Local Government Health Insurance Plan

Effective January 1, 2023

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

STATE OF ALABAMA

LOCAL GOVERNMENT HEALTH INSURANCE BOARD

201 SOUTH UNION STREET, SUITE 200
MONTGOMERY, ALABAMA 36104
334-263-8326 | 1-866-836-9137

LOCAL GOVERNMENT HEALTH INSURANCE PLAN
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

The Local Government Health Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

THE PLAN'S RESPONSIBILITIES

The Plan is required by a federal law to keep your health information private, to give you notice of the Plan's legal duties and privacy practices, and to inform you about:

- the Plan's uses and disclosures of your protected health information;
- your privacy rights with respect to your protected health information;
- the Plan's obligations with respect to your protected health information;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

Effective Date of Notice: This notice is effective as of January 1, 2023.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION

This section of the notice describes uses and disclosures that the Plan may make of your health information for certain purposes without first obtaining your permission as well as instances in which we may request your written permission to use or disclose your health information. The Plan also requires their business associates to protect the privacy of your health information through written agreements.

Uses and disclosures related to payment, health care operations and treatment. The Plan and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, the State of Alabama for purposes related to payment or health care operations.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

Health care operations include but are not limited to underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services and auditing functions, including fraud and abuse programs, business planning and development, business management and general administrative activities. However, the Plan will not use genetic protected health information for underwriting purposes. It also includes quality assessment and improvement and reviewing competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to conduct a review of the accuracy of how benefit claims are being paid.

The Plan will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other uses and disclosures that do not require your written authorization. The Plan may disclose your health information:

- To persons and entities that provide services to the Plan and assure the Plan they will protect the information;
- If it constitutes summary health information, and it is used only for modifying, amending or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan;
- If it constitutes de-identified information;
- If it relates to workers' compensation programs;
- If it is for judicial and administrative proceedings;
- If it is about decedents;
- If it is for law enforcement purposes;
- If it is for public health activities;
- If it is for health oversight activities;
- If it is about victims of abuse, neglect or domestic violence;
- If it is for cadaveric organ, eye or tissue donation purposes;
- If it is for certain limited research purposes;
- If it is to avert a serious threat to health or safety;
- If it is for specialized government functions;
- If it is for limited marketing activities.

Additional disclosures to others without your written authorization. The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Officer at 334-263-8326.

Uses and Disclosures Requiring Your Written Authorization. In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan an authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Officer at 334-263-8326.

YOUR PRIVACY RIGHTS

This section of the notice describes your rights with respect to your health information and a brief description of how you may exercise these rights.

Notice of Breach. You have a right to notice of a breach of unsecured PHI.

Restrict Uses and Disclosures. You have the right to request that the Plan restricts uses and disclosure of your health information for activities related to payment, health care operations and treatment. The Plan will consider, but may not agree to, such requests. (Exception: the Plan must grant a restriction on PHI disclosed to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.)

Alternative Communication. The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plan to send health information to a different address than that of the Employee.

Inspect or Copy Health Information. You have a right to inspect or obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access,

although in certain circumstances you may request a review of the denial. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

You may request your records in an electronic format. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You may also be asked to pay a fee of $1.00 per page based on the Plan's copying, mailing, and other preparation costs.

Amend Health Information. You have the right to request an amendment to health information that is in a "designated record set." You must provide a statement to support the request. The Plan may deny your request to amend your health information if the Plan did not create the health information, if the information is not part of the Plan's records, if the information was not available for inspection or the information is accurate and complete.

Accounting of Certain Disclosures. You have the right to receive a list of certain disclosures of your health information. The accounting will not include: (1) disclosures made for purposes of treatment, payment or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosure for national security purpose; and (6) disclosures incident to other permissible disclosures.

You may receive information about disclosures of your health information going back six (6) years from the date of your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to access electronic records. You may request access to electronic copies of your health information, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic protected health information will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide an electronic copy.

Right to a Copy of Privacy Notice. You have the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

Complaints. You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Plan, contact the Plan's Privacy Officer at 334-263-8326. You will not be penalized for filing a complaint.

How to exercise your rights in this notice

To exercise your rights listed in this notice, you should contact the Plan's Privacy Officer at 334-263-8326.

THIS NOTICE IS SUBJECT TO CHANGE

The terms of this notice and the Plan's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plan. If any material changes are made, the Plan will distribute a new notice to participants and beneficiaries.

YOUR QUESTIONS AND COMMENTS

If you have questions regarding this notice, please contact the Plan's Privacy Officer at 334-263-8326.

Revision 11-2022

Local Government Health Insurance Plan
JANUARY 1, 2023

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, **AlabamaBlue.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 the "Benefit Conditions" section of the Plan's hand book.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Precertification is required for inpatient admissions (except medical emergency, maternity and as required by Federal law); 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 copay per day for days 2-5	Covered at 80% of the allowance, subject to a $200 per admission deductible and $50 copay 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 provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. 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 copay. 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 copay for treatment of sudden and severe symptoms that require immediate medical attention and meet medical emergency guidelines. Claims with emergency room charges that do not meet medical emergency guidelines will be covered under Major Medical.	Covered at 100% of the allowance, subject to the $200 facility copay for treatment of sudden and severe symptoms that require immediate medical attention and meet medical emergency guidelines. Claims with emergency room charges that do not meet medical emergency guidelines will be covered under Major Medical.
Accidental Injury	Covered at 100% of the allowance with no deductible or copay	Covered at 100% of the allowance with no deductible or copay
Diagnostic X-rays & Tests	Covered at 100% of the allowance, subject to the $100 facility copay per visit or cost of service, whichever is less.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic Lab & Pathology Certain outpatient x-rays and tests require precertification, call 1-866-803-8002.	Covered at 100% of the allowance, subject to a $7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance, subject to the $25 facility copay.	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 provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Primary Care Physician Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $40 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Specialist Physician Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $50 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Nurse Practitioners / Nurse Midwives, Physician Assistant Office Visits, Registered Dietician, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $20 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Physician fees for Outpatient Surgery and Anesthesia (other than in a physician's office)	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Second Surgical Opinion	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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 and online video consultations are available 24 hours a day, 7 days a week.	Covered at 100% of the allowance; no copay or deductible	Not covered.
Emergency Room	Covered at 100% of the allowance, subject to the office visit copay.	Covered at 100% of the allowance, subject to the office visit copay.
Inpatient Visits	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Lab & Pathology Exams	Covered at 100% of the allowance, subject to a $7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Tests	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
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 immunizations and preventive services or call the BCBS Customer Service Department for a printed copy	Covered at 80% of the allowance subject to the calendar year deductible. • See **AlabamaBlue.com/preventiveservices** for a listing of the immunizations and preventive services or call Customer Service Department for a printed copy
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 allowance, subject to a $200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.
Inpatient Provider Services	Covered at 80% of the allowance, no copay or deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.
LGHIP Outpatient Provider Services **(See Mental Health and Substance Abuse chapter in your plan book for more information on approved LGHIP providers.)**	**Approved LGHIP providers**: Covered at 100% of the allowance, subject to a $14 copay per visit; limited to 24 visits per person per calendar year. Other copays may apply based on services rendered. **Blue Choice Behavioral Network providers:** Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person per calendar year.
Residential Treatment Facilities for treatment of Eating Disorders	Covered at 80% of the allowance, subject to the calendar year deductible. Services must be approved by New Directions; precertification and ongoing medical necessity review required; limited to 60 days per member per calendar year	Covered at 80% of the allowance, subject to the calendar year deductible. Services must be approved by New Directions; precertification and ongoing medical necessity review required; limited to 60 days per member per calendar year

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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 Provider Services	Covered at 80% of the allowance; no copay or deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.
LGHIP Outpatient Provider Services **(See Mental Health and Substance Abuse chapter in your plan book for more information on approved LGHIP providers.)**	**Approved LGHIP providers:** Covered at 100% of the allowance, no copay or deductible; limited to 40 visits per person per calendar year. **Blue Choice Behavioral Network providers:** Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible	$200 per person each calendar year; maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$9,100 individual annual out-of-pocket maximum; $18,200 family maximum. **In-Network Services:** Deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum, including prescription drugs. 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. After you reach your Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowance for remainder of the calendar year.	
MAJOR MEDICAL SERVICES		
Precertification is required for certain major medical services and a select group of provider administered drugs; please see benefit booklet. Call 1-800-248-2342 for precertification. If no precertification is obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
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.
Applied Behavioral Analysis (ABA) Therapy	For children 18 years or younger, covered at 100% of the allowance after $14 copay per visit and subject to the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter or for any member nearing the ABA annual maximum to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.	For children 18 years or younger, covered at 80% of the allowance subject to calendar year deductible and following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter or for any member nearing the ABA annual maximum to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Physical Therapy, Speech Therapy and Occupational Therapy related to the screening, diagnosis, and treatment of Autism Spectrum Disorder	For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	For children 18 years or younger, 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 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
Rehabilitative and Habilitative Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	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 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification 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.	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.
Ground Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	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.
Air Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	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.	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.
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 1-800-821-7231.	Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required; call 1-800-821-7231. In Alabama: No coverage for services rendered by a non-participating Home Health agency.
Home Infusion Services	Covered at 100% of the allowance, subject to the $25 office visit copay when services are rendered by a participating Home Infusion Service Provider; Precertification is required for provider-administered drugs; call 1-800-821-7231.	Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required for provider-administered drugs; call 1-800-821-7231. In Alabama: No coverage for services rendered by a non-participating Home Infusion Service Provider.
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.	Not covered.
Medical Nutrition Therapy For Adults and Children, 6 hours per member per calendar year	Covered at 100% of the allowance, subject to the applicable office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS		
Prescription drug benefits are covered through OptumRx®. For more information, call OptumRx Member Services at 1 844-785-1603 or visit the website at www.OptumRx.com.		
TIER 1 DRUGS (PRESCRIPTION DRUG CARD PROGRAM) • Generic non-maintenance drugs may be dispensed up to a 30-day supply. • Generic maintenance drugs may be dispensed up to a 60-day supply, for one $15 copay, after an initial 30-day supply fill. • The plan utilizes the OptumRx Premium Formulary; however, plan benefits will supersede the Premium Formulary drug list.	Covered at 100% of the allowance subject to a $15 copay per prescription	No benefits are available for prescriptions purchased at a non-participating pharmacy.
TIER 2 AND TIER 3 DRUGS (POINT OF SALE DRUG PROGRAM) • Brand drugs (Tier 2 and Tier 3) may be dispensed up to a 90-day supply. Member must pay the cost of the drug and file a claim for reimbursement. • The prescription receipt (not the register receipt) is required for reimbursement requests. See the Prescription Drugs Chapter in the Planbook for additional receipt requirements. • Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Optum Specialty Pharmacy. Call Optum Specialty Pharmacy at 1-855-427-4682 for more information.	Covered at 80% of the allowance after being submitted for reimbursement. Subject to the calendar year deductible of $200.	No benefits are available for prescriptions purchased at a non-participating pharmacy.
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231 and press 7.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions. For more information, please call 1-833-964-1448 and press 0.	
Baby Yourself®	A maternity program that will waive the hospital deductible and daily copays for inpatient admission at delivery. For the waived hospital deductible and daily copays to apply, the member must enroll in the Baby Yourself program within the first two trimesters of pregnancy. Members may enroll at **AlabamaBlue.com/BabyYourself**. For more information, please call 1-800-222-4379.	

Note: Teladoc Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

For precertification call 1-800-248-2342. Call Blue Cross and Blue Shield of Alabama at 1-800-321-4391. Visit the Local Government Health Insurance Board's website at www.lghip.org.
The LGHIP is a self-insured health benefits plan administered by the LGHIB. The LGHIP provides minimum essential coverage and meets the minimum value standard as defined by the Affordable Care Act.
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 at www.AlabamaBlue.com.

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Group 30000
Effective January 1, 2023

MKT-180 (REV 11-2022)

Table of Contents

Chapter 1
Introduction

This summary of health care benefits of the Local Government Health Insurance Plan (LGHIP) is designed to help you understand your coverage. This planbook 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), Blue Cross and Blue Shield of Alabama (BCBS), OptumRx, and UnitedHealthcare or other third-party administrators that the LGHIB may contract with that it deems is necessary to carry out its statutory obligations.

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.

Chapter 2
Overview of the Plan

Purpose of the Plan

The Local Government Health Insurance Plan (LGHIP or "plan") 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 healthcare. For example, you may be required to pay deductibles, copayments, and coinsurance. Coverage is provided under this plan pursuant to applicable laws and is limited to those services, supplies and/or drugs that may be legally performed, prescribed or dispensed by a licensed health care provider, supplier or pharmacy.

The LGHIP complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability or sex.

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. Register for **myBlueCross** at www.AlabamaBlue.com/register and receive 24-hour access to personalized healthcare information. 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 planbook or Summary of Benefits and Coverage.
- Request replacement or additional ID cards.
- View your medical claim reports.
- Find a doctor.
- Track your health progress.
- Take a health assessment quiz.
- Get fitness, nutrition, and wellness tips.

BlueCare Health Advocate

By being a member of the LGHIP, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research, and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you, and much more. To find out more or to contact your BlueCare Health Advocate, call our Customer Service Department at the number on the back of your ID card.

Definitions

Near the end of this planbook, you will find a "Definitions" Chapter that identifies words and phrases that have specialized or particular meanings. To make this book 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 certain 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/FindADoctor.

Seeing a specialist or behavioral 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 Eligibility Chapter explains what is required for you to be covered under the LGHIP and when your coverage begins.

Limitations and Exclusions

To maintain the cost of the LGHIP at an overall level that is reasonable to all plan members, the LGHIP contains several provisions with which compliance is necessary in order to access benefits. There are also exclusions that you need to pay particular attention to, which can be found through the remainder of this book. You need to be aware of these provisions and exclusions to take maximum advantage of the LGHIP.

Medical Necessity and Precertification

The plan will only pay for care that is medically necessary and not investigational, as determined by BCBS. The definitions of medical necessity and investigational are found in the Definitions Chapter.

In some cases, described below, the plan 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. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered.

In some cases, your provider will initiate the precertification process for you. You should be sure to check with your provider to confirm whether precertification has been obtained. It is your responsibility to ensure that you or your provider obtains precertification.

In-Network Benefits

One way in which the LGHIP manages healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this book, 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 certain out-of-network providers, 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. In most cases, if the out-of-network services are covered you will have to pay significantly more than 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 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 more than the allowed amounts under the LGHIP.

In-network providers are hospitals, physicians and other healthcare providers or suppliers that contract with BCBS or any Blue Cross and/or Blue Shield plans for furnishing healthcare services or supplies at a reduced price. Examples of the Plan's Alabama in-network providers are:

Doctor or Other Healthcare Provider Networks:

- Bariatric Surgery
- Blue Choice Behavioral Health
- Expanded Psychiatric Services
- Participating Chiropractors
- Participating Physician Extenders
- Participating Speech Language Pathologists
- Preferred Medical Doctors (PMD)
- Preferred Optometry
- Preferred Podiatry
- Preferred Provider Organization (PPO)
- Preferred Home Health Network
- Preferred Home Infusion Network

Facility or Supplier Networks:

- Blue Choice Behavioral
- Hospital Choice Network
- Long Term Care Provider
- Participating Residential Treatment Facility

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

1. In the search box, you can select the category you would like to search under (doctor, hospital, dentist, pharmacy, etc.) or keep on “All Categories” to search all. Type in the provider’s name to search or leave blank to see all results.

2. In the “Network or Plan” section, use the drop-down menu to select a specific provider network.

Search tip: If your search returns zero results, try expanding the number in the “Distance” drop-down.

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local BCBS plan designates which of its providers are PPO providers. 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 AlabamaBlue.com/FindADoctor and log into your *my*BlueCross. Search for a specific provider by typing their name in the Search Term box or click Search to see all in-network providers for your plan. To receive in- network PPO benefits for lab services, the laboratory must contract with the BCBS 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 BCBS plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the BCBS plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local BCBS plan where services are rendered. The local BCBS 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 BCBS 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."

Continuity of Care

If you qualify as a continuing care patient, and your healthcare provider or facility is no longer in your network due the termination of a contractual relationship, you may request to continue treatment with such provider or facility until your treatment is complete or for 90 days from notification, whichever is shorter, at in-network cost-sharing rates under the plan. A continuing care patient is defined as an individual who:

- Is or was determined to be terminally ill and is receiving treatment for such illness;
- Is undergoing a course of treatment for a serious and complex condition;
- Is pregnant and undergoing a course of treatment for the pregnancy;
- Is undergoing a course of institutional or inpatient care;
- Is scheduled to undergo non-elective surgery, including receipt of post-operative care, with respect to such a surgery; or

Under these circumstances, the provider or facility cannot bill you for amounts in excess of the in- network allowed amounts under the plan. Continuity of care does not apply if your provider or facility was involuntarily terminated from your network for failure to meet applicable quality standards or for fraud.

If you have successfully transitioned to another in-network provider, if you have met or exceeded benefit limitations of the plan, or if care is not medically necessary, you will no longer be eligible for this continuity of care. If we deny your request for continuity of care, you may file an appeal following the procedures described in the Claims and Appeals section of this booklet.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out- of-network providers and facilities directly.

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Hospital Choice Network

BCBS has developed a Hospital Choice Network within the state of Alabama to evaluate cost, quality, and patient experience in member hospitals. Hospitals are categorized into either Lower Member Cost Share or Higher Member Cost Share, based on their performance.

Only Alabama general acute care hospitals are eligible for participation in the Hospital Choice Network. Rehabilitation hospitals, psychiatric hospitals, specialty facilities, out-of-state hospitals, VA hospitals and long-term care hospitals are exempt from Hospital Choice Network scoring.

All hospitals are evaluated annually with changes made effective January 1. In addition, reviews are completed on a quarterly basis, allowing hospitals to improve their status. To review the evaluation criteria for all hospitals and/or the level of Member Cost Share for a particular hospital, please use the "Find a Doctor" tool located at AlabamaBlue.com. The Member Cost Share level will be included in the information provided for each hospital that participates in the Hospital Choice Network. For more information on the evaluation criteria, click on the name of the hospital and then click on the "Cost", "Quality" or "Patient Experience" tabs. If you have any questions, please call the Customer Service Department number on the back of your ID card.

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 LGHIB 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 planbook.

Termination of Coverage

Chapter 2, “Eligibility”, 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 terminated. In some cases, you will have the opportunity to buy COBRA coverage after your LGHIP coverage terminates. See the COBRA chapter for more information.

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 BCBS Customer Service Department number on the back of your ID card.

If you believe you’ve been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint. Or you can submit a complaint online at **https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing**.

Visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.

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 planbook 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.

Direct Deposit

Blue Cross and Blue Shield of Alabama offers Direct Deposit as an option for receiving payments electronically. Enrolling in Direct Deposit will provide you with faster and more secure payments as your funds will be deposited directly into your bank account. Direct Deposit eliminates the need for mobile deposit, trips to the bank and the risk of your checks getting lost or stolen.

Please take a moment to consider this option. If you decide you would like to take advantage of Direct Deposit, you may do so by selecting one of the options below:

- Registering for or logging in to myBlueCross at AlabamaBlue.com and selecting Direct Deposit.
- Accessing myBlueCross through the Alabama Blue mobile app on your smart phone.

Chapter 3
Eligibility

Employee Participation Requirement

If you are an eligible employee, you must be enrolled in the LGHIP at all times during your employment unless you provide proof of other acceptable insurance. If you decline coverage, you must submit a Declination of Coverage form (LG04) and provide acceptable proof of other coverage. Other acceptable coverage includes but is not limited to: Affordable Care Act (ACA) qualified group and individual plans that meet minimum essential coverage standards, Marketplace, Medicare, Medicaid and Tricare.

If you have declined coverage and later lose your other acceptable coverage, youmust immediately enroll in the LGHIP. Coverage will be effective the date the other acceptable coverage ended.

Elected officials, if covered by the unit, must elect to enroll, decline coverage by providing acceptable proof of other coverage, or opt out of the LGHIP.

Eligible Participants

Employee

An employee who receives a W-2, is in an employee/employer relationship and regularly works 30 or more hours per week.

Note: Under the LGHIP rules, temporary, seasonal, intermittent and emergency employees are not eligible for LGHIP coverage; however, if you work for a unit with 50 or more employees, you may be eligible if you work, on average, 30 hours per work or 130 hours per month. For more information, see the ACA Exception Section under Ineligible Participants.

Elected Officials

An elected official is an individual elected to public office by the vote of the people at the state, county, or municipal level of government. The unit decides when it joins the LGHIP whether it will cover its elected officials.

Employees and Elected Officials Entitled to Medicare

If you are an employee or elected official who elects coverage in the LGHIP and entitled to Medicare, you and your dependents will be provided benefits through the LGHIP under the same conditions as employees and their dependents not entitled to Medicare. Medicare is secondary to benefits payable under the LGHIP. If a 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.**

Retirees

The unit decides when it joins the LGHIP whether it will allow eligible retirees to continue coverage with the LGHIP and whether it will only provide coverage until Medicare entitlement or continue coverage after Medicare entitlement. If your unit has elected to cover retirees, please see the Retirement Chapter later in this Book for more information.

Eligible Dependents

The term “dependent” includes the following individuals:

- Your spouse (excludes a divorced spouse)
- A child under age 26, only if the child is:
  - your biological son or daughter;
  - a child legally adopted by you or your spouse;

- your stepchild;

- A dependent, under age 19, for whom the participant, or his or her spouse, has legal and physical custody granted by a court of competent jurisdiction.
- An incapacitated dependent child* over age 25 will be considered for coverage provided dependent is:
  - unmarried,
  - permanently mentally or physically disabled or incapacitated,
  - incapable of self-sustaining employment,
  - dependent upon the eligible participant for 50% or more financial support,
  - otherwise eligible for coverage as a dependent except for age,
  - had the condition prior to the dependent's 26th birthday, and
  - not eligible for any other group insurance benefits.

Dependents who are eligible under multiple eligible employees can only be enrolled in one LGHIB contract. For example, if a dependent is eligible under a parent's coverage and also eligible under their spouse's coverage, the dependent must choose one to enroll in and cannot be enrolled in both.

*The above requirements must be met to be eligible for coverage as an incapacitated child. The LGHIB will decide whether an application for incapacitated status will be accepted, and final approval of incapacitation will be determined by medical review conducted by BCBS. The LGHIB reserves the right to periodically recertify incapacitation. Neither a reduction in work capacity nor inability to find employment is evidence of eligibility. If a mentally or physically incapacitated child is employed, the extent of their earning capacity will be evaluated.

See the "Enrolling an Incapacitated Child" section for critical enrollment deadlines. If deadlines are not met, coverage may be denied.

Dependent Definitions and Documentation Requirements

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	• Government issued marriage certificate or other government issued document evidencing the marriage; or • Court documents recognizing marriage; or • Naturalization papers indicating marital status **Common Law Marriage** Only for common-law marriage that began before January 1, 2017. Alabama law requires clear and convincing evidence of the following basic requirements: • Both parties must have the present legal capacity to marry; • The parties must have entered into a mutual agreement to enter a permanent marriage; and • There must be public recognition of the marital relationship and public assumption of marital duties and cohabitation. A member requesting to add a common law spouse will receive a letter from the LGHIB detailing necessary documentation.
Biological child	A biological child under age 26	• Birth certificate; or • Certificate of Report of Birth (DS-1350); or • Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or • Certificate of Birth Abroad; or • Any legal document that establishes relationship between the child and the participant; or • A National Medical Support Notice
Adopted child	A child under age 26 the participant has adopted or is in the process of legally adopting	• Court documents filed with the court petitioning to adopt; or • Court documents signed by a judge showing that the participant has adopted the child; or • International adoption papers from country of adoption; or • Papers from the adoption agency showing intent to adopt. • Birth certificate
Legal and Physical Custody of a Dependent	A dependent, under age 19, for whom the participant, or his or her spouse, has been granted legal and physical custody by a court of competent jurisdiction	Court Order granting legal and physical custody.
Stepchild	The biological or adopted child under age 26 of the participant's spouse	• Verification of marriage between participant and spouse and birth certificate, or documents outlined in thebiological child section, showing the relationship to the spouse; or • Any legal document that establishes relationship between the stepchild and the participant's spouse.
Incapacitated Child	An unmarried child over the age of 25 and due to a mental or physical disability, is unable to earn a living. The child's disability must have begun before age 26. The child must rely on the participant for 50% or more financial support and must not be eligible for other group insurance.	• Completed Incapacitated Child Certification form to be evaluated by Medical Review. • Birth Certificate, or other documents outlined in the biological child section, showing the relationship to the participant or spouse.

Ineligible Participants

Ineligible Employees

An employee of a unit who: (a) does not receive a W-2, is not in an employee/employer relationship, or does not regularly work 30 or more hours per week; or (b) is a temporary, part-time, seasonal, intermittent, emergency, or contract employee.

Affordable Care Act (ACA) Exception

Under the ACA, you may be eligible for coverage if you are a temporary, seasonal, intermittent, or emergency employee otherwise ineligible for coverage under the LGHIP's enrollment rules but your unit is subject to the ACA because it has 50 or more full-time employees (or full-time equivalents) in the prior calendar year and you average working more than 30 hours a week, or 130 hours in a month, during the unit's measurement period. If your unit is subject to the ACA and you believe that you qualify for coverage even though you are a temporary, part-time, seasonal, intermittent, or emergency employee, your unit must verify that:

- your unit is subject to the ACA;
- you average working more than 30 hours a week, or 130 hours a month, during the unit's measurement period.

In addition, your unit must provide the following information by completing the ACA Verification Form (LG23):

- start and end date of the measurement, administrative, and stability period; and
- the number of hours the employee averaged during the measurement period

If you are eligible pursuant to the ACA provisions, you must enroll in the LGHIP or submit a Declination of Coverage form with acceptable proof of other coverage.

Ineligible Elected Officials

An individual that does not meet the elected official definition under the LGHIP rules. For example, a board member elected by a governmental entity or an association.

Ineligible Retirees

An individual that does not meet the LGHIP retiree eligibility criteria, such as an individual who is terminated.

Ineligible Dependents

- Your spouse or other dependents if they are eligible to be independently covered as an employee of a participating unit
- An ex-spouse or ex-stepchildren, regardless of what the divorce decree may state
- Your biological child if the child has been adopted by someone other than your spouse and you have been relieved of your parental rights and responsibilities
- Children age 26 and older
- Foster children
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements under Eligible Dependent
- A child of a dependent child
- A daughter-in-law or son-in-law
- Grandchildren or other individuals related to the member by blood or marriage for which the member does not have legal and physical custody
- A dependent, other than the participant's spouse or eligible child, aged 19 and older regardless of whether the participant has legal custody
- Grandparents

- Parents
- A fiancé or live-in girlfriend or boyfriend

National Medical Support Notices

A National Medical Support Notice (Notice) is an order from a child support enforcement agency directing the LGHIP to cover your child regardless of whether you have enrolled your child for coverage. If the LGHIB receives a Notice from a child support enforcement agency directing the LGHIP to cover your child, the LGHIB will determine whether the Notice is qualified. The LGHIB has adopted procedures for determining whether a Notice is qualified, and a copy of the procedures may be obtained free of charge by contacting the LGHIB.

The LGHIP will cover your child if required to do so by a Qualified Notice and your child will be enrolled for coverage effective as specified by the LGHIB, but not earlier than the first day of the month following the LGHIB's determination the Notice is qualified. If a unit is not able to withhold the necessary contribution from your paycheck, the LGHIB is not required to extend coverage your child.

Coverage may continue for the period specified in the Notice until your child ceases to qualify as an eligible dependent. If you are required to pay extra to cover your child, the LGHIB will charge the unit for that coverage. During the period your child is covered due to a Qualified Notice, all LGHIP provisions and limits remain in effect except as otherwise required by federal law.

While the Qualified Notice 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. Claims reports will be sent directly to your child's custodial parent or legal guardian.

Notification of Eligibility Changes

It is your responsibility to notify the LGHIB immediately of any eligibility changes, including change of address. You will be responsible for any claims paid by the LGHIP because of your failure to promptly notify the LGHIB of a change in your enrollment status or the eligibility of a covered dependent.

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.

Chapter 4
Enrollment

New Eligible Employees

If you are an eligible employee, you must either enroll in the LGHIP or decline coverage and provide proof of other acceptable coverage.

Effective Date of Coverage of New Eligible Employees

Depending upon the election made by your unit, your coverage will begin either on (1) your date of hire or the date you became an eligible employee; (2) the first day of the second month following your date of hire or the date you became an eligible employee; or (3) if you are eligible pursuant to the ACA, the first day of the stability period.

Probationary Period for New Eligible Employees

Some units have a probationary period applicable to employees' effective date of LGHIP coverage. If your unit has such a probationary period, the effective date your unit has elected for coverage will begin once the probationary period has ended.

Elected Officials

If your unit chooses to cover elected officials and you are an elected official, you have the following options:

- Enroll in the LGHIP – You may enroll within 30-days of assuming the elected office. Elected Officials will be treated as an eligible employee for coverage purposes.
- Decline coverage in the LGHIP – You may decline coverage when you assume office by submitting a declination form with proof of other acceptable coverage. An elected official may enroll in the LGHIP upon loss of other acceptable coverage or at open enrollment.
- Opt-out of the LGHIP – If you opt to not enroll when you assume office and do not submit a declination form with proof of other acceptable coverage, you may only be offered the option to enroll in the LGHIP upon election to a new term of office.
- An elected official who is covered as a dependent in the LGHIP may continue coverage as a dependent.
- Elected officials who fail to elect one of the above options will be treated as if they chose to opt-out of the LGHIP.

Enrollment of Eligible Dependents

You may apply for family coverage at your initial enrollment by submitting an Enrollment form (LG01) or, if an eligible dependent qualifies for special enrollment, by submitting a New Dependent form (LG02-B) within 60 days of the qualifying event, or during annual open enrollment. See the Special Enrollment and Open Enrollment sections for more information.

Appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.) must be submitted to the LGHIB.

Enrolling an Incapacitated Child

To apply, contact the LGHIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the LGHIB no more than 60 days after the dependent's 26th birthday*. If the form and proof of incapacity is not submitted within the required time, your child is not eligible for future enrollment except in the following two situations:

- If you are a new participant and you request coverage for your incapacitated child within 60 days of employment; or

- When your incapacitated child is covered under your spouse's employer group health insurance for at least 18 consecutive months and:
    - your spouse loses the other coverage because:
        - the employer ceases operations, or
        - of termination of employment or reduction of hours of employment, or
        - the employer stopped contributing to coverage
    - a New Dependent form is submitted to the LGHIB within 60 days of the incapacitated child's loss of other coverage, and
    - Medical review approved incapacitation status.

In these two situations, child must meet all the Incapacitated Child eligibility requirements.

*The 60-day time limit does not apply to enrollment in a Southland Voluntary Plan.

Open Enrollment
An annual open enrollment period is held in November during which you may make certain changes which will be effective January 1. Forms must be completed and submitted to the LGHIB by November 30, with an effective date of January 1 indicated on the form.

During open enrollment, you may enroll by submitting an LGHIP Enrollment form (LG01) and you may add dependents or family coverage by submitting a New Dependent form (LG02-B). If you do not want to change plans or add/drop family coverage during open enrollment, no paperwork is necessary.

Special Enrollment
Special enrollment allows eligible employees and dependents who previously declined health coverage to enroll in coverage upon the loss of other coverage and participants may add new dependents due to certain qualifying events (marriage, birth, etc.). Special enrollment rights arise regardless of the LGHIP's open enrollment period. You must request enrollment and provide proof of the qualifying event within 60 days of the event triggering the special enrollment.

If proof of the qualifying event is not submitted within 60 days of the qualifying event the request will be denied.

Note: To ensure that enrollment deadlines are met, forms should be submitted to the LGHIB even if all the required documentation is not available.

Special Enrollment Due to the Loss of Other Coverage
Eligible employees and dependents who decline coverage due to other acceptable coverage have special enrollment rights to enroll in the LGHIP when they lose their other coverage. Proof of loss of eligibility must be provided within 60 days of the event. Examples of qualifying events include:

- COBRA coverage (if elected) is exhausted;
- loss of eligibility (including termination, divorce, death, termination of employment or reduction of hours of employment);
- employer stopped contributing to coverage;
- a substantial change in their other acceptable coverage;
- substantial change in cost of other acceptable coverage; or
- eligible employees and their dependents who lose coverage under Medicaid or the state Children's Health Insurance Program (CHIP). The employee or participant must request enrollment within 60 days of the loss of coverage.

To request special enrollment, you must submit an Enrollment form (LG01) within 60 days of losing other coverage and:

- a letter requesting participation in the special enrollment; and

- documentation listing the name, reason and date of loss for each individual affected by loss of coverage (e.g. employment termination on company letterhead)

Special Enrollment to Add Family Coverage or Add a New Dependent

You are permitted to special enroll a new dependent because of marriage, birth, adoption, placement for adoption, or legal custody. In addition, these qualifying events also allow you to enroll in the LGHIP.

> **Tag-Along Rule:** When a new dependent becomes eligible for special enrollment, all eligible dependents can be added to LGHIP coverage at that time.

To add family coverage or add a new dependent, you must submit a New Dependent form (LG02-B), and:

- proof of gaining a new dependent (e.g. marriage certificate, birth certificate, adoption papers); or
- documentation listing the name, reason and date of loss or change in coverage (e.g. employment termination on company letterhead)

In the event you declined coverage and now want to enroll due to gaining a new dependent, you should submit an Enrollment form (LG01) along with the proper documentation.

The effective date of coverage will be:

- the date of birth;
- the date of marriage;
- the date the child was placed for adoption;
- the date of the court's order granting custody.

Cancellation of Dependent/Family Coverage

You may only drop dependent/family coverage upon the occurrence of a qualifying event or during annual open enrollment. Proof of the qualifying event must be provided if dropping dependent(s) outside of open enrollment. If you request a dependent to be dropped outside of Open Enrollment, you must complete a Dependent Cancellation form and submit it to the LGHIB within 60 days of the event.

Qualifying events to cancel family coverage or drop a dependent from coverage include, but are not limited to:

- Divorce;
- Loss of custody;
- Commencement of dependent employment;
- Dependent's employer has a different open enrollment than LGHIP;
- Medicare/Medicaid entitlement;
- Dependent change of residence; or
- Dependent no longer qualifies for LGHIP coverage.

If approved, the effective date of coverage will be the date other acceptable coverage ceased.

Third Party Medicare Vendor Enrollment

As a service to its members, the LGHIB has approved two companies to offer assistance and coverage options for Medicare retirees. These two companies, SpringBoard (SelectQuote) and Empower Brokerage, provide Medicare retirees and their Medicare dependents with unbiased price comparisons on individual Medicare Supplement, Medicare Advantage and Prescription Drug (Part D) plans. This option is available to all Medicare retirees and their Medicare dependents, even if your unit does not offer retiree coverage to Medicare retirees.

Enrolling in a Medicare option through SelectQuote or Empower Brokerage:

- The Medicare enrollment period is held annually from October 15 through December 7. The effective date of coverage will be January 1 of the following year.

- Medicare coverage obtained through SelectQuote or Empower Brokerage is offered in lieu of LGHIP coverage.
- At the time of retirement or during the LGHIP's open enrollment period, if a Medicare retiree declines coverage in the LGHIP in lieu of Medicare coverage through SelectQuote or Empower Brokerage, they may return to the LGHIP during the LGHIP open enrollment period, if there has been no break in coverage.
- At the time of retirement, if a Medicare retiree declines coverage in both the LGHIP and a Medicare option offered through SelectQuote or Empower Brokerage, he or she cannot enroll in the LGHIP at a later date. However, a Medicare retiree can enroll for Medicare coverage through SelectQuote or Empower Brokerage during the Medicare enrollment period.
- Medicare retirees who are currently covered by the LGHIP can enroll for Medicare coverage through SelectQuote or Empower Brokerage during the Medicare enrollment period. They may return to the LGHIP during the LGHIP open enrollment period if there has been no break in coverage.

Transfers

Only new eligible employees who meet the following criteria will be considered as transfers under the LGHIP:

- previously covered by the LGHIP; and
- terminated employment with another unit and began employment with the current unit during the same calendar month of termination.

Dependents who begin employment with a unit who meet the following criteria will be considered as transfers under the LGHIP and will not have a gap in coverage:

- covered by the LGHIP at the time employment with the unit begins.

Transfers may make a new coverage election which will be effective the first day of the month following the date of hire.

Rehires

If you are rehired by the same unit within 13 weeks from the termination of your employment and you were enrolled in the LGHIP before your employment ended, you may re-enroll with coverage effective on the date of your rehire.

If you are rehired by the same unit after 13 weeks from the termination of employment or you were not enrolled in the LGHIP before your employment ended, you will be treated as a new employee and your coverage will be effective based on your unit's effective date for all new employees.

Premium Payments

To be eligible for coverage members must comply with the LGHIP's enrollment and eligibility rules. Acceptance of premium payment does not guarantee coverage.

Chapter 5
Retirement

Retiree Enrollment Rules

If your unit provides retiree coverage, you may elect to continue your LGHIP coverage as a retiree if, at the time of retirement, you have at least 10 years of coverage in the LGHIP (coverage not required to be continuous) and:

- a combination of 25 years, or more, of service with a participating unit or other service approved by the LGHIB, regardless of age, or
- are 60 years old, or older, or
- are determined to be disabled by the Social Security Administration.

If you are retiring from a unit that has been a participating unit less than 10 years, you must have been enrolled in the LGHIP continuously from the date the unit joined the LGHIP.

Only retirees who retire from active status are eligible to continue LGHIP coverage as a retiree. Terminated employees are not eligible for retiree coverage.

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

Service Retirements

For service retirements, proof of your years of full-time service with a unit covered under the LGHIP must be provided. In addition to service with a participating unit, the LGHIB may also consider proof of other approved employers, such as the State of Alabama or a non-participating local government employer.

Disability Retirements

You must provide proof that an application for a disability determination from the Social Security Administration (SSA) was made prior to retiring. 18 months of COBRA coverage will be offered at retirement. If you do not receive a SSA determination during the COBRA period, your COBRA coverage will expire after 18 months and no further coverage through the LGHIB will be offered. If you receive an SSA approved disability determination and provides a copy of the determination letter to the LGHIB during the 18-month COBRA period, your COBRA coverage will be converted to LGHIP non-Medicare retiree coverage.

If the retiree's unit does not offer Medicare retiree coverage, the retiree's coverage will end either when the retiree is entitled to Medicare or 24 months from the SSA disability determination, whichever comes first.

If the retiree's unit offers Medicare retiree coverage the retiree must provide the LGHIB with proof of Medicare Parts A and B coverage within 24 months of the SSA disability determination to maintain LGHIP retiree coverage. Once a copy of the SSA disability determination letter and proof of Medicare Parts A and B is provided, the employee will be enrolled in Medicare Advantage coverage. Failure to provide proof of Medicare coverage within 24 months of the SSA disability determination will result in termination of coverage.

Continuation of Coverage

Eligible retirees whose local government unit covers retirees may continue their coverage with the LGHIP. You must enroll on the date you first become eligible for retiree health benefits.

If you decline coverage at retirement, enrollment will not be allowed at a later date.

Exception: At the time of retirement, if you are a Medicare retiree and you decline coverage in the LGHIP in lieu of coverage through SelectQuote or Empower Brokerage, you may return to the LGHIP during the LGHIP open enrollment period, if there has been no break in coverage.

Termination of Coverage

If you retire from a unit that allows retirees to continue coverage, you have the option of electing retiree coverage or COBRA. If you choose to cancel health insurance, the unit must send a signed Cancellation form 30 days prior to the retirement date. If COBRA coverage is elected, you will forfeit their right to elect retiree coverage later. If you intend to request COBRA, it should be indicated on the Cancellation form prior to the retirement date.

If your unit does not allow Medicare retirees to continue coverage in the LGHIP, you must submit a Cancellation form 30 days prior to your Medicare eligibility date. A copy of the Medicare card may be required. COBRA will be offered to you and your dependents for 18 months.

Retired members do not pay LGHIP premiums with pre-tax dollars so you can cancel your LGHIP retiree coverage anytime during the plan year on a prospective basis. A signed Cancellation or Dependent Cancellation form must be sent to the LGHIB to cancel coverage. The coverage will be canceled the last day of the month following receipt of the Cancellation or Dependent Cancellation form.

Supernumeraries

Supernumeraries will be classified for insurance purposes as retired employees.

Chapter 6
Medicare

Medicare is the federal program that most Americans receive when they turn age 65. Medicare can also cover younger people who qualify due to disability or permanent kidney failure.

Medicare Part A is the part of Medicare that pays for medical facility fees and is free for most people at age 65.

Medicare Part B is the part of Medicare that pays for physicians' fees and outpatient medical care. Medicare Part B premiums are your responsibility.

Medicare Part D is the component of Medicare that pays for prescription drugs.

Retired Employees – Non-Medicare

If you retire from a unit that has elected coverage for non-Medicare retirees, the LGHIP (Group 30000) remains primary for you until you are entitled to Medicare.

If you retire from a unit that has elected coverage for both non-Medicare and Medicare retirees, and you or your dependent becomes entitled to Medicare because of a disability before age 65, you must notify the LGHIB to be eligible for a reduced premium and to ensure that claims are paid properly. A copy of your or your dependent's Medicare card, and a Change form that indicates the premium change, must be submitted to the LGHIB.

Retired Employees – Entitled to Medicare with Parts A & B

Medicare Advantage

If you and your dependents are entitled to Medicare and have both Parts A and B, you will be automatically enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan (Medicare Advantage), a Medicare health and Part D plan.

You and/or your Medicare dependent must have both Medicare Parts A and B to be enrolled in Medicare Advantage. Medicare Part B premiums are your responsibility.

Members enrolled in Medicare Advantage will receive an Evidence of Coverage book that outlines the plan's eligibility, rules, regulations, and benefits. A link to the Evidence of Coverage, a current drug formulary, participating pharmacy directory, and a provider finder is available at www.lghip.org. Once enrolled in Medicare Advantage, a retiree has the right to appeal plan decisions about payment of services if they disagree.

Medicare Advantage Opt-Out Option

You and your Medicare dependents may completely opt-out of Medicare Advantage by submitting a UnitedHealthcare Medicare Advantage Opt-Out form to the LGHIB. An Opt-Out form will be sent to all Medicare retirees when the LGHIB is notified of Medicare entitlement. The opt-out forms must be returned to the LGHIB within 21 days from the date of the opt-out notice. If you opt-out, re-enrollment is not permitted. Members who opt-out of Medicare Advantage will have no coverage in the LGHIP.

Exception: If you are a Medicare retiree who opts-out of coverage in the Medicare Advantage Plan and elects coverage through SelectQuote or Empower, you may return to the Medicare Advantage Plan during the LGHIP open enrollment period, as long as there has been no break in coverage, provided the unit still allows retiree Medicare coverage.

If you are diagnosed with end-stage renal disease (ESRD), and are serving your 30-month coordination period, you will remain in group 30000 and the LGHIP will remain primary payer until the completion of the 30-month coordination period.

Medicare Notification Requirements

Active Employees

If your unit provides coverage for Medicare retirees and you are entitled to Medicare on or before your date of retirement, you must notify the LGHIB at least 30 days prior to their date of retirement in order to be enrolled in Medicare Advantage without a gap in coverage. Medicare Advantage enrollment cannot be backdated. If you are entitled to Medicare on or before your date of retirement and fail to provide the LGHIB with at least a 30-day notice of your retirement, you may have a gap in coverage until you can be enrolled in the Medicare Advantage.

Retired Employees

If you become entitled to Medicare because of a disability before age 65, you must notify the LGHIB at least 30 days prior to your date of entitlement to be enrolled in Medicare Advantage without a gap in coverage. Medicare Advantage enrollment cannot be backdated. If you become entitled to Medicare due to disability, and fail to provide the LGHIB with at least a 30-day notice, you may have a gap in coverage until you can be enrolled in Medicare Advantage.

In addition, any claims paid by the LGHIP while you were still classified as a retiree not eligible for Medicare due to your late notification of your entitlement to Medicare due to disability will be recalled. You will be liable for any claims that cannot be recalled.

Changes to Medicare Coverage

Medicare limits when changes can be made to coverage. You may leave Medicare Advantage only at certain times of the year or under certain special circumstances. There is an open enrollment period at the end of each year when changes can be made to Medicare coverage that will be effective January 1 of the following year. To request to leave Medicare Advantage, please submit the UnitedHealthcare Medicare Advantage Opt-Out form to:

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

Chapter 7
Termination of Coverage

When Coverage Terminates

You or your dependents' coverage will terminate on the last day of the month after the following events:

- Death
- Employment termination;
- Leave without pay
- Retirment
- Elected official's term of office ends;
- If you chose to cancel coverage to enroll in another plan (i.e. to enroll in other acceptable coverage);
- When premium payments cease;
- When your unit withdraws from the LGHIP;
- If you are eligible pursuant to the ACA, coverage terminates on the last day of the month after the end of the applicable stability period if you do not average 30/130 or more hours per week/month during a subsequent measurement period.

In you change from full-time to part-time employment, coverage will end on the last day of the month after the unit notifies the LGHIB of the change.

In addition to the above, coverage terminates for your dependent:

- on the last day of the month in which your dependent ceases to be an eligible dependent; or
- if your dependent becomes eligible for coverage as an employee.

In many cases, you and your dependents will have the option to choose COBRA continuation coverage. (See COBRA Chapter for more information)

If you perform an act or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, coverage may be terminated retroactively to the date of the act or omission. The LGHIB may recover the amount of any claims paid in error due to the act or omission.

Family and Medical Leave Act

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

Leave without Pay (LWOP)

You may continue health insurance coverage for a maximum of 12 months if you are on leave without pay or are receiving proceeds or pay through a workers' compensation policy.

Chapter 8
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 because it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it.

This Chapter 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 "Who is a Qualified Beneficiary?" 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, 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. 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."

COBRA Medicare Enrolled in Medicare Advantage

COBRA beneficiaries with Medicare Parts A and B will be enrolled in the Medicare Advantage plan.

What Coverage is Available?

If you choose COBRA 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 Should Your Employer Notify the LGHIB?**
  Your employer is responsible for notifying the LGHIB within 30 days of the following qualifying events:
  - End of employment,
  - Reduction of hours of employment, or
  - Death of an employee.

- **When Should You Notify the LGHIIB?**
  The employee or a family member has the responsibility to inform the LGHIB within 60 days 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 the applicable timeframe listed above from 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 must be sent to the address listed under "LGHIB Contact Information" at the end of this Chapter.

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, 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 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, if 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; (3) the date of Social Security's determination; or (4) the date on which you, or the qualified beneficiary, is informed, through the furnishing of the SPD or COBRA general notice, of the responsibility to notify the plan and the procedures for doing so. You must also notify the LGHIB within 30 days of any revocation of Social Security disability benefits.

Extensions of COBRA for Second Qualifying Events –If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the LGHIB is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage had the first qualifying event not occurred. You must notify the LGHIB within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

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 added 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 the COBRA Coverage Premium?

If you qualify for continuation coverage, you will be required to pay the local government unit’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 local government unit'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 on time.

When is the COBRA Coverage Premium Due?

The initial premium payment is due 45 days after the date you make your election for coverage. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

When does my COBRA Coverage End?

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

- LGHIB no longer provides group health coverage;
- The unit withdraws or is terminated from the LGHIP;
- The premium for your continuation coverage is not paid on time;
- The covered beneficiary becomes covered by another group plan;
- You become entitled to Medicare;
- You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the LGHIP. For example, if a fraudulent claim is submitted, coverage will terminate.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your COBRA continuation coverage. There is a grace period of 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. You must have Medicare Parts A and B to have full coverage. If COBRA is elected, the individual will be enrolled in the LGHIP's Medicare Advantage plan.

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

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, visit the Centers for Medicare & Medicaid Services (CMS) website at //www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/COBRA.html. 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
LGHIB COBRA Section
PO Box 304900
Montgomery, AL 36130-4900

Chapter 9
Health and Wellness Programs

The LGHIB has designed a wellness program to help support each member's wellness journey and to assist you with your health management. The principal component of the LGHIP's wellness program is the wellness screening. The wellness screening includes taking your blood pressure, and measuring your height, weight and waist size. It also includes taking a blood sample to check your cholesterol (HDL, LDL, and total), triglycerides, and glucose. You will also be asked whether you have or have had high cholesterol, high blood pressure, or diabetes and whether you take medicine for those conditions. The wellness screening is a voluntary program available to active employees, non-Medicare retirees, and their spouses, who are covered by the LGHIP (Group 30000).

The screening is intended to identify whether you are at risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes. You are also encouraged to share the results or any concerns with your medical provider. Early detection is a key to reducing or eliminating the risk of developing hypertension, prediabetes, diabetes, heart disease and obesity. If you are eligible, we will provide program information to you at your biometric screening, or through electronic or regular mail. We encourage you to enroll in the programs at your biometric screening, but you can also enroll after reviewing the information provided via the contact information below. The programs are available to eligible members at no cost to you and offer a health care professional specializing in your condition to assist you in managing your condition(s) and improving your quality of life.

Chronic Conditions	Program Description	Enrollment / Contact Information
Type 2 Diabetes	Virta Health provides the opportunity for diabetes reversal – normal blood sugar, no diabetes medications, and good health. Virta addresses the root cause of diabetes: nutrition. They use carbohydrate restriction, a powerful tool for people with type 2 diabetes that lowers blood sugar while allowing people to eat to satisfaction. Virta is available for participants and covered spouses with type 2 diabetes.	**Step 1** is to start the application process on Virta's website: www.virtahealth.com/lghip **Step 2** is to be paired with an Enrollment Advisor, who can answer questions related to: • The Virta Treatment • Application Process • Insurance Coverage • International Coverage • Admittance based on medical history If you have questions or need general information, please email support@virtahealth.com or visit their website www.virtahealth.com/lghip

Chronic Conditions	Program Description	Enrollment / Contact Information
Weight Management and Prediabetes	Wondr Health is a common-sense digital counseling program that teaches participants simple skills tochange when and how they eat, instead of what they eat. Plus, it creates other healthy habits leading to increased physical activity, better sleep, less stress, and better control over their long- term health. It is available via your desktop, laptop, or mobile device including apps for both iPhone andAndroid. Wondr Health is available for participants and covered spouses with a Body Mass Index greater than 25.	Apply or join the waitlist for the next class on WondrHealth's website. www.wondrhealth.com/lghip If you have questions or need general information, please email info@wondrhealth.com or visit theirwebsite www.wondrhealth.com/lghip.
• Coronary Artery Disease • Congestive HeartFailure • Chronic Kidney Disease • Chronic Obstructive Pulmonary Disease • Asthma • Hypertension • Musculoskeletal Pain • Diabetes • Prediabetes • Weight Management	The BCBS Disease Management program focuses on chronic health conditions that are sometimes debilitating but can be managed through early intervention, awareness of appropriate treatment, and lifestyle changes. Participants receive: • 1:1 coaching via telephone orApp with a Registered Nurse, Dietician, or other clinical resource • A health assessment, if needed, to assist in better managing the condition • Educational materials such as helpful self-monitoring charts, resource listings, self-care tips, and bi-annual newsletters BCBS programs are available for members with one or several of the conditions listed.	Call BCBS at 1-833-964-1448 or email myBlueHealth@bcbsal.org

Please note that the programs and information resources available may change from time to time.

Physician Supervised Weight Management & Nutritional Counseling Program

The LGHIB will cover approved physician supervised weight management and nutritional counseling programs. The LGHIB will reimburse 80% of the cost of a physician supervised weight management program and/or nutritional counseling, with no deductible, not to exceed $150 per member, per calendar year. You can apply for reimbursement by mailing 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
1-866-836-9137, option 4

Only medications dispensed or administered at the provider's office are eligible for reimbursement. Food and dietary supplements are excluded from the program.

You must file your claims for this benefit with the LGHIB, not BCBS; however, BCBS will process the reimbursement.

Tobacco Cessation Reimbursement Program

A Tobacco Cessation Reimbursement Program is provided by the LGHIB for its covered members. Program information can be obtained by contacting our Wellness Division. For more information about available cessation 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.

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. You can apply for reimbursement by mailing your name, address, contract number and a copy of 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; however, BCBS will process the reimbursement.

Chapter 10
Benefit Conditions

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

- They must be furnished after your coverage becomes effective;
- BCBS 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 provider-administered drugs must be precertified by BCBS. 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 BCBS Customer Service if you have any questions whether your provider is recognized by BCBS as an approved provider for the services or supplies you plan to receive.
- Services and supplies must be furnished when you are eligible and enrolled in the LGHIP and your coverage is fully paid for. If it is determined later that you or your dependent(s) were not eligible for coverage, you will be responsible to pay for services provided during the period of ineligibility. 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.

Chapter 11
Cost Sharing

	In-Network	Out-Of-Network
Calendar Year Out-of-Pocket Maximum	$9,100 per member, $18,200 per family. Certain benefits pay at 100% of the allowed amount thereafter	Out-of-network services do not apply to the out-of-pocket maximum

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 are 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 toward 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:

Most cost sharing amounts (deductibles, copayments, and coinsurance) paid for any out-of-network services or supplies that may be covered under the plan (except for covered out-of-network mental health disorders and substance abuse services for medical emergencies):

- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies more than 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 more than 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).

In certain circumstances, as and when required by Federal law, the cost-sharing amounts (deductibles, copayments, and coinsurance) that you are required to pay for out-of-network services will apply to the in-network calendar year out-of-pocket maximum. Those services include:

- Medical or Accident emergency
- Air Ambulance
- Certain non-emergency services performed by out-of-network providers at certain in-network facilities

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 $9,100, 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 $18,200.

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 for services at a doctor's office.
- **Coinsurance:** Coinsurance is the amount that you must pay as a percentage of the allowed amount.
- **Amounts more than 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 more than the allowed amount. For example: certain 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 could be responsible for these charges if you use an out-of-network provider.
- **Provider Administered Specialty Drug Financial Assistance:** In most cases, only the amount you pay out-of-pocket for your provider administered specialty drugs will apply to your cost-sharing responsibilities or out-of-pocket limit. Except for certain specialty drugs, the dollar amount of any financial assistance provided to you by providers or manufacturers will not count towards coinsurance, copays, or deductible cost-sharing responsibilities or out-of-pocket limit.

Out-of-Area Services

BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, generally referred to 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., 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 considers 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also consider 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] made available to BCBS by the host plan. Refer to the description of negotiated price under Section A., BlueCard Program.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded plans. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed to you.

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

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.

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.

E. Blue Cross Blue Shield Global Core

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 Blue Cross Blue Shield Global Core when accessing covered healthcare services. Blue Cross Blue Shield Global Core is not served by a Host Blue.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Blue Cross Blue Shield Global Core 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 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 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 Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the 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 service center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Chapter 12
Preferred Provider Organization

When you use a preferred provider organization (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 BCBS website at **AlabamaBlue.com** to find out if your provider is a PPO member.

Preferred Provider (PPO) Benefits for Physicians, Nurse Practitioners, & 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 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 precertification. 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 copay or a $20 nurse practitioner or physician assistant copay for each visit.
    - Routine Preventative Office Visit: No copay for one routine preventative visit per year (adults 19 and older).
- **Telephone and Online 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 and video (where available) consultations are available 24 hours a day, 7 days a week. 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, coinsurance, or copayment. **Out-of-network services are not covered.**
- **Surgical Care Services** - services for operations and cutting procedures and inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, heart catherization 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 copay**.
- **Maternity care -** includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- **Inpatient hospital visits** related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.

- **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. (Subject to the facility copay.)
- **Outpatient Diagnostic Lab and Pathology** - coverage is provided for outpatient diagnostic lab and pathology services when performed by a PPO provider. **The member pays $7.50 copay 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 the applicable copay (i.e. physician $40, nurse practitioner or physician assistant $20, or specialist $50) copay for each visit. (Subject to the facility copay.)

Chapter 13
Teladoc

Teladoc is a free service for members of the LGHIP that provides consultations with board-certified doctors via phone or video 24 hours a day, seven days a week. This service is available with no copay. Members can speak with a doctor about a variety of issues such as cold, flu, allergies, infections, and more. When necessary, the doctor can prescribe an appropriate medication needed for treatment. This benefit can be used in place of the emergency room or urgent care for non-emergency situations.

To enroll, download the mobile app through the App Store (Apple products) or Google Play (Android products); visit Teladoc.com/Alabama; or call 1-855-477-4549. Teladoc consultations are covered at 100% of the allowance with no deductible, coinsurance, or copayment.

Availability	Nationwide 24/7/365 by phone, web, or mobile app
How to access	Telephone or video visits with a physician
Information needed	Blue Cross and Blue Shield of Alabama ID card
Cost	$0 Copay
Website	www.teladoc.com/Alabama
Phone	1-855-477-4549 or 1-800-Teladoc
Apps	Search Teladoc in App Store or Google Play
Physicians	Internal Medicine, Family Medicine, Emergency Medicine, Pediatric Medicine Board certified in their specialty Average 20 years of experience
Common conditions treated	Cold, flu, sinus problems, allergies, minor skin problems, pink eye

Chapter 14
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 copayment.

Visit **AlabamaBlue.com/preventiveservices** for a listing of specific immunizations and preventive care services. Please note 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 copayment:

- 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.

Chapter 15
Inpatient Hospital Benefits

Out-Of-Network Benefits: Medical Emergency or Accidental Injury

If you receive out-of-network physician benefits (such as out-of-network laboratory services) for a medical emergency or accidental injury in the emergency room of a hospital, those services will also be paid at the applicable in-network coinsurance amounts for such benefits described in the matrices in the beginning of this book, and subject to the in-network calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the requirements of the applicable Federal law.

Out-Of-Network Benefits: Non-Emergency Medical Benefits

If you receive non-emergency services performed by an out-of-network provider at certain participating facilities, those services will be paid at the applicable in-network coinsurance and/or copayment amounts for such benefits described in the matrices in the beginning of this book, and subject to the in-network calendar year deductible, provided the out-of-network provider has not satisfied the applicable notice and consent requirements. The allowed amount for such non-emergency services performed by an out-of-network provider at certain participating facilities will be determined in accordance with the requirements of the applicable Federal law.

Attention: Precertification is required for all hospital admissions except for medical emergency services, maternity admissions, and as required by Federal law.

For medical emergency services, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

For precertification call 1-800-248-2342 (toll-free).

Generally, if precertification 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.)

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 than 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 more than 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 and will be a separate hospital admission.

Deductible

The deductible for each certified inpatient hospital admission is **$200 (with a $50 per day copay for the second through the fifth day)**. You are responsible for payment of the deductible and copayment 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 Transplant Benefits

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 bone marrow function stronger, 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 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 preapproved by BCBS;
- 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;
- prediagnostic 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 acceptable 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.

Chapter 16
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 information on precertifications, please call the appropriate number in the Precertification section below.

- Charges to treat an accidental injury
- Charges for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention) **after a $200 copayment**. 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 copayment per visit**.
- Hospital charges for hemodialysis services in its outpatient department **after a $25 copayment per visit.** Services received in a free-standing dialysis center are only covered under Major Medical.
- IV therapy **after a $25 copayment per visit**.
- Laboratory and pathology services **after a $7.50 copayment per test**.
- Diagnostic X-rays test **after a $100 copayment per visit**.
- Charges for outpatient surgery **after a $100 copayment 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 not pay 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 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 preoperative 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.

Precertification

Precertification is required for certain outpatient hospital benefits, physician benefits and other covered services. The general categories or descriptions of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the filing of this booklet are set forth below. Examples are for illustrative purposes only. You can find more information about the specific services that require precertification at AlabamaBlue.com/Precert. This list will be updated no more than twice per calendar year. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services

Services that require precertification currently include:

- Certain advanced imaging (for example, MRA, MRI, CT, CTA and PET)
    - For precertification, call 1-866-803-8002 (toll free)
- Mental health intensive outpatient services and partial hospitalization
    - For precertification, call 1-800-548-9859 (toll free)
- Certain select procedures: (for example, implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, and surgery for obstructive sleep apnea)
    - For precertification, call 1-800-248-2342 (toll free).
- Certain reconstructive procedures: (for example, blepharoplasty; rhinoplasty, and surgery for varicose veins)
    - For precertification, call 1-800-248-2342 (toll free)
- Certain durable medical equipment:
    - For precertification, call 1-800-248-2342 (toll free)
- Home health and hospice when services are rendered outside the state of Alabama.
    - For precertification, call 1-800-821-7231 (toll free).
- Certain radiation therapy management services: (for example, proton beam therapy, cyberknife and stereotactic radiosurgery)
    - For precertification, call 1-866-803-8002 (toll free)
- Certain genetic laboratory testing: for example, breast cancer (BRCA) testing and genetic carrier screening)
    - For precertification, call 1-866-803-8002 (toll free)
- ABA therapy.
    - For precertification, call 1-877-563-9347 (toll free)

If precertification is not obtained, no benefits will be payable under the plan for the services.

You will be required to pay the billed charges for such services, if we later determine that it was not medically necessary**.**

Chapter 17
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 three deductibles per family. Major medical deductibles and coinsurance apply to annual out-of-pocket maximums of $9,100 for individuals and $18,200 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 preadmission certification and post-admission review.
- Emergency room charges that do not meet medical emergency guidelines.
- 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. *Precertification* is required after the 15th habilitative or rehabilitative visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-248-2342.
- Speech therapy is covered at 80% of the allowance, subject to the calendar year deductible. *Precertification* is required after the 15th habilitative or rehabilitative visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-248-2342.
- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible. *Precertification* is required after the habilitative, or rehabilitative 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-248-2342.
- Coverage for Autism Spectrum Disorder – The plan covers the screening, diagnosis, and treatment of Autism Spectrum Disorder for children 18 years of age or under. For coverage related to the screening, diagnosis, and treatment of Autism Spectrum Disorder, precertification shall be based on the most recent treatment plan. BCBS may only request an updated treatment plan once every six months from the treating licensed physician or licensed psychologist to review medical necessity, unless BCBS and the treating licensed physician or licensed psychologist agree that a more frequent review is necessary for a particular patient. Coverage is limited to children 18 years of age or under. Additional specific benefit limits include:
    - Applied Behavioral Analysis (ABA) Therapy
        - **In Network (PPO)** – Covered at 100% of the allowance, subject to a $14 copay per visit and the annual maximum benefits below. *Precertification* is required

before rendering ABA therapy to determine the medical necessity. *Precertification* is also required every six months thereafter to determine the medical necessity for continued therapy or to exceed the annual maximum benefit. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For more information, please call 1-877-563-9347.

- **Out of Network – (NON-PPO)** – Covered at 80% of the allowance, subject to the calendar year deductible and the annual maximum benefits below. *Precertification* is required before rendering ABA therapy to determine the medical necessity. *Precertification* is also required every six months thereafter to determine the medical necessity for continued therapy or to exceed the annual maximum benefit. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For more information, please call 1-877-563-9347.
- **Annual Maximum Benefits**:

Age	Annual Maximum
0 to 9	$40,000
10 to 13	$30,000
14 to 18	$20,000

- Physical therapy is covered at 80% of the allowance, subject to the calendar year deductible. *Precertification* is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-248-2342.
- Speech therapy is covered at 80% of the allowance, subject to the calendar year deductible. *Precertification* is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-248-2342.
- Occupational therapy is covered at 80% of the allowance, subject to the calendar year deductible. *Precertification* is required after the 15th visit to determine the medical necessity for continued therapy. If precertification 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. For more information, please call 1-800-248-2342.

- 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 more than this maximum must be certified through case management; call 1-800-248-2342 for precertification.
- Prosthetic devices such as an artificial arm and orthopedic devices such as a leg brace.
- Medical supplies, other than insulin supplies, such as oxygen, crutches, splints, casts, trusses and braces, syringes and needles, 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 Standalone Participating Renal Dialysis Facility is covered at 80% of the allowance, subject to the calendar year deductible.
- Private duty nursing services of a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.) if: the services 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. To be covered, private duty nursing services must be **precertified** 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 1-800-821-7231 for precertification.

Chapter 18
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 an 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 the 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.

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 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 precertify.

Baby Yourself Maternity Management Program
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 1-800-222-4379. **By participating in Baby Yourself and notifying BCBS before the end of the second trimester, your inpatient deductible and applicable daily copay(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. For more information call 1-800-551-2294.

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 with that decision. After receiving the decision, you may make a written request 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 60 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, chronic obstructive pulmonary disease (COPD), congestive heart failure, asthma, and other specialized conditions. This program is available to eligible members at no cost as a part of your benefits.

BCBS 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, BCBS 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 BCBS know you are in the program. Call BCBS at 1-888-841-5741 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 and 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 authorized. 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 four 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
PO 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.

Chapter 19
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 BCBS' payment (along with the 20% coinsurance due from the patient) as payment in full; the patient will not be balance-billed for any charges over the allowed amount. 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.

Chapter 20
Mental Health and Substance Abuse Preferred Provider Organizations

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 an 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 24 visits each calendar year at $14 copay per visit. (Other copayments 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 also receive up to 40 outpatient substance abuse sessions covered at 100% of the allowance at a day/evening or weekend treatment program offered by a Certified Regional Mental Health Center or other approved provider. See www.AlabamaBlue.com for a list of approved providers. Substance abuse services provided by a non-approved LGHIP provider will be covered at 80% subject to the calendar year deductible and limited to 24 visits per person per calendar year.

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 non-approved hospital will be covered at 80% of the fee schedule after a $200 deductible per admission. You are responsible for 20% of the 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.

Chapter 21
Provider Administered Drug Benefits

Precertification is required for certain provider-administered drugs. You can find a list of precertification requirements at AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. This list will be updated monthly.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office, or home healthcare setting. Provider-administered drugs also include gene therapy and cellular immunotherapy. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy; claims for these drugs process through the medical benefit

For BCBS precertification, call the Customer Service Department number, 1-800-248-2342.

If precertification is not obtained, no benefits will be payable under the plan for the physician-administered drug.

HealthSmartRx: Smart RxAssist Program

Many provider-administered dugs have manufacturer financial assistance programs to help patients with the cost of these high-cost drugs. Your benefit requires participation in the program to ensure you are paying the lowest possible cost for your eligible drugs. You can find a list of eligible drugs in this program at AlabamaBlue.com/Providers/HealthSmartRx. The copays may vary and be set to the maximum of any available manufacturer financial assistance (coupon). The Local Government Health Insurance Board is offering the Program so the member copayment will be less than the otherwise applicable copayment or reduced to zero. Please contact HealthSmartRx at 1-833-800-4032 to complete your required enrollment process. Only actual out-of-pocket payments will count toward your annual out-of-pocket maximum.

Chapter 22
Prescription Drugs

Prescription Drug Benefits

Prescription drug benefits are administered by OptumRx. OptumRx's customer service number is 1-844-785-1603. Please refer to the OptumRx Prescription Drug List for a list of covered drugs and the associated tiers. The OptumRx Prescription Drug List is available by signing in to your OptumRx account at www.optumrx.com or at www.LGHIP.org.

Prescription Drug Card Program

Tier 1 drugs, which mainly include covered generic drugs, are covered at 100% of the allowance, subject to a $15 copay per prescription when you use a participating pharmacy.

Point-of-Sale Drug Program

For Tier 2, Tier 3, and Specialty drugs, which mainly include brand name drugs, you are responsible for paying 100% of the cost of the drug at the point-of-sale at the pharmacy. When you use a participating pharmacy, **you may request reimbursement of 80% of what you paid for the drug at the point-of-sale**, subject to the calendar year Major Medical deductible of $200.

To obtain the 80% reimbursement for a Tier 2, Tier 3, or Specialty drug, you must file your prescription claim with OptumRx, using the LGHIB Direct Member Reimbursement form available by signing into your OptumRx account at www.optumrx.com or at www.lghip.org. Use this form to request reimbursement for covered medications purchased at the point-of-sale from a participating pharmacy and mail to:

OptumRx Claims Department
PO Box 650334
Dallas, TX 75265-0334.

Complete one form per member. To submit the form online, you will need to select the "eForm" version of the form located on the OptumRx website.

You must also include the original pharmacy receipt for each medication (not the register receipt). If you do not have pharmacy receipts, you can ask your pharmacy to provide them to you.

Your receipt or prescription details must contain the following information:

- Date prescription filled
- Prescription number (Rx number)
- Name and address of pharmacy
- Name of drug and strength
- Amount Paid

To file the reimbursement claim, you will need to complete the information as requested.

Specialty Medications

Specialty medications are subject to the cost sharing requirements in the Point-of-Sale Drug Program as referenced above. These medications require special handling, administration or monitoring and are used for the treatment of serious health conditions requiring complex therapies such as cancer, multiple sclerosis or rheumatoid arthritis. Most specialty medications must be filled by Optum Specialty Pharmacy and are limited to a 30-day supply. Optum Specialty Pharmacy can be reached by calling 1-855-427-4682 or by visiting specialty.optumrx.com. Go to specialty.optumrx.com/drug-list for a listing of specialty medications.

Point-of-Sale Exception List

Certain blood glucose lowering drugs used to treat diabetes, along with certain other drugs, are covered at 80% of the allowance at the point-of-sale (i.e., the member is not responsible to pay 100% of the cost of the drug at the point-of-sale) and members are only responsible for 20% coinsurance at the point of sale. A member is not eligible for the 80% post point-of-sale reimbursement for drugs on this list, as that benefit is built into this tier of drugs.

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.
- Coverage of medications included on the Preventive Care Medications List are subject to plan design. Medications included on the Preventive Care Medications List can be covered at $0 copay. Refer to the Preventative Medication List available at www.lghip.org for additional details. Brand-name medications will follow the Point-of-Sale Drug Program.
- Plan specific exclusions will supersede OptumRx's Premium Prescription Formulary and OptumRx's Drug Pricing and Information tool.

Prescription Drug Card Replacement

Additional or replacement prescription drug cards are available to print at www.OptumRx.com or through the OptumRx mobile app. You may also order a replacement ID card by calling OptumRx at 1-844-785-1603.

OptumRx Customer Service

If you have questions about your prescription drug coverage, or need additional information about how to file claims, you should contact OptumRx. The phone number is 1-844-785-1603.

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

- Your contract number
- Date of service
- Prescription number

Prescription Drug Appeal Process

You have the right to appeal any decision that denies payment for an item or service (in whole or in part). You may also submit written comments, documents, or other information relevant to the appeal.

You, your prescriber, or your authorized representative (someone you name to act for you, such as a family member, an attorney, or a friend) may file an appeal. OptumRx reserves the right to establish and implement reasonable procedures to determine whether an individual has been authorized to act as your representative.

You have the right to appeal a medication coverage decision within 180 calendar days from the date of the denial notification. You or your prescriber can get appeals information, including independent appeal rights, by calling OptumRx's appeals coordinator at 1-888-403-3398.

To file an appeal, please send any written comments, documents, or other relevant documentation with your appeal to the address listed below:

OptumRX
c/o Appeals Coordinator
PO Box 25184
Santa Ana, CA 92799
Phone: 1-888-403-3398
Fax: 1-877-239-4565

If you proceed with the appeals process, OptumRx will review the denial decision and provide you with a written determination within 30 calendar days of receiving your appeal.

If any of the following occurs, you may be able to request an external review of your claim by an independent third party, known as an independent review organization (IRO), which will review the denial and issue a final decision:

- You do not receive a timely decision
- OptumRx continues to deny the payment, coverage or service requested after the final level of internal appeal
- OptumRx does not adhere to certain legal requirements regarding claims procedures

If your situation meets the definition of urgent under the law, your review will be rushed. Generally, an urgent situation is one in which the standard time frame for a decision:

- Could seriously jeopardize your life or health or your ability to regain maximum function, based on a prudent layperson's judgment
- In the opinion of a practitioner with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request

If you believe your situation is urgent, you may request an expedited appeal by calling OptumRx at 1-888-403-3398.

You will be notified of the result of your expedited appeal within 72 hours from the receipt of the appeal request. If you are in an urgent situation, you may be allowed to proceed with an expedited external review at the same time as the internal appeals process under your plan.

External Review Process

An external review is a complete re-examination of your case by an independent review organization (IRO).

You, your prescriber, or your authorized representative (someone you name to act for you, such as a family member, an attorney or a friend) may request an external review. OptumRx reserves the right to establish and implement reasonable procedures to determine whether an individual has been authorized to act as your representative.

To file an external review, you must send OptumRx a letter within four months of receiving the final letter of denial (or if you meet the situation above regarding an urgent appeal) and explain the reason for your disagreement with this denial decision.

You are not required to bear any costs, including filing fees, when requesting a case to be sent for external review to an IRO.

OptumRx will forward your letter and the entire case file to the IRO within five business days of receiving your information, or within two business days for an expedited external review.

Upon receiving your information, the IRO will notify you whether your request is eligible and accepted for an external review. Once you receive this letter, you have 10 business days to submit (in writing) additional information for the IRO to consider in its review.

The IRO will provide you with written notice of the final external review decision within 45 calendar days after the IRO receives the request for the external review, or within 72 hours for urgent requests. If the IRO overturns the denial, OptumRx will authorize or pay for the services in question.

To file an external appeal and provide additional information about your request, please send any written comments, documents, or other relevant documentation with your appeal to the address listed below:

OptumRx
c/o Appeals Coordinator
PO Box 25184
Santa Ana, CA 92799
Phone: 1-888-403-3398
Fax: 1-877-239-4565

You may request an expedited external review by contacting OptumRx within four months of the date of notice of denial by calling 1-888-403-3398 or by faxing 1-877-239-4565.

Chapter 23
Coverage Exclusions

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

A

- Services, expenses or supplies for **abortion** (except when necessary to prevent a serious health risk to the woman as permitted by applicable laws).

- 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 **precertified** 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 BCBS.

- Services or expenses for a **claim 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. For exceptions, see “Women’s Health and Cancer Rights Act”. 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 performed. 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 performed 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.

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.

- **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

- **Implantable devices** (and services, supplies, equipment and accessories ancillary to implantation of same), unless provided by an in-network provider or in-network third party vendor and covered by the terms of the applicable in-network contract or as otherwise required by law.

- **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 and 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

- Unless otherwise expressly covered under this Plan, 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** (rehabilitative or habilitative) for the 16th and subsequent visits that were not precertified.

- **Private duty nursing services** that have not been precertified.

R

- Services or expenses for **recreational** or educational therapy (except for diabetic self-management programs, pulmonary rehabilitation programs, or Phase 1 or 2 cardiac rehabilitation programs).

- 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 prosthetics), even if the warranty has expired.

- Services or supplies furnished by a facility that is solely classified as a **residential treatment center**. This does not exclude covered services or supplies for treatment of a eating disorder furnished by a residential treatment center or covered substance abuse services or supplies furnished by a general hospital, psychiatric specialty hospital or substance abuse facility.

- **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 childcare** and routine immunizations except for the services described in the “Routine Preventive Care” Chapter.

- **Routine physical examinations** except for the services described in “Routine Preventive Care.”

S

- Services or expenses for or related to **sex therapy** programs or treatment for **sex offenders**.

- **Services** or expenses for treatment while confined in a prison, jail or other penal institution.

- Services or expenses of any kind for, or related to, reverse **sterilizations**.

- Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease.

- Services or supplies furnished by a **substance abuse residential facility.**

- Services, **supplies**, equipment, accessories, or other items which can be purchased at retail establishments or otherwise over the counter without a doctor's prescription that are not otherwise covered services under this plan, including but not limited to:
    - Hot and cold packs
    - Standard batteries used to power medical or durable medical equipment
    - Solutions used to clean or prepare skin or minor wounds, including: alcohol solution or wipes, povidone- iodine solution or wipes, hydrogen peroxide, and adhesive remover
    - Standard dressing supplies and bandages used to protect minor wounds such as band aids, 4 x 4 gauze pads, tape, compression bandages, eye patches
    - Elimination and incontinence supplies such as urinals, diapers, and bedpans; as well as blood pressure cuffs, sphygmometers, stethoscopes and thermometers.

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 unless otherwise required by law. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.

- **Transcutaneous Electrical Nerve Stimulation (TENS)** equipment and all related supplies including TENS units, conductive garments, application of electrodes, leads, electrodes, batteries, and skin preparation solutions.

- 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, whether 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.

Chapter 24
Protecting Your Privacy

Privacy of Your Protected Health Information

The confidentiality of your protected health information (PHI) is important to the LGHIB. Under HIPAA, plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations. This Chapter explains some of HIPAA's requirements. Additional information is contained in the LGHIP's notice of privacy practices. You may also request a copy of this notice by contacting the LGHIB.

Disclosures of Protected Health Information to the Plan Sponsor

For your benefits to be properly administered, the LGHIP needs to share your PHI with the plan sponsor, the State of Alabama. The LGHIP may disclose your PHI to the plan sponsor under the following circumstances:

- 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 PHI 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.

The following restrictions apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your PHI 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 PHI under HIPAA.
- If the plan sponsor discloses any of your PHI to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your PHI as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your PHI 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 PHI that is inconsistent with the uses or disclosures allowed in this Chapter.
- The plan sponsor will allow you or the LGHIP to inspect and copy any PHI 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 PHI 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 PHI 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 PHI 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 PHI 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 PHI 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 PHI 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 PHI 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

The following restrictions 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 PHI in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic PHI 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. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law. Additionally, we may use or disclose your personal health information for treatment, payment, or healthcare operations, or as permitted or authorized by law pursuant to the privacy regulations under HIPAA.

HIPAA Exemption

As a non-federal governmental health plan, the LGHIB can elect to exempt the LGHIP from certain provisions of HIPAA. The LGHIB 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 all medical and surgical benefits covered by the plan.

The privacy provisions of HIPAA require that you be notified at least once every three years about the availability of the LGHIB'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
PO Box 304900
Montgomery, AL 36130-4900

Chapter 25
General Provisions

Delegation of Discretionary Authority to Blue Cross or OptumRx

The LGHIB has delegated to BCBS or OptumRx 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 or OptumRx make 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 or OptumRx finds out later the payments were incorrect, you or the provider will be required to repay any overpayment or BCBS or OptumRx may deduct the amount of the overpayment from any future payment to you or the provider. If BCBS or OptumRx does this, they will notify you.

Responsibility for Actions of Providers of Services

BCBS, OptumRx and the 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, OptumRx and the 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, OptumRx and the LGHIB are not required to do anything to enable providers to furnish services, supplies, or facilities to you.

Misrepresentation

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

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 or OptumRx 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 or OptumRx any such records or information it requests.

Your authorization allows BCBS or OptumRx 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 OptumRx 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 or OptumRx.
- 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 or OptumRx 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 or OptumRx requests.

Refusal by any member or provider of services to provide BCBS or OptumRx 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 or OptumRx makes in deciding claims or administering the contract, that is reasonable and not arbitrary or capricious, will be final.

Medical 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 more than 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 the provisions of the LGHIP at any time by an instrument in writing.

No representative or employee of BCBS or OptumRx 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 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

As discussed in more detail in the Claims and Appeals section, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network provider (as required by our contract with your in-network provider) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the provider. When we pay you or your provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our 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 are 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 are not 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 are not 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 **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

You may be eligible for assistance paying your employer health plan premiums. For more information on eligibility, and 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, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa | 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.gov | 1-877-267-2323, Menu Opt. 4, Ext 61565

Chapter 26
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 Chapter.

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:

- 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:
    - first, the plan of the custodial parent;
    - second, the plan covering the custodial parent's spouse;
    - third, the plan covering the non-custodial parent; and,
    - last, the plan covering the non-custodial parent's spouse.
- 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:

- first, the plan of the spouse of the court-ordered parent;
- second, the plan of the non-court-ordered parent; and,
- 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.

- 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

- The plan that covers a person as an active employee (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.
- 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.
- 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

- 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.
- 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.
- 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 is the primary plan and the plan that covered the person for the shorter period 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 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

- If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
- 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, copayments, 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 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 or OptumRx 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 or OptumRx are not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give BCBS or OptumRx any facts it needs to apply these COB rules and to determine benefits payable because 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 or OptumRx 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 or OptumRx 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 or OptumRx is more than BCBS or OptumRx should have paid under this COB provision, BCBS or OptumRx 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 not pay 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 not pay benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.

Chapter 27
Subrogation

Right of Subrogation

If BCBS or OptumRx pays or provides any benefits for you, 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 because of a claim or a lawsuit, whether by settlement or otherwise, you must repay the LGHIP. 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 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 or OptumRx 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 or OptumRx in protecting and obtaining the LGHIP's reimbursement and subrogation rights in accordance with this Chapter. **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 or OptumRx before filing any suit or settling any claim to enable the LGHIP to participate in the suit or settlement to protect and enforce the LGHIP's rights under this Chapter. If you do notify BCBS or OptumRx 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 us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), the LGHIP's reimbursement or subrogation recovery under this Chapter will not be decreased by any attorney's fee for your attorney or under the common fund theory.

You further agree not to allow the reimbursement and subrogation rights of the LGHIP under this Chapter 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.

Chapter 28
Claims and Appeals

The following explains the rules under the LGHIP for filing claims and appeals. The procedures relating to BCBS's precertification, preapproval 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 Chapters.

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 communication with BCBS by you, your provider, or anyone else about the existence or extent of coverage can be relied upon 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, BCBS 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) 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) 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 or OptumRx 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, preservice, 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. 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 website at www.AlabamaBlue.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.

For urgent preservice 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.

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 or physician), 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.

Preservice Claims

What is a Preservice Claim?

A preservice 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 preprocedure review of other medical services or supplies to obtain coverage under the plan. Preservice claims pertain only to the medical necessity of a service or supply. If BCBS grants a preservice 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.

To file a preservice 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 preservice claims in writing. Written preservice claims should be sent to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent preservice claims (for example, those relating to elective services and supplies) must be submitted to BCBS during its regular business hours. Urgent preservice claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a preservice 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 preservice claim but fail to follow BCBS's procedures for doing so, BCBS will notify you of the failure within 24 hours (for urgent preservice claims) or five days (for non-urgent preservice 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 preservice 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 Preservice 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 Preservice 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 Predeterminations: 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 predetermination. If you ask for a

courtesy predetermination, BCBS will do its best to provide you with a timely response. If BCBS decides that it cannot provide you with a courtesy predetermination (for example, BCBS cannot get the information it needs to make an informed decision), BCBS will let you know. In either case, courtesy predeterminations are not preservice claims under the plan. When BCBS processes requests for courtesy predeterminations, BCBS is not bound by the time frames and standards that apply to preservice claims. To request a courtesy predetermination, 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 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 preapproved 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 preservice 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 while 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 medical coverage or need additional information about how to file medical benefit 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 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 copayments you make, or are required to make, when you see your provider;
- The denial by BCBS of a preservice claim;
- An adverse concurrent care determination (for example, BCBS denies your request to extend previously approved services); or
- Your group's denial of your or your dependents' initial eligibility for coverage under the plan or your group's retroactive rescission of your or your dependents' coverage for fraud or intentional misrepresentation of a material fact.

In all cases other than determinations by BCBS to limit or reduce previously approved care and determinations by your group regarding initial eligibility or retroactive rescission, you have 180 days following an adverse benefit determination by BCBS within which to submit an appeal.

How to Appeal Your Group's Adverse Eligibility and Rescission Determinations: If you wish to file an appeal of your group's adverse determination relating to initial eligibility for coverage or retroactive rescission of coverage, you should check with your group regarding your group's appeal procedures.

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 www.AlabamaBlue.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 and Blue Shield of Alabama
Attention: Customer Service Appeals
PO 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 strive to resolve your questions or concerns.

How to Appeal Preservice Adverse Benefit Determinations

You may appeal an adverse benefit determination by BCBS relating to a preservice 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 (205) 220-7202.
- For care from a Participating Chiropractor call (205) 220-7202.
- For inpatient hospital care and admissions:
  Blue Cross and Blue Shield of Alabama
  Attention: Health Management – Appeals
  PO Box 2504
  Birmingham, Alabama 35201-2504

or

- For in-network physical therapy, occupational therapy, or care from an in-network chiropractor:
  Blue Cross and Blue Shield of Alabama
  Attention: Health Management – Appeals
  PO 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 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 preservice 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 preservice 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 time-period or number of treatments, (see Concurrent Care Determinations above), BCBS will decide 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 decide on your appeal within one business day or 72 hours if over a long weekend (in urgent preservice cases), 30 days (in non-urgent preservice 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 preservice 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
PO 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 Preservice Claims

If your preservice 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 preservice 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).

Chapter 29
LGHIB Appeals Process

General Information

Issues involving eligibility and enrollment should be addressed directly with the LGHIB through the appeal process outlined below. However, all issues regarding benefit determinations should be addressed through the appeal process for either BCBS or OptumRx. The following issues will not be reviewed under the LGHIB appeal process:

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

Note: Medical decisions will not be questioned.

All requests must be sent to the following address:

Local Government Health Insurance Board
Attention: Legal Department
PO Box 304900
Montgomery, Alabama 36130-4900

Informal Review

If you feel an enrollment or eligibility decision was not in conformity with LGHIB rules, policies, or procedures, you may request an informal review. In many cases, the issue can be resolved over the phone without the need for an administrative review or formal appeal. A request for an informal review must be received by the LGHIB within 60 days from the date of an adverse decision by the LGHIB. Untimely requests will be denied.

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 received by the LGHIB within 60 days from the date of the informal review decision. Untimely requests will be denied. If the LGHIB determines that an administrative review is appropriate, you will be sent an LGHIB administrative review form to complete and return. A copy of the initial adverse determination and informal review decision must be submitted with the administrative review form. The appropriate Board committee will review the request, usually within 60 days. Oral arguments will not be considered unless approved by the LGHIB. The committee will issue a decision in writing to all parties involved in the review.

Formal Appeal

If you do not agree with the administrative review decision, you may file a request for a formal appeal before the Board. Requests for a formal appeal must be received by the LGHIB within 60 days following the date of the committee's decision. Untimely requests will be denied. Oral arguments will not be considered unless approved by the LGHIB. If your request for a formal appeal is granted, generally, a decision will be issued within 90 days following approval of the request for a formal appeal. The number of days may be extended by notice from the LGHIB. If you have not received a decision or notice of extension within 90 days, you may consider your appeal denied. The Board's decision is the final step in the LGHIB appeal process and will exhaust all administrative remedies.

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

Chapter 30
Definitions

ABA Therapy: ABA therapy is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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 copayments, 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 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,” section, for a description of the contracting arrangements that exist outside the state of Alabama.

Out-of-Network Providers: In accordance with Blue Cross and Blue Shield of Alabama’s applicable provider payment policies in effect at the time the service is rendered, the allowed amount for care rendered by out-of-network providers may be based on the negotiated rate payable to in-network providers for the care in the area, may be based on the average charge for the care in the area, or may be based on a percentage of what Medicare would typically pay for the care in the area (or, if no Medicare rates are available, an approximation of what Medicare would pay for care using various sources), or in accordance with applicable Federal law. In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;
- 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 certain out-of-network providers, the provider may bill the member for charges more than the allowed amount. The allowed amount will not exceed the amount of the provider's charge.

For out-of-network emergency services for medical emergencies or for air ambulance services, the allowed amount will be determined in accordance with the requirements of the applicable Federal law.

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. 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 and 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 and Blue Shield of Alabama: The company chosen by the LGHIB, through competitive bid, to process medical 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.

COBRA: See the explanation in the "Continuation of Group Coverage" Chapter.

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" Chapter.

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: Refer to the “Eligibility” Chapter.

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 member begins as listed in the LGHIB records.

Elected Official: any person elected to public office by the vote of the people at the state, county, or municipal level of government. An elected official may also be an individual appointed to an elected public office to fill an unexpired term of a vacant elected public office.

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” Chapter.

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.

Habilitative Services: Healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living.

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 precertification 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 Infusion Service Provider: A home infusion service provider is a state-licensed pharmacy that specializes in provision of infusion therapies to patients in their home or other alternate sites associated with the home infusion provider such as a home infusion suite.

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 Chapter.

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 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 to determine 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 Local Government Health Insurance Plan. 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.

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

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 makes available to the medical community and 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.

Medicare Advantage: A Medicare approved PPO plan administered by UnitedHealthcare.

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 officials 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 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 an OptumRx 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.

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

OptumRx: The company chosen by the LGHIB, through competitive bid, to process pharmacy benefit claims filed by members.

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 BCBS has a contract for furnishing health care services.

Participating Pharmacy: Any pharmacy with which OptumRx 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.

Pharmacy Benefit Manager: The company chosen by the LGHIB, through competitive bid, to process pharmacy benefit claims filed by members. The Pharmacy Benefits Manager is OptumRx.

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.

Precertification (Preauthorization): The procedures used to determine the medical necessity of the treatment prior to the service.

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.

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.

Rehabilitative Services: Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

Residential Treatment: Continuous 24 hour per day care provided at a live-in facility for mental health or substance abuse disorders.

Residential Treatment for treating of eating disorders: 24-hour level of care that is medically monitored, with 24-hourmedical and nursing services and typically provides less intensive medical monitoring than inpatient care.

Retired Employee: See explanation in the “Eligibility” Chapter.

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

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.

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.

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 provides outpatient substance abuse services.

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.

Unit: Pursuant to Section 11-91A-2 Code of Alabama, 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, the Alabama Network of Children's Advocacy Centers and its member Children's Advocacy Centers, the Care Assurance System for the Aging and Homebound and its affiliated local centers, 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.

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, OptumRx, 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
PO Box 304900
Montgomery, Alabama 36130-4900

Phone: (334) 263-8326
Toll-Free: 1-866-836-9137
Website: **www.lghip.org**

Medical 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: 1-800-222-4379
Case Management: 1-800-551-2294
Disease Management: 1-888-841-5741
Medical/Surgical Precertification: 1-800-248-2342
Website: **www.AlabamaBlue.com**

Pharmacy Benefit Manager:
OptumRx Claims Department
PO Box 650334
Dallas, TX 75265-0334
OptumRx Customer Service: 1-844-785-1603
Website: **www.OptumRx.com**

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