for Continuation Coverage, you will be required to pay the group’s premium plus a 2% administrative fee directly to the LGHIB. 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.

When is the COBRA Coverage Premium Due?

The initial premium payment must be submitted to the LGHIB within 45 days from the date of election. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

When Does COBRA Coverage End?

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

1. LGHIB no longer provides group health coverage;
2. The unit withdraws from the LGHIP;
3. The premium for your continuation coverage is not paid on time;
4. The covered beneficiary becomes covered by another group plan;
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.

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 30 days for payment of the regularly scheduled premium.

Note: If you are entitled to Medicare before you become a qualified beneficiary, you may elect COBRA continuation coverage; however, your Medicare coverage will be primary and your COBRA continuation coverage will be secondary. You must have Medicare Parts A and B in order to have full coverage.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for a qualified beneficiary through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Individuals can learn more about many of these options at www.healthcare.gov.

Keep the LGHIB Informed of Address Changes

In order to protect your family's rights, you must keep the LGHIB 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 LGHIB.

If You Have Any Questions

Questions concerning your COBRA continuation coverage rights may be addressed by calling the LGHIB at 1.866.836.9137 or 334.263.8326 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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

LGHIB Contact Information

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

Local Government Health Insurance Board
LGHIP COBRA Section
P.O. Box 304900
Montgomery, AL 36130-4900

BENEFIT CONDITIONS

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

- They must be furnished after your coverage becomes effective;

- Blue Cross must determine before, during, or after services and supplies are furnished that they are medically necessary. (Note: all inpatient hospital stays, certain outpatient procedures, including radiology procedures, and a select group of physician-administered drugs must be pre-certified by Blue Cross. Visit AlabamaBlue.com for a complete list of procedures or drugs that require precertification).

- PPO benefits must be furnished while you are covered by the LGHIP and the provider must be a PPO provider when the services are furnished to you.

- Separate and apart from the requirement in the previous paragraph, services and supplies must be furnished by a provider (whether Preferred Provider or not) who is recognized by BCBS as an approved provider for the type of service or supply being furnished. For example, BCBS reserves the right not to pay for some or all services or supplies furnished by certain persons who are not Medical Doctors (MD's), even if the services or supplies are within the scope of the provider's license. Call Blue Cross Customer Services if you have any question whether your provider is recognized by BCBS as an approved provider for the services or supplies you plan on receiving.

- Services and supplies must be furnished when the LGHIP 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 which began before the LGHIP or your coverage ends.

COST SHARING

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Out-of-Pocket Maximum	$6,250 per member, $12,500 per family Certain benefits pay at 100% of the allowed amount thereafter	Out-of-network services do not apply to the out-of-pocket

Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is specified in the table above. All cost-sharing amounts (calendar year deductible, copayment and coinsurance) for in-network covered services that you or your family is required to pay under the LGHIP apply to the calendar year out-of-pocket maximum. Once the maximum has been reached, covered expenses of the type that count towards the maximum will be paid at 100% of the allowed amount for the remainder of the calendar year.

There may be expenses you are required to pay under the LGHIP that **do not** count toward the calendar year out-of-pocket maximum, and that you must continue to pay even after you have met the calendar year out-of-pocket maximum. The following are some examples:

Out-of-network cost-sharing amounts (deductibles, copayments, coinsurance):

- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges);
- Amounts paid for services or supplies in excess of any plan limits (for example, a limit on the number of covered visits for a particular type of provider); and,
- Amounts paid as a penalty (for example, failure to precertify).

The calendar year out-of-pocket maximum applies on a per person per calendar year basis, subject to the family maximum.

The calendar year family out-of-pocket maximum is an aggregate dollar amount. This means that all amounts that count toward the individual calendar year out-of-pocket maximum will count toward the family aggregate amount. Once the family calendar year out-of-pocket maximum is met, affected benefits for all covered family members will pay at 100% of the allowed amount for the remainder of the calendar year.

Example: If one member in the family reaches the maximum of $6,250, that one member's covered benefits would be covered at 100%. Out of pocket expenses for all other family members will continue to count toward the family maximum of $12,500.

Other Cost Sharing Provisions

The LGHIP may impose other types of cost sharing requirements such as the following:

- **Admission deductibles:** These apply upon admission to a hospital. Only one admission deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- **Copayments:** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor's office.
- **Coinsurance:** Coinsurance is the amount that you must pay as a percent of the allowed amount.

- **Amounts in excess of the allowed amount:** As a general rule, and as explained in more detail in "Definitions," the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with BCBS or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount. For example: Out-of-network provider claims may include expensive ancillary charges (billed by the facility or a physician) such as implantable devices for which no extra reimbursement is available as these charges are not separately considered under the LGHIP. This means you will be responsible for these charges if you use an out-of-network provider.

Out-of-Area Services

BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of BCBS's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program and may include negotiated National Account arrangements available between BCBS and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the BCBS service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host" Plan). In some instances, you may obtain care from non-participating healthcare providers.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Plan, BCBS will remain responsible for fulfilling their contractual obligations. However, the Host Plan is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside the BCBS service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Plan makes available to BCBS.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or under estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBS uses for your claim because they will not be applied retroactively to claims already paid.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through Negotiated Arrangements for National Accounts.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the negotiated price [lower of either billed covered charges or negotiated price] (Refer to the description of negotiated price under Section A., BlueCard Program) made available to BCBS by the Host Plan

C. Non-Participating Healthcare Providers Outside the BCBS of Alabama Service Area

1. Member Liability Calculation
   When covered healthcare services are provided outside of BCBS service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Plan's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment BCBS will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions
   In certain situations, BCBS may use other payment methods, such as billed covered charges, the payment BCBS would make if the healthcare services had been obtained within its service area, or a special negotiated payment to determine the amount they will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBS will make for the covered healthcare services as set forth in this paragraph.

D. BlueCard Worldwide® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the BlueCard Worldwide® Program when accessing covered healthcare services. The BlueCard Worldwide Program is not served by a Host Plan.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. You must contact us to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a BlueCard Worldwide Claim**
  When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBS, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

INPATIENT HOSPITAL BENEFITS

Pre-admission Certification and Post-admission Review

BCBS provides all health management for LGHIP members and covered dependents. To be eligible for inpatient hospital benefits, all inpatient hospital admissions and stays (except medical emergencies that must have Post-admission Review) must be reviewed, approved, and certified by BCBS as medically necessary before you are admitted to the hospital.

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

To obtain pre-admission certification:

- You or your provider must telephone BCBS at least seven days before the proposed elective hospital admission at 1.800.248.2342. **It is your responsibility to make sure this is done. Failure to comply may result in reduced benefits.**

- BCBS will determine whether the proposed inpatient hospital admission and stay are medically necessary.

To obtain post-admission review for out-of-network services:

- You, your provider or a person acting for you must telephone BCBS at 1.800.248.2342 with details of an elective admission prior to the admission. Admissions due to emergency diagnosis should be reported to BCBS no later than 48 hours after the admission. It is your responsibility to make sure this is done. After your admission, you or your physician may be asked to supply written information regarding your condition and treatment plan. Failure to comply may result in reduced benefits. Generally, if preadmission certification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician. There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the plan.

- Your provider and the hospital must provide BCBS with all medical records about your admission upon request.

- BCBS will determine whether the inpatient hospital admission and stay were medically necessary and whether the admission was for a medical emergency.

Subject to your rights of appeal, if you do not obtain pre-admission certification or post-admission approval of an admission and stay, BCBS will pay no benefits for your hospital stay or for any related charges. <u>It is your responsibility to make sure all procedures are correctly followed.</u>

Inpatient Hospital Benefits for Maternity

The LGHIB may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less that 96 hours following a cesarean section, or require that a provider obtain authorization from the LGHIP or insurance issuer for prescribing a length of stay not in excess of the above periods. However, if the inpatient hospital stay is greater than 48 hours for vaginal delivery and 96 hours for Cesarean Section, post admission review must be obtained from BCBS.

NOTE: Newborns who remain hospitalized after the mother is discharged will require certification of medical necessity from BCBS.

Deductible

The deductible for each certified inpatient hospital admission is **$200 (with a $50 per day co-pay for the second through the fifth day).** You are responsible for payment of the deductible and co-payment to the hospital. There is a separate deductible for each admission or readmission of each member to a hospital except when:

- There is more than one admission to treat the same pregnancy,
- Two or more family members with family coverage are admitted for accidental injuries received in the same accident, or
- You are transferred directly from one hospital to another.

Inpatient Hospital Benefits in a Non-Participating Hospital in Alabama

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

Women's Health and Cancer Rights Act

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications at all stages of the mastectomy, including lymphedema.

The attending physician and patient make treatment decisions. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Organ and Bone Marrow Transplants

The organs for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney; and (6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on the BCBS list of approved facilities for that type of transplant and it must have BCBS's advance written approval. When BCBS approves a facility for transplant services it is limited to the specific types of transplants stated. Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma. Transplant benefits for cadaveric donor organ costs are limited to search, removal, storage, and transporting the organ and removal team. Transplant benefits for living donor expenses are limited to:

- solid organs: testing for related and unrelated donors as pre-approved by us
- bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrow registry
- pre-diagnostic testing expenses of the actual donor for the approved transplant
- hospital and surgical expenses for removal of the donor organ, and all such services provided to the donor during the admission
- transportation of the donated organ
- post-operative hospital, medical, laboratory and other services for the donor related to the organ transplant limited to up to 90 days of follow-up care after date of donation.

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copays, coinsurance, and other plan limitations. For example, if the member's coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

There are no transplant benefits for: (1) any investigational/experimental artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) donor costs if the recipient is not covered by this plan; (7) recipient or donor lodging, food, or transportation costs, unless otherwise specifically stated in the plan; (8) a condition or disease for which a transplant is considered investigational; (9) transplants (excluding kidney) performed in a facility not on our approved list for that type or for which BCBS has not given written approval in advance.

Tissue, cell and any other transplants not listed above are not included in this organ and bone marrow transplant benefit but may be covered under other applicable provisions of the plan when determined to be medically necessary and not investigational. These transplants include but are not limited to: heart valves, tendon, ligaments, meniscus, cornea, cartilage, skin, bone, veins, etc.

OUTPATIENT FACILITY BENEFITS

The benefits below are available for charges by a facility for the types of services and supplies listed (except bed, board, and nursing care) when ordered by a provider and provided as outpatient services. Precertification is required for certain outpatient hospital procedures, including radiology procedures, and physician administered drugs. Some of the procedures are listed below and are subject to change. For a complete listing and for precertification please call 1.800.248.2342.

- Charges to treat an accidental injury within 72 hours after the injury.
- Charges for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention) **after a $200 co-payment.** Claims with emergency room charges that do not meet medical emergency guidelines will be considered under Major Medical.
- Payment of the hospital's charges for sleep disorder services rendered in an approved sleep disorder clinic. Please contact the BCBS Customer Service Department for a list of the approved facilities.
- Chemotherapy and radiation therapy services after **a $25 co-payment per visit.**
- Hospital charges for hemodialysis services in its outpatient department **after a $25 co-payment per visit.** Services received in a free-standing dialysis center are only covered under Major Medical.
- IV therapy **after a $25 co-payment per visit.**
- Laboratory and pathology services **after a $3 co-payment per test.**
- Diagnostic X-rays test **after a $100 co-payment per visit**.
- Charges for outpatient surgery **after a $100 co-payment or cost per visit**.

It is your responsibility to make sure that your provider obtains prior authorization from CareCore National, BCBS's radiology review organization, for certain outpatient diagnostic procedures. Failure to comply may result in reduced benefits. If you do not obtain prior authorization of an outpatient diagnostic procedure listed below, BCBS will pay no benefits for your outpatient procedure or for any related charges. You are also responsible for being aware of the limitations of your benefits.

- CAT Scan
- MRI
- PET Scan
- MUGA-gated Cardiac Scan
- Angiography/ Arteriography
- Cardiac Cath/Arteriography

- **Bariatric Surgical procedures are limited to one per lifetime, subject to prior authorization by BCBS.** Benefits for these services are provided only when the services are performed by a PPO provider. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.

However, if you are admitted as an inpatient in any hospital immediately after receiving any of the above outpatient services (or within seven days after receiving tests) no outpatient hospital benefits will be available to you for those services, and those services instead will be covered as inpatient hospital benefits. Also, if you are admitted as a hospital inpatient more than seven days after the pre-operative tests, no benefits will be paid for them under any part of this contract.

Outpatient Hospital Benefits in a Non-Participating Hospital in Alabama

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

Pre-certification

Certain outpatient surgical/diagnostic procedures, including radiology procedures and physician administered drugs require pre-certification. Contact BCBS at 1.800.248.2342 before receiving services. Examples of some procedures that require precertification are listed below. This is only a partial list of procedures and is subject to change.

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

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

It is your responsibility to make sure precertification is obtained for certain outpatient/surgical diagnostic procedures. Failure to comply may result in reduced benefits. If you do not obtain precertification of an outpatient/surgical diagnostic procedure, Blue Cross will pay no benefits for your outpatient procedure or for any related charges. You are also responsible for being aware of the limitations of your benefits.

UTILIZATION MANAGEMENT

Inpatient Hospitalization

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

Continued Stay Review

If your hospital stay must be extended beyond the days initially authorized, BCBS will contact your provider 24 hours before your scheduled discharge to obtain clinical data and process a request for extension-of-stay authorization. At the completion of the review, BCBS will confirm discharge or authorize additional days for your stay.

Determinations by BCBS to Limit or Reduce Previously Approved Care

If BCBS has previously approved a course of treatment to be provided over a period of time or number of treatments, and later decides to limit or reduce the previously approved course of treatment, BCBS will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules established for filing of your appeal, such as time limits within which the appeal must be filed.

Retrospective Review

If you fail to notify BCBS about an out-of-network hospitalization you may request a Retrospective Review for medical necessity. Requests for retrospective review must be submitted to BCBS either in writing or by telephone. All information required to process the retrospective review must be submitted to BCBS within two years from the date the claims report is issued by BCBS.

In order to expedite the retrospective review process you may mail a copy of your medical records to BCBS. The records can be obtained from the hospital or treating provider. You will be responsible for any and all charges associated with retrieval and copying of medical records for medical review. Upon determination of medical necessity the claim will be processed according to the plan benefits and will include any applicable penalty for failure to pre-certify.

Maternity Management

"Baby Yourself", LGHIB's Maternity Management Program, offers a mechanism for identifying high-risk pregnancies and managing them to prevent complications at the time of delivery. As soon as a pregnancy is confirmed, the patient or the doctor should call BCBS at 1.800.248.2342. **By participating in "Baby Yourself" and notifying BCBS before the end of the second trimester, your inpatient deductible and applicable daily co-pay(s) will be waived.** After asking some questions regarding the pregnancy and medical history, BCBS's nurse contacts the doctor to obtain additional clinical information.

Following BCBS's evaluation, the expectant mother and the provider are sent information further explaining the program. Additionally, the expectant mother is sent a special Baby Yourself kit that includes educational materials related to pregnancy and childcare.

Case Management

You may be eligible to receive certain alternative benefits through individual case management when your condition is catastrophic or requires long term care. The program is administered by BCBS. To contact them call 1.800.248.2342.

If BCBS determines that you are a suitable candidate for individual case management, they will notify you. The letter will tell you that you are eligible to receive alternative benefits if you, your provider and BCBS can agree on an Alternative Benefit plan. Except for exceptions stated in your alternative benefits plan, all terms and conditions of the contract apply to you while you receive alternative benefits.

Alternative benefits are available to you only when they replace services, care, treatment or supplies covered by another section of this contract. For example, alternative benefits may not be made available as an alternative to any benefit excluded (such as radial keratotomy).

Because individual case management is designed to provide the most appropriate benefits for each individual case, the alternative benefits plan for any member may differ from another member's plan even if they have the same medical condition. Providing alternative benefits to you or any other member is not to be construed as a waiver of the right to administer and enforce the contract exactly as it is written.

If you believe that you should receive alternative benefits, you may write BCBS explaining the reasons for your belief. If BCBS determines that you are a candidate for individual case management, they will contact you and begin the process. If BCBS determines that your medical condition does not make you a suitable candidate for alternative benefits or it is determined that you are not eligible for alternative benefits, they will write you of that decision. After receiving the decision you may write for reconsideration stating all the reasons why you believe that you are still entitled to alternative benefits. You may also submit any additional written information that you think is related to your request for reconsideration. If you fail to submit a request for reconsideration within sixty days of the decision you waive any right to challenge that decision later.

You must follow the procedures in this section before you can bring legal action against BCBS for alternative benefits. This does not change your right to have individual claims reviewed under the section titled "Filing a Claim, Reviewing Claim Decision and Appeal of Benefit Denial."

BCBS will terminate your alternative benefits when any of the following happens:

- The time limit (if any) of the written alternative benefits plan expires.
- BCBS determines that the alternative benefits being provided to you are no longer medically necessary or are no longer cost effective.
- You receive care, treatment, services, or supplies that are not set forth in the alternative benefits plan. This does not apply if care, treatment, services or supplies were for a separate medical condition.
- Your coverage ends.
- You tell BCBS, in writing, that you wish to stop alternative benefits. This will terminate your alternative benefits no more than five days after receipt of your notice by BCBS.

Disease Management

Disease Management is a program for members diagnosed with Diabetes, Coronary Artery Disease, or Chronic Obstructive Pulmonary Disease (COPD). This program is available to eligible members at no cost as a part of your benefits.

Blue Cross translates your doctor's treatment plan into daily actions to improve your health. They educate you in the disease process in hopes of avoiding relapses that can lead to hospital and emergency room visits.

First, Blue Cross identifies members who would benefit from the program by analyzing medical and pharmaceutical claims. Once identified, an invitation and welcome kit is mailed.

Working with you and your doctor, a health care professional specializing in your condition develops your personal health goals such as losing weight or lowering your blood pressure or blood sugar. You get support to help you reach your goals.

Everything about the program is confidential. Only you, your doctor and Blue Cross know you are in the program. Call Blue Cross at 1.800.248.2342 or email membermanagement@bcbsal.org.

Appeal of Utilization Management Decision

BCBS provides a three-step appeals process that either the patient or the attending provider can initiate. All information required to process the appeal must be submitted to BCBS within one year from the date the claims report is issued by BCBS.

"Peer to Peer" Review

The attending provider can initiate **a peer to peer review** by contacting BCBS at 1.800.248.2342 or **1.866.578.7395** to discuss any case for which requested services were reduced or non-authorized. Based on the telephone discussion, the BCBS physician will determine whether the original decision was appropriate or should be amended. Proper documentation is provided to the patient and the attending provider after the review.

Appeal

When a disagreement between the attending provider and a BCBS physician is not resolved by **a peer to peer review**, review of the case can be initiated by the attending provider and/or patient via a telephonic or written request to:

Blue Cross Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298
1.800.248.2342

Medical records are obtained and reviewed once a written release has been received from the patient. If the Committee finds additional medical information to justify the authorization, the services are certified. If not, the non-authorization is upheld. If an original adverse decision is reversed by the Committee, the attending provider, patient and claims office are notified in writing.

Independent Review

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with BCBS for an independent, external review of the decision. You must request this external review within 4 months of the date of your receipt of adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 10744
Birmingham, AL 35202-0744

If you request an external review, an independent organization will review BCBS's decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will provide BCBS with copies of this additional information to allow BCBS an opportunity to reconsider the denial. Both will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding, subject to arbitration.

ROUTINE PREVENTIVE CARE

Routine immunizations and preventive care services when provided by an in-network PPO provider are covered at 100% of the BCBS allowable rate with no deductible or co-payment.

Visit **AlabamaBlue.com/preventiveservices** for a listing of specific immunizations and preventive care service. Please note that this list is subject to change. In addition to the services listed on the website, the following preventive services are also provided at 100% of the allowable rate with no deductible or co-payment:

- Urinalysis (once by age 5, then once between ages 12-17)
- CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and older)
- Glucose testing (once every calendar year age 18 and older)
- Cholesterol testing (once every calendar year age 18 and older)
- TB skin testing (once before age 1, once between ages 14-18)

Routine immunizations and preventive care services when provided by an out-of-network or non-PPO provider are covered at 80% of the allowable rate, subject to the calendar year deductible.

PREFERRED PROVIDER ORGANIZATION (PPO)

When you use a PPO Provider for services or treatment other than routine preventive services, you will receive enhanced benefits. When you DO NOT use a PPO Provider for services covered under the PPO program, covered services are paid at 80% of the PPO fee schedule under Major Medical subject to the deductible.

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

Preferred Provider (PPO) Benefits for Physicians, Nurse Practitioners, and Physicians Assistants

To take advantage of PPO benefits, simply choose a PPO Provider from the BlueCard PPO directory. Your provider will file all claims for PPO benefits. When your PPO provider requests the services of another provider for you, that provider must also be a PPO Provider in order for you to receive PPO benefits for his or her services, i.e., an anesthesiologist when surgery is performed or an independent laboratory or radiologist for diagnostic services.

Certain outpatient surgical/diagnostic procedures, including radiology procedures and physician administered drugs require pre-certification. Contact BCBS at 1.800.248.2342 or AlabamaBlue.com before receiving services. Please note the list of procedures and/or drugs requiring precertification is subject to change.

- **Office Care Services** - the examination, diagnosis, and treatment for an illness or injury in a PPO Provider's office. The term treatment is inclusive of in-office minor surgery. **You must pay a $40 Physician co-pay or a $20 Nurse Practitioner or Physician Assistant co-pay for each visit.**

- **Telephone and on-line Video Consultations -** A telephone and online video consultation service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations (where available) are offered 7 days a week, 7am to 9pm. To enroll, go to Teladoc.com/Alabama or call 1-855-477-4549. Teladoc consultations are covered at 100% of the allowable with no deductible, co-insurance, or co-payment. **Out-of-network services are not covered.**
- **Surgical Care Services -** services for operations and cutting procedures and the usual care before and after operations, for reducing fractures and dislocations, for the endoscopic procedures recognized and accepted by Blue Cross, and of an assisting provider who assists in performance of surgical procedures when medically necessary. Surgeries performed in the office are subject to a **$40 co-pay**.
- **Inpatient Medical Care Services -** visits by a PPO Provider for your care or treatment while you are an inpatient and entitled to inpatient hospital benefits under this contract. However, you will not receive benefits for inpatient medical care services if you receive benefits for surgical care, obstetrical care, or radiation therapy services during the same hospital stay because medical care services are included in the surgical, obstetrical or radiation therapy fee. However, if Blue Cross decides inpatient medical care was medically necessary and unrelated to the condition for which you were hospitalized you will receive medical care services benefits.

  You will not be responsible for non-covered medical services when you use a PPO Provider, except when there is a signed agreement on file in the PPO Provider's office, taking patient responsibility for non-covered services. In which case, you will be responsible for the total charges for the non-covered medical services.
- **Consultation Services** - limited to one consultation each for medicine, surgery, and maternity by a PPO Provider while an inpatient during each period of continual hospitalization. The consultation must be for an illness or injury requiring the special skill or knowledge of the PPO Provider.

- **Diagnostic X-ray -** services are covered in full.
- **Outpatient Diagnostic Lab and Pathology -** coverage is provided for outpatient diagnostic lab and pathology services when performed by a PPO Provider. **The member pays $3 co-pay per test**.
- **Emergency Room Physician Services** - care and treatment by a PPO Provider in hospital emergency rooms in an emergency other than for surgery or childbirth. **You must pay a $40 Physician co-pay or a $20 Nurse Practitioner or Physician Assistant co-pay for each visit.**

MENTAL HEALTH AND SUBSTANCE ABUSE PREFERRED PROVIDER ORGANIZATIONS (PPO)

The LGHIP is designed to provide the following mental health and substance abuse benefits:

- Outpatient Care
  - —- Individual Therapy/Counseling
  - —- Family Therapy/Counseling
- Emergency Services
- Inpatient and Outpatient Services in a LGHIB Approved Facility
- Alcohol and Drug Abuse Counseling

Your benefit coverage will vary depending on whether you choose an approved or non-approved provider. Your coverage with an approved provider is as follows:

Approved Outpatient Providers - When you visit a Certified Regional Mental Health Center or other approved provider (list available at www.AlabamaBlue.com), outpatient treatment for mental and nervous disorders will be covered up to a maximum of 20 visits each calendar year at $14 co-pay per visit. (Other co-payments may apply based on the services received.) Mental illness day hospitalization, intensive day treatment and supportive day treatment are covered up to a maximum of 60 days each calendar year at 80% of fee schedule with no deductible. You can receive up to 40 outpatient substance abuse sessions covered at 100% of fee schedule with no deductible at an approved day/evening or weekend treatment program.

Approved Inpatient Providers - Inpatient psychiatric care and substance abuse treatment received at an approved hospital will be covered at 80% of fee schedule after a $200 facility deductible per admission.

To be eligible for inpatient facility benefits, all inpatient admissions and stays (except medical emergencies that must have post-admission review) must be reviewed, approved, and certified by BCBS as medically necessary. The LGHIB contracts with BCBS for Utilization Management. BCBS can be reached at 1.800.248.2342.

BCBS will only certify the medical necessity of the requested benefit, not whether you are eligible to receive the requested benefit. You are responsible for being aware of the limitations of your benefits.

To take advantage of benefits provided by the approved providers under the LGHIB's Preferred Provider Organization (PPO), contact LGHIB, BCBS Customer Service, or visit www.AlabamaBlue.com. When you make an appointment identify yourself as having the LGHIB's Mental Health and Substance Abuse PPO.

Non-approved Outpatient Providers - When you use a non-approved mental health provider for outpatient mental and nervous and/or substance abuse, services will be covered for up to a maximum of 20 visits per calendar year at 80% of the fee schedule after a $200 annual deductible. You will be responsible for 20% of fee schedule, **plus** any difference between the fee schedule amount and the amount the provider charges. There is **no coverage** for services provided by a non-approved facility that is solely classified as a **substance abuse outpatient or residential facility.**

Non-approved Inpatient Providers - Inpatient psychiatric care and substance abuse treatment received at a nonapproved hospital will be covered at 80% of fee schedule after a $200 deductible per admission. You are responsible for 20% of fee schedule, plus any difference between the fee schedule amount and the amount that the facility charges. This amount can be substantial, as much as 40% of your bill, and is not eligible for coverage under any other part of your contract. Admission precertification is the same as in an Approved Facility.

Note: The term "fee schedule" refers to the LGHIB's negotiated fee that the approved facilities and providers have agreed to accept for providing psychiatric or substance abuse services. The fee schedule applied to non-approved facilities is consistent with the fee paid to the approved facilities.

NOTE: A comprehensive listing of all approved mental health providers is available on the BCBS website at: www.AlabamaBlue.com.

PARTICIPATING CHIROPRACTOR BENEFITS

The Participating Chiropractor Program offers members several advantages when they visit a Participating Chiropractor. Services are covered at 80% of the Chiropractic Fee Schedule with no deductible. Participating Chiropractors have agreed to file all claims and accept Blue Cross' payment (along with the 20% coinsurance due from the patient) as payment in full; the patient will not be balance-billed for any "over-range" charges. All benefit payments will go to the Participating Chiropractor.

Precertification is required after the 18th visit. The Participating Chiropractor will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

TOBACCO CESSATION PROGRAM

A Tobacco Cessation Program is now provided by the LGHIB for its covered members. Program literature can be obtained through our Wellness Program and on our website. For more information about available programs, please call *Alabama's Tobacco Quitline at 1.800.QUIT.NOW (1.800.784.8669)* or visit www.quitnowalabama.com. Both programs offer free master's level counseling and up to four weeks of free nicotine replacement therapy patches if you are in counseling with the Quitline and do not have medical contraindications.

Online resources and support are also available through the following organizations:

American Cancer Society	www.cancer.org www.everydaychoices.org
Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov
National Cancer Institute	www.cancer.gov
American Lung Association	www.lungusa.org/tobacco
Mayo Clinic	www.mayoclinic.org

The LGHIB will reimburse each member 80% of the cost of the program, with no deductible. There is a lifetime maximum benefit of $150. Tobacco cessation seminars and certain forms of nicotine replacement are covered services. Forward your name, address, contract number and a copy of tobacco cessation program receipts to:

Local Government Health Insurance Board
Wellness Division
PO Box 304900
Montgomery, AL 36130-4900

Prescription medications for tobacco cessation are covered through the Prescription Drug Program and are not subject to the $150 lifetime maximum benefit.

Note: E-cigarettes are not eligible for reimbursement through the LGHIB's tobacco cessation program or as an approved tobacco cessation product.

All claims must be filed with the LGHIB, not BCBS.

PHYSICIAN SUPERVISED WEIGHT MANAGEMENT AND NUTRITIONAL COUNSELING PROGRAMS

The LGHIB will cover approved physician supervised weight management and nutritional counseling programs. The LGHIB will reimburse up to 80% of the cost of a physician supervised weight management program and/or nutritional counseling, with no deductible, not to exceed $150 per calendar year. You can apply for reimbursement by forwarding your name, address, contract number, daytime phone number, copy of the program receipt(s), and program contact information to:

Local Government Health Insurance Board
Wellness Division
PO Box 304900
Montgomery, AL 36130-4900
1.866.838.3059

Medications, either by prescription or over-the-counter, food, and dietary supplements, are excluded from the program.

You must file your claims for this benefit with the LGHIB, not BCBS.

LGHIB DISCOUNTED VISION CARE PROGRAM

The LGHIB has contracted independently with eye care providers across the state to form the Routine Vision Care Network. **This is not a Blue Cross provider network**. Check with your provider or visit our web page at www.lghip.org prior to receiving services to determine whether the provider is a participating provider.

Under the Routine Vision Care Network, participating providers will offer the following discounted services:

Routine vision examination (one per year)……..…….$40 Member payment
Routine vision examination-with dilation (one per year)……..…….$45 Member payment
Initial contact lens fitting…… ……$25 Member payment*
Follow-up contact lens visit……..…….$25 Member payment

* Initial contact lens fitting fee of $25 is in addition to the routine vision examination fee.

Routine vision care examinations, initial contact lens fitting and follow-up contact lens visits are subject to the member payments stated above and will be accepted by the participating provider as full and complete. Be sure you identify yourself as a local government employee before receiving services.

Laser vision corrective surgery is available at a discounted rate through Participating Vision Care Providers. You may obtain a list of Participating Providers at: www.lghip.org or contact by calling the LGHIB at 1.866.836.9137.

MAJOR MEDICAL BENEFITS

Services not covered under the BlueCard PPO program are paid at 80% of the allowed amount as Major Medical benefits after a $200 calendar year deductible, maximum of 3 deductibles per family. Major Medical deductibles and coinsurance apply to annual out-of-pocket maximums of $6,250 for individuals and $12,500 aggregate for families.

Only one deductible is applicable to covered Major Medical expenses incurred for treatment of accidental injuries received in the same accident by two or more family members with family coverage.

You are responsible for payment of your covered Major Medical expenses to which the deductible applies.

Covered Major Medical Expenses

Some of the most frequently utilized major medical services are listed below. Contact BCBS Customer Service at 1.800.321.4391 for specific coverage questions prior to services being provided.

- Semi-private room and board, general nursing care and all normal and necessary hospital services and supplies when hospital benefits have expired subject to the requirements and limitations of pre-admission certification and post-admission review.
- Allergy testing and treatment. This coverage is offered only under the Major Medical benefit regardless of whether a PPO Provider is used.
- Physical therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that precertification has been obtained. Please call 1.800.248.2342 for preauthorization.
- Speech therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that preauthorization has been obtained. Please call 1.800.248.2342 for preauthorization.
- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. ***Preauthorization*** is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. It is your responsibility to make sure that precertification has been obtained. Please call 1.800.248.2342 for preauthorization.
- Diabetic education is covered at 100% of the allowance, with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1.800.248.2342 for preauthorization.
- Prosthetic devices such as an artificial arm and orthopedic devices such as a leg brace.
- Medical supplies such as oxygen, crutches, splints, casts, trusses and braces, syringes and needles (other than insulin supplies), catheters, colostomy bags and supplies and surgical dressings.
- Professional ambulance service approved by BCBS to the closest hospital that could furnish the treatment needed for your condition. A provider must certify that the ambulance service was necessary, if BCBS requests it.
- Rental of durable medical equipment prescribed by a Provider for therapeutic use in a member's home, limited to the amount of its reasonable and customary purchase price. If you can buy it for less than you can rent it, or if it is not available for rent, BCBS will pay its allowed purchase price. Some examples of durable medical equipment are wheelchairs and hospital beds.

- Hemodialysis services provided by a Participating Renal Dialysis Facility.

- Private duty nursing services of a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.) if: the services actually require the professional skills of a R.N. or L.P.N.; are provided outside of a hospital or other facility; and are provided by a person not related to you by blood or marriage or a member of your household. No benefits are provided for any custodial care. In order to be covered, private duty nursing services must be **pre-certified** by BCBS.

- Home health care is covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency. It is your responsibility to make sure that precertification has been obtained. Call 1.800.248.2342 for preauthorization.

- **Point-of-sale drug benefits. (See Prescription Drugs section.)**

PRESCRIPTION DRUGS

Active Employees and Non-Medicare Retirees

Prescription Drug Card Program
Tier 1 drugs covered at 100% of the allowance, subject to $10 co-pay per prescription when you use a Participating Pharmacy.

Point-of-Sale Drug Program

Tier 2 and Tier 3 drugs are covered at 80% of the allowance, subject to the calendar year Major Medical deductible of $200 when you use a **Participating Pharmacy**.

- You are responsible for paying the pharmacy for your prescription.
- Claims authorization number is required.
- File your prescription claim with BCBS of Alabama, using the Major Medical Point-of-Sale Prescription Drug Claim form (CL-94) or you can file your claim on-line at www.AlabamaBlue.org.

Certain blood glucose lowering drugs used to treat Diabetes are covered at 80% of the allowance, subject to the calendar year deductible. After the calendar year deductible has been met, you will be responsible for paying the pharmacy 20% of the allowance at the point-of-sale.

NOTE: No benefits are available for prescriptions purchased at a Non-Participating Pharmacy.
Prescription drug coverage is limited to prescription products approved by the Federal Drug Administration (FDA) as evidenced by a New Drug Application (NDA), Abbreviated New Drug Application (ANDA), or Biologics License Application (BLA) on file with the FDA.

Medicare retirees and Medicare Dependents of retirees covered under LGHIP's Employer Group Waiver Plan (EGWP)

Prescription Drug Card Program for Tier 1 Drugs

Preferred/Extended Supply Network Pharmacies
$ 10 co-pay for 30-day supply
$ 20 co-pay for 60-day supply
$ 20 co-pay for 90-day supply

Non-Preferred Pharmacies
$ 10 co-pay for 30-day supply
$ 20 co-pay for 60-day supply
$ 30 co-pay for 90-day supply

Point-of-Sale Drug Program for Tier 2, Tier 3, and Tier 4 Drugs

Retail & Extended Supply Network Pharmacies
20% co-insurance after the $100 drug deductible is met. Deductible applies only to Medicare covered Part D Drugs.

NOTE: All Medicare Part B-eligible prescription drugs, to include Hepatitis Vaccines and all diabetic supplies are excluded from EGWP coverage since they are covered by Part B.

Drugs purchased at an out-of-network pharmacy may be covered under certain circumstances, such as for an illness while traveling outside the plan's service area where a network pharmacy is unavailable.

Drugs purchased at an out-of-network pharmacy may require higher cost-sharing. Additionally, you may have to pay the full charge for the drug and submit documentation to receive reimbursement.

If you are not enrolled in EGWP, you have no prescription drug coverage through the LGHIP. Please see the EGWP plan documents to know the rules you must follow to receive coverage with this Medicare prescription drug plan.

MEDICAL EXCLUSIONS

In addition to other exclusions set forth in this handbook, the LGHIP will not provide benefits for the following, whether or not a Provider performs or prescribes them:

A

- Services or expenses for elective **abortions**.
- Services or expenses for **acupuncture**, biofeedback, and other forms of self-care or self-help training.
- **Anesthesia** services or supplies or both by local infiltration.
- Services, care, treatment, or supplies furnished by a provider that is not recognized by BCBS as an **approved provider** for the type of service or supply being furnished. For example, the LGHIP reserves the right not to pay for some or all services or supplies furnished by certain persons who are not medical doctors (M.D.s), even if the services or supplies are within the scope of the provider's license. Call BCBS Customer Service if you have any question as to whether your provider is recognized as an approved provider for the services or supplies that you intend to receive.
- Services or expenses for or related to **Assisted Reproductive Technology (ART)**. ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

C

- Services or expenses of an out-of-network hospital stay, except one for an emergency, unless BCBS has approved and pre-**certified** it before your admission. Services or expenses of an out-of-network hospital stay for an emergency if BCBS is not notified within 48 hours, or on their next business day after your admission, or if BCBS determines that the admission was not medically necessary.
- Services or expenses for which a **claim** is not properly submitted to Blue Cross.
- Services or expenses for a **claim BCBS has not received within 365 days** after services were rendered or expenses incurred.
- Services or expenses for personal hygiene, **comfort or convenience** items such as: air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.
- Services or expenses for sanitarium care, **convalescent care**, or rest care, including care in a nursing home.
- Services or expenses for **cosmetic surgery**. Cosmetic surgery is any surgery done primarily to improve or change the way one appears. “Reconstructive surgery” is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit, cosmetic surgery is not. (See “Women’s Health and Cancer Rights Act” for exceptions.) Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

- You may contact BCBS prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to BCBS's satisfaction that surgery is reconstructive and not cosmetic. You must show BCBS history and physical exams, visual field measures, photographs and medical records before and after surgery. BCBS may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.
- Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.

- Services or expenses for **custodial care**. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

D

- **Dental** implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.
- Services for or related to a **dependent pregnancy**, including the six-week period after delivery. A dependent pregnancy means the pregnancy of any dependent other than the contract holder's spouse.

E

- Services, care, or treatment you receive after the **ending date of your coverage.** This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.
- Prescription drugs for **erectile dysfunction**.
- **Eyeglasses** or contact lenses or related examinations or fittings, except under limited circumstances.
- Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including LASIK.

F

- Services or expenses in any **federal hospital or facility** except as required by federal law.
- Services or expenses for routine **foot care** such as removal of corns or calluses or the trimming of nails (except mycotic nails).
- Prescription drugs not approved by the Federal Drug Administration **(FDA)**.

G

- Unless otherwise required by applicable law, services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other **governmental** agency that provides or pays for care, through insurance or any other means.

H

- **Hearing aids** or examinations or fittings for them.

I

- **Investigational** treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including investigational services that are part of a clinical trial. Under federal law, the plan cannot deny a member participation in an approved clinical trial, is prohibited from dropping coverage because member chooses to participate in an approved clinical trial, and from denying coverage for routine care that the plan would otherwise provide just because a member is enrolled in an approved clinical trial. This applies to all approved clinical trials that treat cancer or other life-threatening diseases.

L

- Services or expenses that you are not **legally obligated to pay**, or for which no charge would be made if you had no health coverage.

- Services or expenses for treatment which does not require a **licensed provider**, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency, or duration.

M

- Services or expenses BCBS determines are not **medically necessary**.

- Services or supplies to the extent that a member is, or would be, entitled to reimbursement under **Medicare**, regardless of whether the member properly and timely applied for, or submitted claims to Medicare, except as otherwise required by federal law.

N

- Services or expenses of any kind provided by a **Non-Participating Hospital** located in Alabama for Major Medical benefits or any other benefits under this contract except inpatient and outpatient hospital benefits in case of accidental injury.

- Services, care or treatment you receive during any period of time with respect to which payment for your coverage has not been made and that **nonpayment** results in termination of coverage.

O

- Services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, that is based upon weight reduction or dietary control. This exclusion does not apply to Bariatric Surgical procedures if medically necessary and in compliance with BCBS's guidelines. Bariatric Surgical procedures are limited to one per lifetime, subject to prior authorization. Benefits are provided only when the services are performed by a PPO Provider. All physician and anesthesia services related to Bariatric Surgical procedures are limited to 50% of the allowable rate.

- Services or expenses provided by an **out-of-network provider** for any benefits under this plan, unless otherwise specifically stated in the plan.

P

- **Physical, Speech, and/or Occupational therapy** for the 16th and subsequent visits that were not preauthorized.
- **Private duty nursing**.

R

- Services or expenses for **recreational** or educational therapy.
- Hospital admissions in whole or in part when the patient primarily receives services to **rehabilitate** such as physical therapy, speech therapy, or occupational therapy unless the admission is determined to be medically necessary for acute inpatient rehabilitation.
- Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical therapist.
- **Replacement** or upgrade of existing properly functioning durable medical equipment (including prostethics), even if the warranty has expired.
- **Room and board** for hospital admissions in whole or in part when the patient primarily receives services that could have been provided on an outpatient basis based upon the patient's condition and the services provided.
- **Routine well child care** and routine immunizations except for the services described in "Routine Preventive Benefits."
- **Routine physical examinations** except for the services described in "Routine Preventive Benefits."

S

- **Services** or expenses for treatment while confined in a prison, jail, or other penal institution.
- Services or expenses for, or related to, **sexual dysfunctions** or surgical sex transformations.
- **Sleep studies** performed outside of a healthcare facility, such as home sleep studies, whether or not supervised or attended.
- Services or supplies for substance abuse including any service furnished by a **substance abuse residential facility**.

T

- Services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded.

  It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. For example, braces on the teeth are excluded for any

purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw or because of injury of natural teeth. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under major medical.

- Dental treatment for or related to **temporomandibular joint (TMJ) disorders**. This includes Phase II according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.
- Services, supplies, implantable devices, equipment and accessories billed by any out-of-network **third party vendor** that are used in surgery or any operative setting. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.
- Services or expenses for or related to organ, tissue or cell **transplants** except specifically as allowed by this plan.
- **Travel**, even if prescribed by your physician (not including ambulance services otherwise covered under the plan).

W

- Services or expenses for an accident or illness resulting from active participation in **war**, or any act of war, declared or undeclared, or from active participation in riot or civil commotion.
- Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation is available in whole or in part under the provisions of any **workers' compensation** or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the group. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your group has insurance coverage for benefits under the law.

PROTECTING YOUR PRIVACY

Privacy of Your Protected Health Information

The confidentiality of your personal health information is important to the LGHIB. Under 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. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the LGHIP's notice of privacy practices. You may request a copy of this notice by contacting the LGHIB.

Disclosures of Protected Health Information to the Plan Sponsor:

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

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

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

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the LGHIP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you or the LGHIP to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the LGHIP must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the LGHIP to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years. You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.

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

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

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

- Benefits Administration and Operations
- Legal
- Finance

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

Security of Your Personal Health Information:

Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

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

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

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

Our Use and Disclosure of Your Personal Health Information:

As a business associate of the LGHIB, BCBS has an agreement with the LGHIB that allows BCBS to use your personal health information for treatment, payment, healthcare operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the LGHIP, you agree that BCBS may obtain, use and release all records about you and your minor dependents that BCBS needs to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to BCBS about you and your minor dependents that BCBS needs in order to administer the plan.

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

> **Parity in the application of certain limits to mental health benefits:** Group health plans that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance

use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The privacy provisions of the Health Insurance Portability and Accountability Act require that you be notified at least once every three years about the availability of the Local Government Health 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.lghip.org or you can request a copy by writing to us at:

Local Government Health Insurance Board
Attn: Privacy Officer
P. O. Box 304900
Montgomery, AL 36130-4900

GENERAL PROVISIONS

Delegation of Discretionary Authority to Blue Cross

The LGHIB has delegated to BCBS the discretionary responsibility and authority to determine claims under the LGHIP, to construe, interpret, and administer claims, and to perform every other act necessary or appropriate in connection with claims administration services under the LGHIP.

Whenever BCBS makes reasonable determinations that are neither arbitrary nor capricious in the administration of claims of the LGHIP, those determinations will be final and binding on you, subject only to your right of review under the LGHIP.

Incorrect Benefit Payments

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

Responsibility for Actions of Providers of Services

BCBS and the Local Government Health Insurance Board (LGHIB) will not be responsible for any acts or omissions, whether negligent, intentional, or otherwise, by any institution, facility, or individual provider in furnishing or not furnishing any services, care, treatment, or supplies to you. BCBS and LGHIB will not be responsible if any provider of service fails or refuses to admit you to a facility, or treat you, or provide services to you. BCBS and LGHIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

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

Any employee or retiree knowingly and willfully submitting materially false information to the LGHIB or engaging in fraudulent activity that causes financial harm to the LGHIP, may be required, upon a determination by the LGHIB, (1) to repay all claims and other expenses, including interest, incurred by the plan related to the intentional submission of false or misleading information or fraudulent activity and (2) be subject to disqualification from coverage under the LGHIP.

Obtaining, Use, and Release of Information

By submitting your application for coverage or any claims for benefits you authorize BCBS to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records that in its judgment are necessary or desirable for processing your claim, performing our contractual duties or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to BCBS any such records or information it requests.

Your authorization allows BCBS to use and release to other persons or organization any such records and information as considered necessary or desirable in its judgment. Neither BCBS or any provider or other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

Responsibility of Members and Providers to Furnish Information

By submitting an application for coverage or a claim for benefits you agree that in order to be eligible for benefits:

- A claim for benefits must be properly submitted to and received by BCBS.
- A provider, hospital, or other provider that has furnished or prescribed any services or supplies to a member must provide the records, information, and evidence BCBS requests in connection with benefits claimed or paid for the services or supplies.
- A member who receives services or supplies for which benefits are claimed must provide the records, information and evidence BCBS requests.

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

Providers of Services Subject to Contract Provision

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

Benefit Decisions

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

Charges for More than the Allowed Amounts

When benefits for provider's services are based on allowed amounts, the benefit payments are determined and made by BCBS upon consideration of the factors described in the definition of allowed amount. If a provider charges you more than the allowed amount paid by BCBS as benefits, you are responsible for the charges in excess of the allowed amount.

Applicable State Law

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

Plan Changes

- The LGHIB may amend any or all of the provisions of the LGHIP at any time by an instrument in writing.
- No representative or employee of BCBS is authorized to amend or vary the terms and conditions of the LGHIP, make any agreement or promise, not specifically contained in the LGHIP, or waive any provision of the LGHIP.

Rescission

Under the Patient Protection and Affordable Care Act (the ACA), the LGHIB cannot rescind your coverage once you are covered under the LGHIP unless you perform an act, practice, or omission that constitutes fraud, or unless you make an intentional misrepresentation of material fact as prohibited by the terms of the LGHIP. The LGHIB must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded.

A rescission is a retroactive cancellation or discontinuance of coverage. A cancellation of coverage is not a rescission if (a) the cancellation or discontinuance of coverage has only a prospective effect, or (b) the cancellation or discontinuance of coverage is effective retroactively due to a failure to timely pay required premiums or contributions towards the cost of coverage.

No Assignment

The LGHIP will not honor an assignment of your claim to anyone. Some of the contracts BCBS has with providers of services, such as hospitals, require BCBS to pay benefits directly to the providers. With other claims BCBS may choose whether to pay you or the provider. If you or the provider owes the LGHIP money, BCBS may deduct the amount owed from the benefit paid. When BCBS pays or deducts the amount owed from you or the provider, this completes our obligation to you under the LGHIP. Upon your death or incompetence, or if you are a minor, the LGHIP may pay your estate, your guardian or any relative the LGHIP believes is due to be paid. This, too, completes LGHIP's plan obligation to you.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at w**ww.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

You may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility. If you live in Alabama visit www.myalhipp.com or call 1-855-692-5447.

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

COORDINATION OF BENEFITS

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.

Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies:

Noncompliant Plan: If the other plan is a noncompliant plan, then the other plan shall be primary and this plan shall be secondary unless the COB terms of both plans provide that this plan is primary.

Employee/Dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (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 us to reverse this order of payment. 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.

Dependent Child – Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), 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.

Dependent Child – Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:

    a. first, the plan of the custodial parent;
    b. second, the plan covering the custodial parent's spouse;
    c. third, the plan covering the non-custodial parent; and,
    d. last, the plan covering the non-custodial parent's spouse.

2. If a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

    If the court-ordered parent has no healthcare coverage for the dependent child, benefits will be determined in the following order:

    a. first, the plan of the spouse of the court-ordered parent;
    b. second, the plan of the non-court-ordered parent; and,
    c. third, the plan of the spouse of the non-court-ordered parent.

    If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of "Dependent Child – Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.

3. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the "birthday rule" as if those individuals were parents of the child.

Active Employee or Retired or Laid-Off Employee:

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

COBRA or State Continuation Coverage:

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the "COBRA plan") and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the "COBRA plan") and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

Longer/Shorter Length of Coverage: If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

Equal Division: If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Determination of Amount of Payment

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.

2. If BCBS's records indicate this plan is secondary, BCBS 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 required to make a secondary payment according to the above rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term "allowable expense" means any healthcare expense, including coinsurance, co-payments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term "allowable expense" does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for mental health disorders and substance abuse, dental services and supplies, vision care, prescriptions drugs, or hearing aids, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term "allowable expense" does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

Birthday: The term "birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial Parent: The term "custodial parent" means:

- A parent awarded custody of a child by a court decree; or
- In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contract: The term "group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. The term does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Hospital Indemnity Benefits: The term "hospital indemnity benefits" means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Noncompliant Plan: The term "noncompliant plan" means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are "excess" or "always secondary."

Plan: The term "plan" includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term "plan" does not include non-group or individual health or medical reimbursement insurance contracts. The term "plan" also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term “primary plan” means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or
- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan: The term “secondary plan” means a plan that is not a primary plan.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. BCBS may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. BCBS is not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give BCBS any facts it needs to apply these COB rules and to determine benefits payable as a result of these rules.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, BCBS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. BCBS will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by BCBS is more than BCBS should have paid under this COB provision, BCBS may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Special Rules for Coordination with Medicare

Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.

SUBROGATION

Right of Subrogation

If BCBS pays or provides any benefits for you under the LGHIP, the LGHIP 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 the LGHIP has paid or provided. The LGHIP may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, the LGHIP has a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which the LGHIP has paid plan benefits. This means that you promise to repay the LGHIP any money you recover that the LGHIP has paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay the LGHIP. And, if you are paid by any person or company besides the LGHIP, including the person who injured you, that person's insurer, or your own insurer, you must repay the LGHIP. In these and all other cases, you must repay the LGHIP.

The LGHIP has the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay the LGHIP first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay the LGHIP first even if another person or company has paid for part of your loss. And it means that you promise to repay the LGHIP first even if the person who recovers the money is a minor. In these and all other cases, the LGHIP still has the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to promptly furnish BCBS all information that you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with BCBS in protecting and obtaining the LGHIP's 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 BCBS before filing any suit or settling any claim so as to enable the LGHIP to participate in the suit or settlement to protect and enforce the LGHIP's rights under this section. If you do notify BCBS so that the LGHIP is able to and does recover the amount of LGHIP benefit payments for you, the LGHIP will share proportionately with you in any attorneys' fees charged you by your attorney for obtaining the recovery. If you do not give BCBS such notice, the LGHIP's 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 the LGHIP 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, the LGHIB may suspend or terminate payment or provision of any further benefits for you under the LGHIP.

FILING A CLAIM, CLAIM DECISIONS, AND APPEAL OF BENEFIT DENIAL

The following explains the rules under LGHIP for filing claims and appeals with BCBS and for filing voluntary appeals with the LGHIB. The procedures relating to BCBS's pre-certification, pre-approval or review of certain benefits, including inpatient hospital benefits, private duty nursing, and certain surgical/diagnostic procedures, case management and certain predeterminations are explained in other sections of this booklet.

Filing of Claims Required

A claim prepared and submitted to BCBS must be received by BCBS before it can consider any claim for payment of benefits for services or supplies. In addition, there are certain services (such as Preadmission Certification and precertification of nursing services) that must be approved by BCBS in advance before they will be recognized as benefits. No communications with BCBS by you, your provider, or anyone else about the existence or extent of coverage can be relied on by you or your provider or will be binding in any way on BCBS when the communications are made before the services or supplies are provided and a claim for them is submitted and received.

Who Files Claims

Providers of services who have agreements with BCBS generally prepare and submit claims directly to BCBS. Claims for services or supplies furnished to you by providers without agreements with BCBS must be prepared and submitted by either you or the provider. For services requiring preadmission or precertification requests and approvals, the responsibility and manner for submitting requests are mentioned previously.

Who Receives Payment

- BCBS's agreements with some providers require it to pay benefits directly to them. On all other claims it may choose to pay either you or the provider. If you or the provider owes BCBS any sums, it may deduct from its benefit payment the amount that it is owed. Its payment to you or the provider (or deduction from payments to either) of amounts owed will be considered to satisfy its obligation to you. BCBS does not have to honor any assignment of your claim to anyone, including a provider.

  Nothing in the contract gives a provider the right to sue for recovery from BCBS for benefits payable under the contract.

- If you die or become incompetent or are a minor, BCBS pays your estate, your guardian or any relative that, in its judgment, is entitled to the payment. Payment of benefits to one of these people will satisfy its obligation to you.

How to File Claims

When you use your benefits, a claim must be filed before payment can be made. The LGHIP will pay for covered services you receive after the effective date of your coverage.

Hospital Benefits

In most cases, presenting your identification card is all you will need to establish credit for you and your dependents for admission to any hospital in Alabama and across the nation. Benefit payments are normally made to the hospital.

If care is received in a hospital outside of Alabama, reimbursement will be made through the Blue Cross Blue Card Program. If a hospital outside of Alabama does not file claims with BCBS, you should file the claim yourself directly to: BCBS, 450 Riverchase Parkway East, Birmingham, Alabama 35298.

Note: Preadmission Certification and Post Admission Review is required for all hospital admissions, for many outpatient diagnostic tests, surgeries, radiology procedures, and physician administered drugs. Ask your provider to contact BCBS at 1.800.248.2342.

Provider Services and Other Covered Expenses

To file a claim for provider services and other covered Major Medical expenses, present your identification card to the provider of service. Benefit payments are normally made directly to the provider.

However, if the provider does not file for benefits, claims should be filed directly by you. When it is necessary for you to file claims, complete a Medical Expense Claim Form (CL-438) or Major Medical Point-of-Sale Prescription Drug Claim Form (CL-94) and obtain itemized bills from the provider to attach. It is to your advantage to file your claims as they are incurred or at least every three months. The itemized bills must contain:

• Patient's full name	• Contract number	• Name and address of provider
• Type of service	• Date of service	• Diagnosis
• Charge for each service	• Date of accident (if any)	

Send the claim to: BCBS, 450 Riverchase Parkway East, Birmingham, Alabama 35298. You should always make copies for your personal records before filing. For your convenience, Medical Expense Claim Forms (CL-438) or Major Medical Point-of-Sale Prescription Drug Claim Forms (CL-94) are available from any BCBS office.

Blue Cross Preferred Care Benefits

One of the greatest advantages of visiting a PPO Provider or PPO Facility is that you are relieved of any claim filing. Provider and PPO Facilities agree to handle all claim filing procedures for you.

When Claims Must Be Submitted

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

Receipt and Processing Claims

Claims for medical benefits under the LGHIP can be post-service, pre-service, or concurrent. The following explains how BCBS processes these different types of claims and how you can appeal a partial or complete denial by BCBS of a claim.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. BCBS has developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling the BCBS Customer Service Department at 1.800.321.4391. You can also go to the BCBS Internet website at www.bcbsal.com and request a copy of the form. If a person is not properly designated as your authorized representative, BCBS will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet

For urgent pre-service claims, your provider is deemed to be your authorized representative unless you advise BCBS otherwise in writing.

Post-Service Claims

What Constitutes a Post-Service Claim?

For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), BCBS must receive a properly completed and filed claim from you or your provider.

In order for BCBS to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide

BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS's claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the BCBS customer service department and ask for a claim form. Tell BCBS the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and BCBS will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by BCBS within 365 days after the service takes place to be eligible for benefits.

If BCBS receives a submission that does not qualify as a claim, it will notify you or your provider of the additional information needed. Once BCBS receives that information, it will process the submission as a claim.

Processing of Claims

Even if BCBS has received all of the information needed to treat a submission as a claim, from time to time it might need additional information in order to determine whether the claim is payable. The most common example of this is medical records needed to determine whether services or supplies were medically necessary. If additional information is needed, BCBS will ask you to furnish it, and will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. BCBS will send you a copy of its request. However, you will remain responsible for seeing that BCBS gets the information on time.

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

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

Pre-Service Claims

What is a Pre-Service Claim?

A pre-service claim is one in which you or your provider are required to obtain approval before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If BCBS grants a pre-service claim, BCBS is not telling you that the service or supply is, or will be, covered; BCBS is only telling you that the service or supply meets BCBS's medical necessity guidelines.

In order to file a pre-service claim with BCBS, you or your provider must call the BCBS Health Management Department at 205.988.2245 (in Birmingham) or 1.800.248.2342 (toll-free). You must give your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person BCBS can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to BCBS during its regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to BCBS within 48 hours of the admission and BCBS certifies the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD). If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you.

If you attempt to file a pre-service claim but fail to follow BCBS's procedures for doing so, BCBS will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims).

BCBS's notification may be oral, unless you ask for it in writing. BCBS will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of BCBS that is customarily responsible for handling benefit matters, and (2) your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent Pre-Service Claims
BCBS will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician indicates that your claim is urgent, BCBS will treat it as such.

If your claim is urgent, BCBS will notify you of the decision within 72 hours. If more information is needed, BCBS will let you know within 24 hours of your claim. BCBS will tell you what further information is needed. You will then have 48 hours to provide this information to BCBS. You will receive notice of the decision within 48 hours after BCBS receives the requested information. BCBS's response may be oral; if it is, BCBS will follow it up in writing. If the requested information is not received, your claim will be considered denied at the expiration of the 48-hour period you were given for furnishing the information.

Non-Urgent Pre-Service Claims
If your claim is not urgent, you will receive a decision within 15 days. If more information is needed, BCBS will let you know before the 15-day period expires. You will then have 90 days to provide needed information to BCBS. To expedite receipt of the information, BCBS may request it directly from your provider. However, you will remain responsible for seeing that the information is provided on time. You will be notified of the decision within 15 days after BCBS receives the requested information. If the requested information is not received, your claim will be considered denied at the expiration of the 90-day period you were given for furnishing the information.

Courtesy Pre-Determinations: For some procedures BCBS encourages, but does not require, you to contact BCBS before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask BCBS to determine beforehand whether the procedure is cosmetic or reconstructive. BCBS calls this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, BCBS will do its best to provide you with a timely response. If BCBS decides that it cannot provide you with a courtesy pre-determination (for example, BCBS cannot get the information it needs to make an informed decision), BCBS will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When BCBS processes requests for courtesy pre-determinations, BCBS is not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call the BCBS customer service department.

Concurrent Care Determinations

Determinations by BCBS to Limit or Reduce Previously Approved Care
If BCBS has previously approved a course of treatment to be provided over a period of time or number of treatments, and later decides to limit or reduce the previously approved course of treatment, BCBS will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules established for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by You to Extend Previously Approved Care
If a previously approved course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to BCBS or through your treating physician. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 1.800.248.2342 (toll-free).
- For in-network physical therapy or occupational therapy (if covered by your plan) call 1.800.248.2342.
- For care from an in-network chiropractor (if covered by your plan) call 1.800.248.2342.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, BCBS will give you its decision within 24 hours of when your request is submitted. If your request is not made before this 24 hour time frame, and your request is urgent, BCBS will give you its determination within 72 hours. If your request is not urgent, BCBS will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

Your Right to Information
You have the right, upon request, to receive copies of any documents that BCBS relied on in reaching its decision and any documents that were submitted, considered, or generated by BCBS in the course of reaching a decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that BCBS may have relied upon in reaching the decision. If the decision was based on a medical or scientific determination (such as medical necessity), you may also request that BCBS provide you with a statement explaining its application of those medical and scientific principles to you. If BCBS obtained advice from a health care professional (regardless of whether it relied on that advice), you may request that BCBS give you the name of that person. Any request that you make for information under this paragraph must be in writing. BCBS will not charge you for any information that you request under this paragraph.

Member Satisfaction
If you are dissatisfied with the adverse benefit determination of a claim, you may file an appeal with BCBS. You cannot file a claim for benefits under the plan in federal or state court unless you exhaust these administrative remedies.

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

1.800.321.4391

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 the provider

BCBS also has a special 24 hours 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 you are encouraged to use it when you need materials such as:

- Claim Forms
- Replacement ID Cards
- Brochures
- Benefit Booklets

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

The numbers for Rapid Response are:

205.988.5401 in Birmingham or 1.800.248.5123 toll-free.

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

BCBS Appeals

In General

The rules in this section of the summary allow you or your authorized representative to appeal any adverse benefit determination by BCBS. An adverse benefit determination includes any one or more of the following:

- Any determination by BCBS with respect to a post-service claim that results in your owing any money to your provider other than co-payments you make, or are required to make, when you see your provider;
- The denial by BCBS of a pre-service claim; or
- An adverse concurrent care determination (for example, BCBS denies your request to extend previously approved services).

In all cases other than determinations by BCBS to limit or reduce previously approved care, you have 180 days following an adverse benefit determination by BCBS within which to submit an appeal.

How to Appeal Post-Service Adverse Benefit Determinations

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

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

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

You must send your appeal to the following address:

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

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

How to Appeal Pre-Service Adverse Benefit Determinations

You may appeal an adverse benefit determination by BCBS relating to a pre-service claim in writing or over the phone. If over the phone, you should call the appropriate phone number listed:

- For inpatient hospital care and admissions, call 205.988.2245 (in Birmingham) or 1.800.248.2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy call 1-205-220-7202.
- For care from a Participating Chiropractor call 1-205-220-7202. If in writing, you should send your letter to:

- For inpatient hospital care and admissions:

Blue Cross and Blue Shield of Alabama
Attention: Health Management – Appeals
P.O. Box 2504
Birmingham, Alabama 35201-2504

or

- For in-network physical therapy, occupational therapy, or care from an in-network chiropractor:

Blue Cross Blue Shield of Alabama
Attention: Health Management – Appeals
P. O. Box 362025
Birmingham, Alabama 35236

Your written appeal should provide BCBS with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

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

Conduct of the Appeal

BCBS will assign your appeal to one or more persons within the organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires BCBS to make a medical judgment (such as whether services or supplies are medically necessary), BCBS will consult a health care professional who has appropriate expertise. If BCBS consulted a health care professional during its initial decision, it will not consult that same person or a subordinate of that person during the BCBS consideration of your appeal.

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

BCBS will consider your appeal fully and fairly.

Time Limits for Consideration of Your Appeal

If your appeal arises from the denial of a post-service claim, BCBS will notify you of its decision within 60 days of the date on which you filed your appeal.

If your appeal arises from the denial of a pre-service claim, and if your claim is urgent, BCBS will consider your appeal and notify you of its decision within one business day or, if during a long weekend, within 72 hours. If your pre-service claim is not urgent, BCBS will give you a response within 30 days.

If your appeal arises out of a determination by BCBS to limit or reduce a course of treatment that was previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), BCBS will make a decision on your appeal as soon as possible, but in any event before it imposes the limit or reduction.

If your appeal relates to a decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), BCBS will make a decision on your appeal within one business day or 72 hours if over a long weekend (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

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

If You Are Dissatisfied After Exhausting your Mandatory Plan Administrative Remedies
If you have filed an appeal and are dissatisfied with the response, you may do one or more of the following:

- You may ask the BCBS Customer Service Department for further help; or
- You may file a voluntary appeal (discussed below); or
- You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below).

Voluntary Appeals: If BCBS has given you its appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal. Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), BCBS will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. BCBS will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, BCBS will not impose any fees or costs on you as part of your voluntary appeal. You may ask BCBS to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

External Reviews

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with BCBS for an independent, external review of their decision. You must request this external review within 4 months of the date of your receipt of BCBS's adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 10744, Birmingham, AL 35202-0744.

If you request an external review, an independent organization will review the BCBS decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give BCBS copies of this additional information to give BCBS an opportunity to reconsider its denial. Both you and BCBS will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both you and BCBS.

Expedited External Reviews for Urgent Pre-Service Claims

If your pre-service claim meets the definition of urgent under law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling BCBS at 1.800.248.2342 (toll-free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll-free).

LGHIB APPEALS PROCESS

General Information

Members of the LGHIP have a right to question the decisions of the LGHIB. However, all issues regarding benefit determinations should be addressed through the BCBS appeal process. Issues involving eligibility and enrollment must be addressed directly with the LGHIB.

Informal Review

If you feel that an enrollment or eligibility ruling was not in conformity with the rules and procedures of the LGHIP or, after exhausting all administrative procedures with BCBS you still feel that the LGHIP's benefits were incorrectly applied, you may then contact the LGHIB 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.

Administrative Review

If you are unsatisfied with the informal review decision, you may then request an administrative review. All requests for administrative review must be submitted to the LGHIB legal department. If it is determined by the LGHIB that an administrative review is merited, you will be sent a form LG06 to complete and return to the LGHIB. Receipt of your Administrative Review will be acknowledged by returning a copy of the received form to you.

An administrative review request must be received in the LGHIB office within 60 days following receipt of the final notice of a partial or total denial of your claim from BCBS, or within 60 days of the receipt of the enrollment for eligibility ruling of the LGHIB. A copy of the decision of the BCBS or the LGHIB ruling 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. Oral arguments will not be considered in an Administrative Review unless approved by the LGHIB. The Administrative Review Committee shall issue a decision in writing to all parties involved in the grievance.

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

Formal Appeal

If you do not agree with the response to your Administrative Review, you may file a request for a Formal Appeal before the Board of Directors. Requests for a Formal Appeal must be received in the LGHIB 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.

If your request for a Formal Appeal is granted, generally, a decision will be issued within ninety (90) days following the date the request for Formal Appeal was approved. The number of days may be extended by notice from the LGHIB. 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:

- Cosmetic Surgery
- Investigational Related Services
- Custodial Care
- Allowed Amounts

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

DEFINITIONS

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

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.

Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that BCBS 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 BCBS to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

In-Network Providers: Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable co-payments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered 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 in-network provider.

Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2) which subset of those providers will be considered BlueCard PPO providers, and (3) the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.

See “Out-of-Area Services,” earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Alabama.

Out-of-Network Providers: The allowed amount for care rendered by out-of-network providers is often 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 in-network providers or may be based on the average charge for care in the area. In other cases, BCBS determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;
- Pricing data from the local Blue Cross and/or Blue Shield plan where services are rendered;
- The relative complexity of the service;
- The in-network allowance in Alabama for the same or a similar service;
- Applicable state healthcare factors;
- The rate of inflation using a recognized measure; and
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

For services provided by an out-of-network provider, 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.

For emergency services for medical emergencies provided within the emergency room department of an out-of-network hospital, the allowed amount will be determined in accordance with the requirements of the Patient Protection and Affordable Care Act.

Alternative Benefits: A benefit program that gives you and your family an alternative to lengthy hospitalizations. It is designed to provide the patient with the best environment for recovery and in the most cost effective long-term arrangement. Also known as "Comprehensive Managed Care" and "Individual Case Management." This program is administered by BCBS.

Ambulatory Surgical Center: A facility that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed. In order to be considered an ambulatory surgical facility under the plan, the facility must meet the conditions for participation in Medicare.

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

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

BCBS: Blue Cross Blue Shield of Alabama.

Blue Card Program: An arrangement among Blue Cross and/or Blue Shield plans by which a member of one Blue Cross and/or Blue Shield plan receives benefits available through another Blue Cross and/or Blue Shield plan located in the area where services occur.

Blue Cross Blue Shield of Alabama: The company chosen by the LGHIB, through competitive bid, to process benefit claims filed by members (also referred to as BCBS) and to administer your Utilization Review Program such as Preadmission Certification and Individual Case Management.

Certification of Medical Necessity: The written results of BCBS's review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours of the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not consider whether your admission is excluded by the LGHIP.

Chiropractic Fee Schedule: The schedule of Chiropractic procedures and fee amounts for those procedures under the Participating Chiropractic benefits that is on file at the Claims Administrator's office.

Claims Administrator: The company chosen by the LGHIB, through competitive bid, to process benefit claims filed by members. The Claims Administrator is BCBS.

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

Concurrent Utilization Review Program (CURP): A program implemented by BCBS and in-network hospitals in the Alabama service area to simplify the administration of preadmission certifications and concurrent utilization reviews.

Cosmetic Surgery: Any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, trauma or congenital anomalies. For further information on "Cosmetic Surgery", see the "Exclusions" section.

Custodial Care: Care primarily for the purpose of providing room and board (with or without routine nursing care, training in personal hygiene and other forms of self care or supervisory care by a provider) for a person who is mentally or physically disabled. Custodial care does not include specific medical, surgical or psychiatric treatment that would reduce a member's disability to the extent necessary to enable him to live outside an institution providing medical care.

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

Diagnostic: Services performed in response to signs or symptoms of illness, condition, or disease or in some cases where there is family history of illness, condition, or disease.

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

Effective Date: The date on which the coverage of each individual member begins as listed in the LGHIB records.

Elective Abortion: An abortion performed for reasons other than the compromised physical health of the mother, severe chromosomal or fetal deformity, or conception due to incest or rape.

Emergency Treatment: Treatment rendered in a hospital, clinic or doctor's office for an injury or illness that requires immediate care or treatment, and must be performed within 48 hours after the injury is sustained or the illness first becomes manifest. A condition that requires immediate care or treatment means only a permanent health-threatening condition. The condition must be one for which failure to receive care or treatment could result in deterioration to the point where the patient's permanent health would be in jeopardy, bodily functions would be significantly impaired, or serious dysfunction would occur in any organ or other part of the patient's body. Emergency treatment includes ambulance service to the facility where treatment is received.

Employee: See the “Eligibility and Enrollment” section.

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

FDA Approved Drugs Guidelines: Prescription products approved by the Federal Drug Administration (FDA) as evidenced by a New Drug Application (NDA), Abbreviated New Drug Application (ANDA), or Biologics License Application (BLA) on file with the FDA.

Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

Home Health Coverage: Skilled nursing visits ordered by a physician, rendered in a patient's home by a Registered Nurse or Licensed Practical Nurse and billed by a home health agency. Any pre-certification requirements and/or any specified benefit maximums are applicable to the skilled nursing visits only. Other services included are home infusion therapy and medications administered by a home health agency. Services such as speech therapy, occupational therapy and physical therapy may be billed by a home health agency; however, they are considered under the major medical/other covered services portion of the contract and not considered under home health coverage.

Home Plan: The BCBS Plan that providers or subscribers send claims to when the subscriber receives medical care in a different Plan’s geographic area. A group’s Home Plan is the Plan that has control of the group.

Hospice Coverage: Hospice service includes supplies or drugs included in the daily fee for hospice care rendered by a hospice provider to a terminally ill member when a physician certifies the member's life expectancy to be less than six months.

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

Host Plan: The BCBS 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.

Implantables: An implantable device is a biocompatible mechanical device, biomedical material, or therapeutic agent that is implanted in whole or in part and serves to support or replace a biological structure,

support and/or enhance the command and control of a biological process, or provide a therapeutic effect. Examples include, but are not limited to, cochlear implants, neurostimulators, indwelling orthopedic devices, cultured tissues, tissue markers, radioactive seeds, and infusion pumps.

In-Network Provider: A provider is considered to be an in-network provider if, and only to the extent that, the provider is furnishing a service or supply that is specified as an in-network benefit under the terms of the contract between the provider and the Blue Cross and/or Blue Shield plan (or its affiliates). Examples include BlueCard PPO providers, Preferred Medical Doctors (PMD physicians), and Participating Pharmacies. A provider will be considered an in-network provider only if the local Blue Cross and/or Blue Shield plan designates the provider as a BlueCard PPO provider for the service or supply being furnished. This means that if you receive a service or supply from a provider that has a contractual relationship with a Blue Cross and/or Blue Shield plan but is not designated by the local Blue Cross and/or Blue Shield plan as a BlueCard PPO provider, BCBS will pay at the out-of-network level of benefits.

Inpatient: A registered bed patient in a hospital; provided that BCBS reserves the right in appropriate cases to reclassify inpatient stays as outpatient services, as explained above in "Inpatient Hospital Benefits" and "Outpatient Hospital Benefits."

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either BCBS has not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, BCBS will develop written criteria (called medical criteria) concerning services or supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and their members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is considered investigational according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If the investigational nature of a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when BCBS makes determinations about the investigational nature of a service or supply BCBS is making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Local Government Health Insurance Board (LGHIB): The State agency charged with the administration of the LGHIP. This agency is also referred to as LGHIB.

Local Government Health Insurance Plan (LGHIP): A self-insured health benefit plan administered by the Local Government Health Insurance Board.

Local Government Unit: Act 2014-401 - Any county, any municipality, any municipal foundation, any fire or water district, authority, or cooperative, any regional planning and development commission established pursuant to Sections 11-85-50 through 11-85-73, Code of Alabama 1975; the Association of County Commissions of Alabama, the Alabama League of Municipalities, the Alabama Retired State Employees' Association, the Alabama State Employees Credit Union, Easter Seals Alabama, Alabama State University, the Alabama Rural Water Association, Rainbow Omega, Incorporated, The Arc of Alabama, Incorporated, and any of the affiliated local chapters of The Arc of Alabama, Incorporated, United Ways of Alabama and its member United Ways, any railroad authority organized pursuant to Chapter 13, Title 37, Code of Alabama 1975; or any solid waste disposal authority organized pursuant to Chapter 89A, Title 11, Code of Alabama

1975, may, by resolution legally adopt to conform to rules prescribed by the Local Government Health Insurance Board (LGHIB), may elect to have its elected officials, full-time employees, and retired employees become eligible for health insurance coverage under the Local Government Health Insurance Program (LGHIP) without any liability to the state.

Medical Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Medically Necessary or Medical Necessity: BCBS uses these terms to help determine whether a particular service or supply will be covered. When possible, BCBS will develop written criteria (called medical criteria) that BCBS will use to determine medical necessity. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS make available to the medical community and the BCBS members. BCBS does this so that you and your providers will know in advance, when possible, what BCBS will pay for. If a service or supply is not medically necessary according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be medically necessary only if BCBS determines that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not "investigational"; and
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when BCBS makes medical necessity determinations, BCBS is making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

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 local government unit employee or eligible dependent who has coverage under the LGHIP and whose application for coverage under the contract is made and accepted by the LGHIB. A member is also a former dependent and/or employee eligible for and covered under COBRA. Elected officers of the local government unit are eligible for coverage while they are in office.

Mental Health Disorders: These are mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. These disorders, illnesses, and conditions are considered mental health disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders regardless of how they are caused, based, or brought on. Mental health disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and

psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are generally intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Preferred Provider Organization: Those providers who have contracted with the LGHIB to provide certain mental health and substance abuse services.

Non-Participating Chiropractor: A Doctor of Chiropractic (DC) who is not a Participating Chiropractor.

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

Non-Participating Pharmacy: Any pharmacy which is not a BCBS Participating Pharmacy.

Non-PPO Provider: Any provider that is not a PPO Provider with any Blue Cross and/or Blue Shield Plan.

Non-Preferred Home Health Care Agency: Any home health care agency that is not a Preferred Home Health Care Agency.

Non-Preferred Hospice: Any hospice that is not a Preferred Hospice.

Officer: An elected official of the local government unit.

Open Enrollment: The annual open enrollment period is held each November 1 thru November 30 for a January 1 effective date.

Out-of-Area Mental Health Benefits: Benefits for mental health services, including services for chemical dependency, if the subscriber lives permanently outside of Alabama and the subscriber or his dependents or both receive treatment outside Alabama.

Out-of-Network Provider: A provider who is not an in-network provider.

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

Participating Chiropractor: A Doctor of Chiropractic that has a contract with the Claims Administrator for the furnishing of chiropractic services.

Participating Hospital: Any hospital with which the Claims Administrator (BCBS) has a contract for furnishing health care services.

Participating Pharmacy: Any pharmacy with which BCBS has a contract for providing pharmacy services.

Participating Renal Dialysis Facility: Any free-standing hemodialysis facility with which BCBS has a contract for furnishing health care services.

Physician: Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

Plan Administrator: The Local Government Health Insurance Board.

Plan Sponsor: The State of Alabama.

PPO: Preferred Provider Organization.

PPO Allowance: The amount that any Blue Cross and/or Blue Shield Plan has agreed to pay its PPO Provider for plan benefits.

PPO Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Provider program and other Preferred Provider programs as applicable.

Preadmission Certification and Post-admission Review: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or by the next business day after the admission in the case of emergency admissions, based upon medically recognized criteria. The program is administered by BCBS.

Preferred Care: A program whereby providers have agreements with BCBS to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical and surgical procedures, such services and supplies to members entitled to benefits under the Preferred Care program.

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

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.

Preventive or Routine: Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

Private Duty Nursing: A session of four or more hours during which continuous skilled nursing care is furnished to you alone.

Psychiatric Specialty Hospital: An institution that is classified as a psychiatric specialty facility by such relevant credentialing organizations as BCBS or any Blue Cross and/or Blue Shield plan (or its affiliates) determines. A psychiatric specialty hospital does not include a substance abuse facility.

Retired Employee: See explanation in the “Eligibility and Enrollment” section.

Skilled Nursing Facility: Any Medicare participating skilled nursing facility which provides non-acute care for patients needing skilled nursing services 24 hours a day. This facility must be staffed and equipped to perform skilled nursing care and other related health services. A skilled nursing facility does not provide custodial or part-time care.

Substance Abuse: The uncontrollable or excessive abuse of addictive substances, such as (but not limited to) alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use.

Substance Abuse Facility: Any institution that is classified as a substance abuse facility by such relevant credentialing organizations as BCBS or any Blue Cross and/or Blue Shield plan (or its affiliates) determine and that solely provides residential and/or outpatient substance abuse rehabilitation services

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.

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

Teladoc: Consultation, evaluation, and management services provided to patients via telecommunication systems with or without personal face-to-face interaction between the patient and healthcare provider.

Total Disability: The complete inability of an active employee to perform any and every duty pertaining to his occupation or employment, or the complete inability of a retired employee or a dependent to perform the normal activities of a person of like age and sex.

Urgent-Care Center: A primary care provider that provides professional services by a licensed provider in a clinic setting, not requiring an appointment, and offering services outside traditional office hours.

Utilization Review Administrator: The company chosen by the LGHIB to administer your Utilization Review Program such as Preadmission Certification and Individual Case Management. The Utilization Review Administrator is BCBS.

We, Us, Our: BCBS, the LGHIB or the LGHIP as shown by the context.

You, Your: The contract holder or member as shown by the context.

Local Government Health Insurance Program
Benefit Plan Administered By:

Local Government Health Insurance Board
Post Office Box 304900
Montgomery, Alabama 36130-4900

Phone: 334.263.8326
Toll-Free: 1.866.836.9137
Web site: LGHIP.org

Claims Administrator
& Utilization Management

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Customer Service: 1.800.321.4391
Rapid Response: 1.800.248.5123
Fraud Hot Line: 1.800.824.4391
Baby Yourself® Maternity Program: 1.800.551.2294
Case Management: 1.800.551.2294
Medical/Surgical Precertification: 1.800.551.2294
Web site: AlabamaBlue.com

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