Public Education Employees’ Health Insurance Plan

PEEEHIP

Member Handbook

2015-2016

with Open Enrollment information
Contact PEEHIP
(Public Education Employees’ Health Insurance Plan)

Phone     877.517.0020 • 334.517.7000
Fax        877.517.0021 • 334.517.7001
Email      peehipinfo@rsa-al.gov

Because email submissions are unsecured, do not include confidential information like your Social Security number. Please include your full name, employer, home mailing address, and daytime phone number.

Mail       Public Education Employees’ Health Insurance Plan
           P.O. Box 302150
           Montgomery, AL  36130-2150

Website    www.rsa-al.gov

Member Online Services (MOS)

Enroll in PEEHIP coverage online
   https://mso.rsa-al.gov

Building Location

           201 South Union Street
           Montgomery, Alabama

Flexible Spending Accounts

           877.517.0020 • 334.517.7000

Business Hours

           8:00 a.m. - 5:00 p.m.
           Monday - Friday
Plan Administrator Contact Information

Wellness Programs
ActiveHealth - vendor for Health Questionnaires, Wellness Coaching, and Disease Management
855.294.6580
www.MyActiveHealth.com/PEEHIP

Alabama Department of Public Health (ADPH) - vendor for Wellness Screenings and Flu Shots
334.206.5300 or 800.252.1818
www.adph.org/worksitewellness

Tobacco Cessation Quitline
800.QUIT.NOW or 800.784.8669
www.quitnowalabama.com

ALL Kids - administered by ADPH
888.373.5437
www.adph.org/allkids

Blue Cross Blue Shield of Alabama - Administrator of Hospital/Medical, Flexible Spending Accts., & Supplemental Plan
450 Riverchase Parkway East
P.O. Box 995
Birmingham, AL 35298
Customer Service 800.327.3994
Flexible Spending Accounts 800.213.7930
Rapid Response 800.248.5123 - to order ID cards, claim forms, and directories
Baby Yourself 800.222.4379 - Prenatal Wellness Program

MedImpact - Administrator of Core Pharmacy, Specialty Pharmacy, and EGWP Pharmacy Programs
10680 Treena Street
San Diego, CA 92131
Customer Service 877.606.0727 - available 24 hours/day
Pharmacy Help Desk 800.788.2949 - available 24 hours/day
Step Therapy Prior Authorization 800.347.5841 - For Physician Use  Fax - 877.606.0728

Medicare GenerationRx
Customer Service 877.633.7943 - available 24 hours/day
Pharmacy & Provider Help Desk 888.678.7789

VIVA Health Plan
417 20th Street North, Suite 1100
Birmingham, AL 35203
Customer Service 205.558.7474 or 800.294.7780

Southland Benefit Solutions - Administrator of Cancer, Dental, Indemnity, & Vision Optional Plans
2200 Jack Warner Pkwy, Suite 150
P.O. Box 1250
Tuscaloosa, AL 35401
Customer Service 800.476.0677

Common PEEHIP Acronyms

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<th>PEEHIP</th>
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<th>HIPAA</th>
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<td>BCBS</td>
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<td>Preferred Medical Doctor</td>
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<td>Member Online Services</td>
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The Retirement Systems of Alabama (RSA) is pleased to provide you with the 2015-2016 Public Education Employees’ Health Insurance Plan (PEEHIP) Member Handbook with Open Enrollment Information. This handbook is an important part of our commitment to provide our members with valuable information about their health care benefits and Open Enrollment. Please read this handbook thoroughly and keep it with your other benefit materials. Your member handbook is a very useful tool when you have questions about your PEEHIP benefits. It will help you make informed decisions about your future.

Summary of Benefits and Coverage
Availability of Summary Health Information

The Patient Protection and Affordable Care Act (PPACA) of 2010 created a new federal requirement for group health plans to provide the Summary of Benefits and Coverage (SBC) document to health plan members. Health benefits represent a significant component of your compensation package. The benefits also provide important protection for you and your family in the case of illness or injury.

PEEHIP offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, PEEHIP makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about health coverage options in a standard format, to help you compare across coverage options available to you in both the individual and group health insurance coverage markets. The SBC is available at www.rsa-al.gov/index.php/members/peehip/benefits-policies/. A paper copy is also available, free of charge, by calling Member Services toll-free at 877.517.0020.

Note: The SBC is meant as a summary only and the coverage examples in the SBC on pages 2 and 7 are for illustration purposes only and may not be representative of the actual charges for copayments or out-of-pocket expenses for the PEEHIP plan. For more detailed benefit information, see the PEEHIP Summary Plan Description (SPD) at www.rsa-al.gov/index.php/members/peehip/pubs-forms/.

The information in this handbook is based on the Code of Alabama, 1975, Title 16, Chapter 25A. This handbook is not intended as a substitute for the laws of Alabama governing PEEHIP nor will its interpretation prevail should a conflict arise between its contents and Chapter 25A. Furthermore, the laws summarized here are subject to change by the Alabama Legislature. Do not rely solely upon the information provided in this handbook to make any decision regarding your health care benefits, but contact PEEHIP with any questions you may have about your health care benefits.
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Insurance Eligibility

Guidelines for Insurance Eligibility

Full-time employees and permanent part-time employees are eligible for PEEHIP coverage.

Full-Time Employees
A full-time employee is any person employed on a full-time basis in any public institution of education within the state of Alabama as defined by Section 16-25A-1, Code of Alabama, 1975. These institutions must provide instruction for any combination of grades K through 14 exclusively, under the auspices of the State Board of Education or the Alabama Institute for Deaf and Blind.

A full-time employee also includes any person who is not included in the definition of employee in Section 16-25A-1, but who is employed on a full-time basis by any board, agency, organization, or association which participates in the Teacher’s Retirement System of Alabama and has by resolution pursuant to Section 16-25A-11 elected to have its employees participate in PEEHIP.

Permanent Part-Time Employees
A part-time employee is any person employed on a permanent, part-time basis in any public institution of education within the state of Alabama as defined by Section 16-25A-1, Code of Alabama, 1975. These institutions must provide instruction for any combination of grades K through 14 exclusively, under the auspices of the State Board of Education or the Alabama Institute for Deaf and Blind.

A part-time employee also includes any person who is not included in the definition of employee in Section 16-25A-1, but who is employed on a permanent, part-time basis by any board, agency, organization, or association which participates in the Teacher’s Retirement System of Alabama and has by resolution pursuant to Section 16-25A-11 elected to have its employees participate in PEEHIP.

A permanent part-time employee is eligible for PEEHIP if he or she agrees to payroll deduction for a pro rata portion of the premium cost for a full-time employee. The portion is based on the percentage of time the permanent part-time worker is employed. An eligible permanent part-time employee is not a substitute or a transient employee.

Ineligible Employees
These employees are not eligible to participate in PEEHIP.

♦ A seasonal, transient, intermittent, substitute, or adjunct employee who is hired on an occasional or as needed basis.
♦ An adjunct instructor who is hired on a quarter-to-quarter or semester-to-semester basis and/or only teaches when a given class is in demand.
♦ Board attorneys and local school board members if they are not permanent employees of the institution.
♦ Contracted employees who may be on the payroll but are not actively employed by the school system.
♦ Extended day workers hired on an hourly or as needed basis.

Family Coverage Eligibility

Eligible Dependents
Eligible employees may enroll their eligible dependents in PEEHIP coverage. An eligible dependent is defined as the following.

Spouse
The employee’s spouse as defined by Alabama law to whom you are currently and legally married. PEEHIP requires a copy of a marriage certificate to verify eligibility and one additional current document to show proof of current marital status. See page 15 for required documentation. Excludes a divorced spouse.

Children
PEECHIP offers dependent coverage to children up to age 26. Appropriate documentation will be required by PEEHIP before dependents can be enrolled. See page 15 for required documentation. PEEHIP is not required and will not provide coverage for a child of a child receiving dependent coverage. Also, maternity benefits and delivery charges are not covered for children of any age regardless of marital status.
In accordance with the federal Health Care Reform Legislation, the following children are eligible for PEEHIP coverage:

1. A married or unmarried child under the age of 26 if the child is your biological child, legally adopted child, stepchild or foster child without conditions of residency, student status, or dependency. A foster child is a child who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

2. The eligibility requirements for any other children such as grandchildren, for example, must meet the same requirements as foster children and must be placed with you by decree or other order of any court of competent jurisdiction, for example, legal custody or legal guardianship.

3. An unmarried incapacitated child 26 years of age or older who:
   ♦ is permanently incapable of self-sustaining employment because of a physical or mental handicap,
   ♦ is chiefly dependent on the member for support, and
   ♦ was disabled prior to the time the child attained age 26, and the child had to be covered as a dependent on the member’s PEEHIP policy before reaching the limiting age of 26.

Two Exceptions:
   ◊ New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment.
   ◊ Existing member requests coverage of the incapacitated child over the age of 26 within 45 days of the qualifying life event of loss of other hospital medical group coverage.
   ◊ The employee must contact PEEHIP and request an Incapacitated Dependent form. Proof of the child’s condition and dependence must be submitted to PEEHIP within 45 days after the date the child would otherwise cease to be covered because of age. PEEHIP may require proof of the continuation of such condition and dependence.

If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once he or she reaches the limiting age of 26 as an incapacitated child. For example, approved permanently incapacitated children can continue on any PEEHIP plans they are on at the time they age out, but they are not eligible to be covered on other PEEHIP plans once they reach the limiting age of 26. If the child is approved as an incapacitated child and allowed to stay on the PEEHIP Hospital Medical Plan, the child cannot change plans and be covered on other PEEHIP plans, such as VIVA or the Optional Plans if he or she has already reached the limiting age of 26.

Ineligible Dependents
   ♦ An ex-spouse regardless of what the divorce decree may state
   ♦ Ex-stepchildren regardless of what the divorce decree may state
   ♦ Children age 26 and older
   ♦ Disabled children over age 26 who were never enrolled or were deleted from coverage
   ♦ A child of a dependent child cannot both be covered on the same policy
   ♦ A daughter-in-law or son-in-law
   ♦ Grandchildren or other children related to the member by blood or marriage for which the member does not have legal guardianship or legal custody; children not related to the member by blood or marriage for which the member does not have legal guardianship or legal custody who are not foster children or adopted children and temporarily disabled dependent children who have aged out
   ♦ Grandparents
   ♦ Parents
   ♦ A fiancé or live-in girlfriend or boyfriend

Ex-Spouse and Ex-Stepchildren Must be Removed from Coverage
Ex-spouses and ex-stepchildren are not eligible dependents even if a member continues to pay for family coverage and regardless of what the divorce decree states. The ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of divorce. The member will be responsible for an ex-spouse’s and ex-stepchildren’s claims when they are not removed from coverage. An ex-spouse and ex-stepchildren are eligible for COBRA if the request to enroll in COBRA is made within 60 days of the cancellation of coverage (See pages 46-48).

To remove the ex-spouse from coverage effective the 1st day of the month following the divorce:
   ♦ Click the “View/Change Contact Information” link once you have logged in to Member Online Services (MOS). Select the “Update My Marital Status” option, select “Divorce” from the drop down box, and provide the date the divorce was final. This is generally the date the judge signed the Final Order of the Divorce Decree. Be sure to get a Confirmation page to ensure this change was saved and submitted to PEEHIP. This will remove the ex-spouse from your coverage.
   ♦ If you do not have access to the Internet, you must timely notify PEEHIP of your divorce by completing and submitting to PEEHIP a New Enrollment and Status Change form and a copy of your divorce decree.
Benefit and Premium Changes
Effective October 1, 2015

Medical Plan Changes
♦ Specialist office visit copay increases from $30 to $35. (This does not apply to Family/General Practice, Internal Medicine, Gynecology, Obstetrics, Pediatrics, Certified Nurse Practitioner, Physician Assistant, Clinic and Midwives.)
♦ Removal of 4th quarter major medical carryover deductible. Effective 1/1/16, major medical claims in the 4th quarter of the calendar year will no longer be carried over and counted towards the deductible of the following year.
♦ Removal of the accident rider. The accident rider previously allowed first dollar coverage for accidents up to $500. Members were not required to pay the Emergency Room (ER) copay of $150 in the event of an accident. Removing this rider treats accidents like any other illness and all applicable copays will apply.

Premium Rate Changes
These rate changes apply to active and retired members, members who are on leave of absence, COBRA and surviving spouse accounts.
♦ Increase tobacco premium from $28 to $50 for the member and an additional $50 for the spouse per month if both are tobacco users.
♦ Increase family dental premium from $45 to $50 per month. (Note: The single dental rate remains $38. The other optional plans remain $38 per month.)
♦ Spousal Surcharge: Add a monthly spousal surcharge of $75 for spouses on active contracts and non-Medicare-eligible spouses on retired contracts, and $25 surcharge for Medicare primary spouses on retired contracts. The spousal surcharge will be phased in over 3 years. Note: The spousal surcharge will not apply to spouses who are independently eligible for PEEHIP. See 3-year phase-in details below.

3-Year Phase-In Schedule

| Spouses on active contracts and non-Medicare-eligible spouses on retired contracts |
|---------------------------------|-----------------|
| Year 1: $25                     | Effective 10/1/2015 |
| Year 2: $50                     | Effective 10/1/2016 |
| Year 3: $75                     | Effective 10/1/2017 |

| Medicare primary spouses on retired contracts |
|---------------------------------|-----------------|
| Year 1: $10                     | Effective 10/1/2015 |
| Year 2: $20                     | Effective 10/1/2016 |
| Year 3: $25                     | Effective 10/1/2017 |

Pharmacy Plan Changes
♦ Various changes to the commercial plan formulary were made, including Step Therapy, Prior Authorization, Quantity Limits, and the exclusion of some drugs to drive utilization to lower cost alternative drugs. (Note: This does not change the normal current three-tier drug copayments of $6 for generics, $40 for preferred brands, and $60 for non-preferred brands.)
♦ Flu Vaccine to be allowed at most participating retail pharmacies at no cost beginning August 1, 2015.

VIVA Health Plan Benefit Changes
♦ Increase drug copay to $60 for preferred brand and $80 for non-preferred
♦ Change in coverage for biological drugs, biotechnical drugs and specialty drugs to 70%
♦ Change in coverage to 90% for services performed in an outpatient hospital setting; $150 copay remains for outpatient services performed at an ambulatory surgical center
♦ Increase in copay per lab test at independent labs to $7.50 and 90% coverage per test at hospital-based labs
♦ Increase in inpatient copay to $50 copay for days 2-5
♦ Increase in Emergency Room copay to $200 copay per visit
♦ Change diagnostic services (e.g., CT scans, X-rays, etc.) from $150 copay per service to 90% coverage
♦ Change in coverage for genetic testing, dialysis, and allergy testing and treatment to 80%
♦ Combine medical and prescription out-of-pocket maximums (currently separate). Set the combined member out-of-pocket maximum to $6,600, and $13,200 per family per calendar year.
PEEHIP Supplemental Medical Plan Changes
The following additions and revisions were made to the current exclusion language for the Supplemental Medical Plan.
♦ Members enrolled in the VIVA Health Plan offered through PEEHIP cannot also be enrolled in the PEEHIP Supplemental Medical Plan.
♦ Members are not eligible for the PEEHIP Supplemental Medical Plan if they have a primary plan with a deductible greater than $1,450 for individual or $2,700 for family. (Was $1,250 for individual and $2,500 for family)
♦ Annual maximum amount paid for the Supplemental Medical Plan will be indexed to match the PEEHIP Hospital Medical overall maximum out-of-pocket (MOOP). Currently the MOOP is $6,600 per individual, $13,200 per family per calendar year.

Flexible Spending Account Changes
♦ Effective October 1, 2015, the Flex Debit card will no longer be available as a reimbursement method option under the PEEHIP Health Flexible Spending Account. Note: Members will continue to have the automatic bump and the manual reimbursement method options.
♦ The new maximum annual Health Care Flexible Spending Account contribution is $2,550.
Open Enrollment
(Active and Retired Members)

Open Enrollment is your once-a-year opportunity to enroll in or change plans, and add or drop eligible dependents from coverage. Each June, all PEEHIP eligible active and retired members are sent a one-page Open Enrollment notice to their home address. The notice provides information about the Open Enrollment deadlines, how to enroll or make changes online through MOS, and identifies the coverage(s) in which the member is currently enrolled, including the current tobacco status on file with PEEHIP.

The Open Enrollment web page www.rsa-al.gov/index.php/members/peehip/open-enrollment/ is available July 1 every year and provides information about open enrollment deadlines, the PEEHIP Member Handbook, and other important information.

Open Enrollment begins July 1 and ends by the following deadlines:

♦ The deadline for submitting online Open Enrollment changes is midnight of September 10. After September 10, online Open Enrollment changes will not be accepted and the Open Enrollment link will be closed.
♦ The deadline for submitting paper Open Enrollment forms is August 31 or the last business day of the month. Any paper forms or faxes postmarked after August 31 will not be accepted.
♦ The deadline for enrollment or re-enrolling in a Flexible Spending Account online or on paper is September 30.

Open Enrollment changes cannot be submitted after these deadlines.

Other Open Enrollment information:

♦ Members do not need to re-enroll in coverage if they want to continue their current coverage. Their current coverage will remain in effect and premium deductions will continue if they do not add/change/cancel coverage during Open Enrollment.
♦ Flexible Spending Accounts require a new enrollment each year. The preferred method to enroll is online through MOS at https://mos.rsa-al.gov.
♦ The Federal Poverty Level discount program requires a new application each year. The member must submit a paper application to PEEHIP to apply for this discount.
♦ Members enrolling in new insurance plans should receive their new ID cards from the insurance carrier(s) no later than the last week in September.
♦ Payroll deductions for the changes made during Open Enrollment will be reflected in the September paycheck. All members covered by PEEHIP insurance should review their paycheck stub each month to ensure the proper amount has been deducted for their PEEHIP premiums.
♦ Members enrolling in the Flexible Spending Account(s) will have their first contribution withheld from their October paycheck.

Transfers
Employees who transfer from one system to another system are considered current employees and are not considered new employees for insurance enrollment purposes. Transfers must keep existing PEEHIP coverage and cannot make insurance changes until the Open Enrollment period for an October 1 effective date.

Rehired Employee and 3-1 Rule
If an employee is terminated at the end of the school year and transfers to another system or is rehired by the same system for the next school year, or a retiree suspends his or her retirement and comes back to work, the employee is not considered a “new employee” for insurance purposes and the employee cannot make insurance changes until the Open Enrollment period. See page 17 for more information about the 3-1 Rule.

Part-Time to Full-Time Employment
Employees who are employed less than full-time and are enrolled in only Optional Plans cannot add the Hospital Medical Plan outside of the Open Enrollment period if they become full-time. However, members can add the other Optional Plans when they become full-time.
**Full-Time to Part-Time Employment**
A member is not eligible to drop the Hospital Medical Plan outside of the Open Enrollment period when they change from full-time to part-time status.

**Pre-Existing Conditions**
Pursuant to the federal healthcare reform laws, all members and dependents added to coverage no longer have waiting periods applied on pre-existing conditions.
HIPAA Special Enrollment Outside of Open Enrollment

(Active and Retired Members)

HIPAA requires group health plans to provide special enrollment periods during which certain individuals who previously declined health coverage are allowed to enroll. A special enrollee is not treated as a late enrollee.

Examples of situations that qualify for special enrollment are:

- Person becomes a dependent through marriage
- Birth of a dependent child
- Adoption, placement of adoption, or legal custody of a child under the age of 18
- Loss of coverage due to divorce
- An individual with other insurance coverage loses that coverage
- Loss of coverage due to layoffs, employment strike, involuntary termination, voluntary resignation or voluntary change in employment
- Loss of coverage because dependent is fired
- Company discontinues insurance coverage completely, company changes insurance carriers and no longer offers previous carrier (not just a change in benefits and premiums). This does not apply to a self-insured plan that is only changing insurance administrators.
- Exhaustion of COBRA coverage

These individuals are not required to wait until the Open Enrollment period to enroll in the Hospital Medical Plan but must submit the request for special enrollment within 45 days of each scenario. This special enrollment period is available to employees and their dependents who meet certain requirements:

- The employee or dependent must otherwise be eligible for coverage under the terms of their plan.
- When the PEEHIP coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage.
- If the other coverage is COBRA, the special enrollment can only be requested after exhausting COBRA even if the employer pays the COBRA premiums for any length of time.
- If the other coverage is not COBRA, special enrollment can only be requested after losing eligibility for the other coverage or after cessation of employer contributions for the other coverage.

An individual does not have a special enrollment right if the individual loses the other coverage in certain situations.

Examples of coverage loss situations that do not qualify for special enrollment:

- As a result of the individual’s failure to pay premiums
- For cause – such as making a fraudulent claim
- If other coverage has an increase in premiums or a change in benefits
- If other coverage is changed to a Marketplace Exchange plan and employer continues to subsidize the premium
- Voluntarily removing an eligible dependent from another plan

These examples do not qualify as a loss of coverage under the HIPAA Federal guidelines.

Enrolling Due to a Loss of Coverage

When enrolling in a Hospital Medical plan due to a loss of coverage, the member must submit to PEEHIP a New Enrollment and Status Change form AND a letter on company letterhead from the employer through which coverage was lost indicating the reason for the loss of coverage, the employment and termination dates, and the date coverage ended. Enrollment due to loss of coverage may not be done online through MOS.

When the loss of coverage is due to divorce, the member requesting coverage must submit to PEEHIP a New Enrollment and Status Change form AND provide a copy of the divorce decree signed by a judge of a court of competent jurisdiction.

If PEEHIP is not notified within 45 days of the date of the loss of coverage, the member is required to wait and enroll during the Open Enrollment period (July 1 – August 31) with a coverage effective date of October 1. Members must wait until Open Enrollment to enroll in the Optional Plans. The member cannot enroll in dental or vision outside of Open Enrollment even if it was part of the plan in which they lost coverage. A member is eligible to drop any of the Optional Plans when enrolling in a Hospital Medical plan due to a loss of other coverage if he/she had the Optional Plans for at least one year.
HIPAA Special Enrollment Outside of Open Enrollment

Cancelling or Changing Coverage Due to a Qualifying Life Event (QLE)

All active members pay their premiums using pre-tax dollars. Therefore, active members must have an IRS Qualifying Life Event (QLE) before they can be allowed to cancel their Hospital Medical plan, change the status of their coverage, or drop/add dependents outside of the Open Enrollment period.

**QLE change requests must be submitted to PEEHIP within 45 days after the date of the QLE**

Members may submit requests **online through MOS** to change coverage for the following QLE’s:

- Adoption of a child
- Birth of a child
- Legal custody of a child
- Marriage of the subscriber

Requests for change for QLE’s that **cannot be submitted online through MOS** are the following. A **New Enrollment and Status Change** form must be submitted to PEEHIP within 45 days of the QLE.

- Death of a spouse or dependent
- Divorce or annulment
- Marriage of dependent child
- Spouse/dependent loss of coverage
- Commencement of spouse/dependent employment
- Termination of spouse employment and loss of insurance coverage
- Medicaid and Medicare entitlement
- FMLA/LOA

**If a newborn is not added within 45 days of the date of birth for coverage to be effective the date of birth, claims incurred at the time of birth will not be paid.**

Appropriate documentation must be received and approved before the change can be made.

If all dependents on the policy are ineligible, the coverage will automatically change to an individual plan effective the first of the month following the cancellation of the last remaining dependent. Policies are only cancelled effective on the first day of the month and cannot be cancelled in the middle of the month.

**Changing Single to Family Coverage**

Members enrolled in single Hospital Medical coverage who marry can request to change coverage to family adding their newly acquired dependents within 45 days of the date of marriage. Members can add all eligible dependents when changing to family coverage. Enroll online through MOS at [https://mos.rsa-al.gov](https://mos.rsa-al.gov) and mail a copy of the marriage certificate (and birth certificates, if applicable) to PEEHIP. The effective date of coverage can be the date of marriage or the first of the following month. A member who is only enrolled in the Optional Plans cannot enroll in the Hospital Medical plan due to a QLE. **Members will be required to make payment for the additional family premium at the time of enrollment.** Prior notification is not required. However, if coverage is not added within 45 days of the date of marriage, the member must wait until the following Open Enrollment period.

**Adding Dependents to Family Coverage**

Members can add a new dependent(s) to existing family coverage through MOS at [https://mso.rsa-al.gov](https://mso.rsa-al.gov) within 45 days of acquiring the dependent(s) and mail a copy of the marriage certificate and/or birth certificate to PEEHIP. Prior notification is not required. However, if coverage is not added within 45 days of the date the dependents are acquired, the member must wait until the following Open Enrollment period.
New Employee Enrollment

New employees must enroll online through Member Online Services (MOS) within 30 days of their hire date. (See pages 13-14 for more information regarding MOS.) The effective date of coverage can either be their date of hire or the first of the month following their date of hire. They can choose to enroll in coverage during the Open Enrollment period July 1 – August 31 for coverage to be effective October 1.

If online enrollment is not completed within 30 days:
♦ The “New Employee” enrollment link within MOS will be removed on the 31st day after the date of employment.
♦ The new employee will only be permitted to enroll in single Hospital Medical coverage. The employee will be required to submit a New Employee and Status Change form to PEEHIP, and the effective date will be the date the form is received by PEEHIP. The employee must wait until Open Enrollment to enroll in family Hospital Medical coverage and/or enroll in the Optional Coverage plans.

Premium payments:
♦ Premiums are payroll deducted at the end of each month to pay for the following month of coverage.
  ◊ New employees do not have a paycheck from which to deduct their initial premium and the initial premium payment is due at the time of enrollment. Therefore, the initial payment should be paid through MOS using a credit card, debit card, or e-check.
♦ Payment can also be made to PEEHIP by mailing a check or money order payable to PEEHIP.
♦ Your account will be placed on claim hold until PEEHIP receives the initial premium.

Optional Plan Coverage
New employees employed during the Open Enrollment period cannot enroll in the Optional Plans effective the date of hire or the first month after the hire date and cancel the plans October 1 of that same year. The coverage must be retained for at least one year or until the next Open Enrollment period.

Family Coverage
New employees can add family coverage to be effective on their date of hire, the first of the month following their date of hire, or effective 60 days from their date of hire. To have the family coverage effective 60 days from the date of hire, the enrollment request must be made within 30 days of the date of hire.

See pages 13-14 for more information regarding Enrollment Procedures.
Enrollment Procedures

Member Online Services (MOS)

General Information

Enrollments are handled by PEEHIP through Member Online Services (MOS) located on the RSA website https://mso.rsa-al.gov, not by the employer. The “MOS Login” link is at the top of every web page on the RSA website www.rsa-al.gov.

Using the RSA’s MOS eliminates the need for paper forms, envelopes, stamps or last minute runs to the post office. RSA and PEEHIP continually strive to improve the services we provide to its members. MOS benefits everyone providing greater efficiency and effectiveness as well as savings in time and money!

MOS Services Include

New Employee Enrollment
- Enroll in coverage online within 30 days of hire date (for an effective date of either the date of hire or the first day of the month following the date of hire).
- New employees are required to enroll online and pay their initial premiums at the time of enrollment. Subsequent premiums will be payroll deducted.

Year Round Updates
- View Current Coverage
- View and/or Update Contact Information (address, phone number, email and marital status)
- View Confirmation Page History and Other Important Documents from PEEHIP
- Update Marital Status
- Update Member and/or Spouse Tobacco Status
- Add or Update Other (non-PEEHIP) Insurance Coverage Information
- Update Retiree Employment Information (only members who retired on or after October 1, 2005)

Open Enrollment Options (July 1 - September 10)
- Enroll, Change or Cancel your Hospital Medical Plan or your Optional Coverage Plans (Cancer, Dental, Indemnity and Vision)
- Add or Update Other (non-PEEHIP) Health Insurance Coverage Information (COB)
- Enroll or Re-enroll in Flexible Spending Accounts (not available to retirees)
- Add or Update Retiree Employment Information
- Update Member and/or Spouse’s Tobacco Usage Status
- Add Dependent(s) to Coverage such as a child or spouse
- Cancel Dependent(s) from Coverage

Qualifying Life Event (QLE) Special Enrollment
Coverage for new dependents can be added for the following Qualifying Life Events (QLE) for an effective date of the date of the event or the 1st of the month following the date of the event:
- Adoption of a Child or Placement of Adoption for a Child
- Birth of a Child
- Legal Custody of a Child
- Marriage of a Subscriber

Changes must be submitted within 45 days of the QLE.

If a member does not have access to a computer or the Internet, enrollments and/or changes can be made by submitting a New Enrollment and Status Change form to PEEHIP. The form is on page 69 or can be obtained upon request by calling Member Services at 877.517.0020.
Information Needed to Enroll Online
1. Your Personal Identification (PID) Number
   If you do not know your PID number, you can request a PID letter online. 
   **You will need your PID to create a User ID and Password.**
2. Last 5 digits of your Social Security number
3. Email address
4. Social Security numbers and dates of birth for dependents
5. Additional health insurance information under which you and your dependents are covered
6. Credit, debit card, or e-check to make first premium payment.

Register and Enroll Using MOS
1. Go to [www.rsa-al.gov](http://www.rsa-al.gov) and click “MOS Login” located at the top of the web page.
2. Enter the User ID and Password that you created.
   a. If this is the first time you have used MOS, you will need to “Register”.
   b. If you have used MOS but do not recall your User ID and/or Password, you will need to “Reset Account”.
3. You will need your Personal Identification Number (PID) number.
   a. If you are a new member and do not have your PID, you can request a PID letter when registering online.
   b. If you are adding or changing coverage and already have a PID and do not recall what it is, remember that it is the 8-digit number on your insurance card following EDUO.
4. Click “Enroll or Change PEEHIP Coverages” from the PEEHIP menu found on the left of your screen.
5. Select “New Enrollment” (available for new employees for 30 days from their hire date), or “Open Enrollment” (available during the Open Enrollment period, or “Qualifying Life Event” (to add a newly acquired dependent within 45 days of the QLE).
6. Click “Continue” and follow the on screen prompts until you receive a Confirmation page.

You Must Receive a Confirmation Page
If you do not receive a Confirmation page, enrollment and/or change requests have not been successfully submitted.

Your confirmation history may also be obtained in MOS through the “My Documents” link.

The Open Enrollment link to enroll online is available beginning July 1 and remains available through the entire online Open Enrollment period ending September 10.
Enrollment Documentation Required

General Information
Every member who enrolls dependent(s) in his or her PEEHIP coverage(s) is required to certify dependent eligibility to PEEHIP. Certification requires submission of appropriate documents to verify dependent eligibility. **Black out Social Security numbers, account numbers, income, or statement balances prior to sending your documents to PEEHIP.** Under no circumstances does PEEHIP solicit this type of information from members.

Documents must be mailed, emailed, or faxed to PEEHIP. See “Contact PEEHIP” information at the front of this guide. Enrollments cannot be processed without the appropriate documentation. PEEHIP is not bound by court order to insure dependents who do not meet PEEHIP guidelines.

**Note:** To insure that enrollment deadlines are met, you should submit your enrollment even if all documents are not available to you at the time of enrollment.

Spouse
A spouse is defined by Alabama law as a person to whom you are currently and legally married. Ex-spouses are not eligible dependents even if a member continues to pay for family coverage. The ex-spouse must be deleted from coverage effective the first day of the month following the date of divorce. Eligibility documents required for spouses are:
- Marriage certificate
- AND one of the following documents to show marriage is still current:
  - Page 1 and signature page (if manually completed) of member’s most current Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the spouse
  - Page 1 and Certificate of Electronic Filing or transmission page (if electronically completed or completed by a tax professional) of member’s most current Federal Income Tax Return (1040, 1040A, 1040EZ) **as filed with the IRS** listing the spouse
  - Transcript of member’s most current Federal Income Tax Return (1040, 1040A, or 1040EZ) listing the spouse
  - Current mortgage statement, home equity loan, or lease agreement listing both member and spouse
  - Current Property Tax documents listing both member and spouse
  - Automobile registration that is currently in effect listing both member and spouse
  - Current utility bill listing both member and spouse
  - Current utility bill listing spouse at the same address as the member

**Note:** “Current” is defined as **within the last six months, and supporting documents must be dated within the last six months to qualify as appropriate documentation.**

Separated Spouse
A separated spouse is defined as a legally separated spouse. Required document for separated spouse is:
- Notice of Legal Separation (court documents signed by a judge)

Biological Child
A biological child is defined as a member’s biological child who is under age 26. Required document for a biological child is:
- Birth certificate (issued by a state, county or vital records office)

Foster Child
A foster child is defined as a child who is placed with a member by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Required documents for foster children are:
- Placement Authorization signed by a judge **OR**
- Final Court Order with presiding judge’s signature and seal

Adopted Child
An adopted child is defined as a member’s legally adopted child under age 26. Required documents for adopted children are:
- Certificate of Adoption or
- Papers from the adoption agency showing intent to adopt or
- Court documents signed by a judge showing the member has adopted the child or
- International adoption papers from country of adoption or
- Birth Certificate (issued by a state, county, or vital records office naming the adopted parents
**Step Child**
A step child is defined as a child under age 26 who is the natural offspring or adopted child of the covered member’s spouse. Required documents for step children are:
- Birth certificate of stepchild showing member’s spouse’s name AND
- Marriage certificate showing stepchild’s biological parent is married to member

If the spouse is not covered under the PEEHIP plan, in addition to the above documents, you must submit proof that your marriage is still current. Please refer to the “Spouse” category on page 15 for a list of acceptable documentation.

**Incapacitated Child**
An incapacitated child is defined as an unmarried incapacitated child 26 years of age or older who:
- is permanently incapable of self-sustaining employment because of a physical or mental handicap,
- is chiefly dependent on the member for support, and
- was disabled prior to the time the child attained age 26, and the child had to be covered as a dependent on the member’s PEEHIP policy before reaching the limiting age.

**Two Exceptions:**
1. New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment; or
2. Existing member requests coverage of an incapacitated child over the age of 26 within 45 days of the qualifying life event of loss of other hospital medical group coverage.

If approved for coverage, the child is not eligible to be covered on any other PEEHIP plans once he or she reaches the limiting age of 26 as an incapacitated child. Required documents for incapacitated children are:
- Incapacitated Dependent form. Proof of the child’s condition and dependence must have been submitted to PEEHIP within 45 days after the date the child would otherwise have ceased to be covered because of age.
- Proof of the required documents(s) for one of the dependent categories as noted above to show the child is your biological child, adopted, or stepchild AND
- Medicare Card (if eligible)

**Other Child**
Any other children, such as grandchildren, for example, must meet the same requirements as foster children and must be placed with you by decree or other order of a court of competent jurisdiction, for example, legal custody, legal guardianship. Required documents for other children are:
- Placement Authorization signed by a judge OR
- Final Court Order with presiding judge’s signature and seal
Employer Contributions

An active member is eligible to receive PEEHIP coverage at the member premium rates during each month the member is in pay status at least one-half of the working days of that month. (As set forth on pages 46-48, an employee may be eligible to extend their PEEHIP coverage through COBRA during a month in which the employee is in pay status less than one-half of the working days of that month.)

Example:
An employee who works October 1 through November 6 is eligible to receive PEEHIP coverage for October but not for November, assuming there were more than 12 working days in November. (As set forth, below, the employee may still be eligible to extend their PEEHIP coverage through COBRA.)

Note than an employee may get paid for a portion of a month but may not be eligible to receive PEEHIP coverage for the remainder of that month if he or she is not in pay status at least one-half of the working days of that month.

To be eligible for full coverage under PEEHIP, a teacher, counselor, librarian, administrative employee or other professional employee must be employed full-time. A support worker, such as a janitorial staff employee, custodian, maintenance worker, lunchroom worker, or teacher aide must be employed at least twenty (20) hours per week (excluding bus drivers who are full-time, by law) to receive full coverage. Permanent part-time employees who meet the required qualifications will be entitled to coverage on a pro rata basis as follows:

<table>
<thead>
<tr>
<th>Professional/Administrative Employee Works</th>
<th>Entitlement if Enrolled in Hosp/Med or HMO Plan</th>
<th>Entitlement if Enrolled in Optional Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than ¼ time</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>At least ¼ time but &lt; ½ time</td>
<td>¼ insurance coverage</td>
<td>1 Plan</td>
</tr>
<tr>
<td>At least ½ time but &lt; ¾ time</td>
<td>½ insurance coverage</td>
<td>2 Plans</td>
</tr>
<tr>
<td>At least ¾ time but &lt; Full-time</td>
<td>¾ insurance coverage</td>
<td>3 Plans</td>
</tr>
<tr>
<td>Full-time</td>
<td>Full coverage</td>
<td>4 Plans</td>
</tr>
</tbody>
</table>

(Each additional optional plan can be purchased for $38/month or $50/month for the family dental plan.)

<table>
<thead>
<tr>
<th>Support Worker Works</th>
<th>Entitlement if Enrolled in Hosp/Med or HMO Plan</th>
<th>Entitlement if Enrolled in Optional Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 4.9 hours/week</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5.0 to 9.9 hours/week</td>
<td>¼ insurance coverage</td>
<td>1 Plan</td>
</tr>
<tr>
<td>10.0 to 14.9 hours/week</td>
<td>½ insurance coverage</td>
<td>2 Plans</td>
</tr>
<tr>
<td>15.0 to 19.9 hours/week</td>
<td>¾ insurance coverage</td>
<td>3 Plans</td>
</tr>
<tr>
<td>20 or more hours/week</td>
<td>Full coverage</td>
<td>4 Plans</td>
</tr>
</tbody>
</table>

(Each additional optional plan can be purchased for $38/month or $50/month for the family dental plan.)

3-1 Rule
A member earns one month of additional insurance coverage for every three months the employee is in pay status at least one-half of the working days in the month for that school year. The 3-1 Rule only applies when an employee has terminated employment, retires, is not in pay status at least one-half of the working days of the month, goes on an approved leave of absence without pay, or begins employment in the middle of the year.

The 3-1 Rule is applied using a September through September year.
- Extra months of coverage earned by a member must be applied to insurance premiums immediately after the member is separated from employment.
- The member cannot pick and choose the months to use the coverage.
- An employee must be in pay status at least one-half of the available workdays for three full months to earn an extra one month of insurance coverage.
- An employee can only use the coverage month for the current fiscal year, i.e., the coverage cannot be used after September 30.
- The 3-1 Rule is handled in the same manner for all employees regardless of whether they are paid on a 9-, 10-, 11-, or 12-month basis.
If a terminated employee is hired back before he or she has exhausted their extra coverage months, the employee will not have a lapse in coverage and the same insurance plans will automatically get reinstated. These employees are treated as existing not new employees and will not be allowed to pick up or drop coverage except during the Open Enrollment period.

Employees who terminate employment and have a break in coverage can enroll as new employees the day they return to work, or during Open Enrollment for an October 1 effective date of coverage. PEEHIP must receive an online enrollment request.

The table below should be used when calculating the number of months an employee is entitled to receive insurance coverage.

<table>
<thead>
<tr>
<th>Service Months</th>
<th>Coverage Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>2</td>
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<td>12</td>
</tr>
</tbody>
</table>

**Leave**

A member can use his or her accrued or donated sick leave in order to be in pay status to remain eligible for PEEHIP coverage. However, sick leave, annual leave, or catastrophic leave cannot be manipulated in such a way that a member receives coverage inappropriately. **A member must use his or her accrued sick leave, annual leave or catastrophic leave continuously and consecutively when not actively employed.**

**Family Medical Leave Act (FMLA)**

The 3-1 Rule applies even when a member is granted leave under the FMLA. If the employee earns additional months of coverage under the 3-1 Rule prior to going on leave under the FMLA, the extra months are applied following said leave.

**Military Leave**

If an employee is on military leave status, the employee earns credit for the insurance coverage which is paid by the PEEHIP Plan. The employer will not be charged for the insurance contribution when a member is on military leave status in the Employer Portal.

**Terminated Employee**

The school system is not required to pay the September contribution amount for an employee terminating the end of May when the employee has worked September through May. These employees are eligible to receive insurance coverage through August, only.

**Additional Information about Employer Contributions**

A contribution for the month will be due if a member is hired on the first day of the month. A contribution can be used for the month of September. **Example:** An employee has been in hire status for 9 consecutive months and terminates employment after June 16. The member will be eligible for coverage for July, August, and September.

A full August contribution is due if the member has had continuous coverage through the summer. A member who has paid a LOA rate or COBRA for July and returns to work after August 1 but prior to August 15 is eligible for full coverage in August.

Insurance premiums are deducted one month in advance. An enrollment request for insurance to begin the date of hire should be accompanied with a payment made online or by personal check.
Transferring School Systems
When an employee transfers from one participating system to another without a break in coverage, the new system will be responsible for paying the contribution for the first full month of the employee’s contract and all additional months of coverage, thereafter.

Death
Extra insurance contributions earned under the 3-1 Rule can only be used by the employee and cannot be used by the employee’s family in the event of the employee’s death.

Active Employees Not Enrolled in Coverage
Section 16-25A-5, Code of Alabama, 1975, requires the insurance contribution amount must be paid for all employees eligible for insurance even if no coverage is elected.

Example:
A new employee begins work August 23 and does not enroll in coverage until October 1.

PEEHIP would not require the system to pay the pro rata contribution for August if the employee does not elect coverage on his date of employment; however, PEEHIP would require the insurance contribution amount for the full month of September.

Members who are not enrolled in any insurance coverage are allowed to enroll in single medical coverage effective on the date of notification.

Employers are not required to pay the pro rata insurance contribution for a new employee if the employee does not enroll in insurance coverage on his date of employment. However, Section 16-25A-9, Code of Alabama, 1975, requires the insurance contribution to be paid for a full month of coverage even if the employee does not enroll in any coverage.

Retiring Members
Retiring members are eligible to receive the extra coverage months earned under the 3-1 Rule.

Example:
♦ A June 1 retiree who works 9 months during the school year may receive coverage through August 31.
♦ A July 1 retiree who works the entire school year may receive coverage through September 30.

The school system is required to provide the appropriate insurance contribution earned under the 3-1 Rule. PEEHIP assumes that the system will not pay the September contribution for June 1 retirees, in most cases. June 1 retirees should continue to receive coverage through August.

The 3-1 Rule is handled in the same manner for retirees as for active employees regardless of whether they are paid on a 9-, 10-, 11- or 12-month basis.

Note: If a member and/or spouse is Medicare eligible at the time of retirement, the date of retirement is the date when Medicare becomes primary, regardless of the 3-1 Rule. Medicare-eligible members and/or dependents must have Medicare Part B on their retirement date to have adequate coverage with PEEHIP.

Medicare
If a member or dependent is already Medicare eligible due to age or disability at the time of his or her retirement, Medicare will become the primary payer and PEEHIP the secondary payer effective on the date of the member’s retirement.

It is extremely important for the member and/or dependent to have Medicare Part A and Part B to assure adequate coverage with PEEHIP. The member will continue to earn the extra coverage months under the 3-1 Rule, but Medicare will be the primary payer for claims beginning the date of retirement for Medicare-eligible members or dependents. If the member and only dependent are both eligible for Medicare, the reduced Medicare out-of-pocket cost will be deducted.

Medicare rules require a Medicare eligible, active PEEHIP member covered by his or her spouse’s PEEHIP retired contract to have Medicare as the primary payer on the active PEEHIP member. In this scenario, the active, Medicare-eligible member must have Medicare Part A and Part B coverage.
If the active member does not want Medicare as his or her primary payer and does not want to enroll in Medicare Part B until retirement, he or she will have to enroll in a PEEHIP active contract and will not be able to remain on the contract with the retired PEEHIP eligible spouse. Most of the time, in this situation, active members must wait until the next Open Enrollment period to enroll in their own PEEHIP medical plan or on their spouse’s date of retirement. When the active Medicare-eligible member retires, he or she must enroll in Medicare Part B to have adequate coverage with PEEHIP. The effective date of Medicare Part B must be the date of retirement to avoid a lapse in coverage.

Medicare-eligible members and Medicare-eligible dependents should not enroll in a separate standard Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. All retired Medicare-eligible members and Medicare-eligible dependents on retired contracts are enrolled in the Medicare GenerationRx Medicare Part D program offered by PEEHIP unless they are enrolled in a separate standard Medicare Part D plan or they choose not to participate/opt out.
PEEHIP Hospital Medical Plan
(Active Members and Non-Medicare-Eligible Retirees)

Hospital Benefits (Administered by Blue Cross)
♦ Inpatient Hospitalization: Plan pays 100% of the allowed amount for the first 365 days subject to a $200 per admission deductible and $25 per day copayment for days 2-5 (maximum copayment of $300). The plan allows for a semi-private room. The member is responsible for the difference in cost of a private and semi-private room and other non-medical items, such as TV, phone, etc.
♦ Preadmission Certification (PAC): All hospital admissions require preadmission certification. To obtain PAC, call 800.248.2342.
♦ Inpatient Rehabilitation: Plan pays 100% of the allowed amount, subject to a $200 per admission copayment and a $25 per day copayment for days 2-5 (maximum copayment of $300). Coverage in a rehabilitation facility requires Preadmission Certification and is limited to a lifetime maximum of 60 days per member.
♦ Outpatient Hospital Benefits: Plan pays 100% of the allowed amount, subject to a $150 facility copay for outpatient surgery and $150 facility copay for medical emergencies, and accidents.
♦ Hemodialysis: $25 copay
♦ Non-medical Emergencies: Plan pays 80% of the allowed amount, subject to the $300 calendar year deductible.

Major Medical Benefits (Administered by Blue Cross)
♦ Calendar Year Deductible: $300 per person; $900 maximum per family per year.
♦ Coinsurance: Once deductible is met, benefits are payable at 80% of the allowed amount. The member is responsible for the remaining 20% when using an in-network provider. There is a $400 per member out-of-pocket maximum for each plan year.
♦ Covered Services: Physician services for medical and surgical care when a PMD physician is not used; laboratory and X-rays, (outpatient MRI's must be pre-certified); ambulance service; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; podiatrist services; physical therapy; and allergy testing and treatments.
♦ Sleep Studies: Services are covered when rendered by a Blue Cross approved sleep facility. The following copayments apply:
  ◊ Free-standing sleep clinic: $10 facility copayment
  ◊ Hospital outpatient facility: $150 facility copayment for adults and $10 copay for children 18 and under

Effective January 1, 2016, major medical claims incurred in the 4th quarter of the calendar year will no longer be carried over and applied towards the following year’s deductible.

Preferred Medical Doctor (PMD)
♦ Office Visit and Consultations: $30 copayment per visit
♦ Routine Preventative Office Visit: No copayment for one routine preventative visit per year (adults 19 and older)
♦ Specialist Office Visit and Consultations: $35 copayment per visit (Does not apply to Family/General Practice, Internal Medicine, Gynecology, Obstetrics, Pediatrics, Certified Nurse Practitioner, Physician Assistant, Clinic and Midwives)
♦ Outpatient Diagnostic Lab and Pathology: $5 copayment per test (including pap smears)
♦ Outpatient Diagnostic X-ray: No deductible or copayment

PPO Blue Card Benefits (Out-of-State Providers)
♦ The Blue Card PPO program offers “PMD-like” benefits when members access out-of-state providers if the physician or hospital is a participant in the local Blue Cross PPO program in that state. This program allows members to receive PMD benefits such as well baby care, routine physicals and routine mammograms when accessing out-of-state PPO providers.

Non-Participating Hospitals and Outpatient Facilities
♦ Currently there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are a Blue Cross and Blue Shield participating provider. With your health plan benefits, you have the freedom to choose your health care provider.
♦ To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don’t have to worry about extra out-of-pocket expenses.
Out-of-Country Coverage
♦ If you receive medical treatment outside of the United States and the services are medically necessary, PEEHIP will pay primary under the major medical benefits. All PEEHIP deductible and coinsurance amounts and contract limitations will apply. The claims must be stated in U.S. dollars and filed with Blue Cross of Alabama.

Excluded Services and Prescription Drugs
♦ Excluded services include but are not limited to nursing home costs, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids and experimental procedures. Certain prescription drugs may be excluded to drive utilization to lower cost therapeutic alternative drugs. Effective July 1, 2015, bulk chemical powders will no longer be covered under PEEHIP.

Prescription Drug Benefits – Participating Pharmacy (Administered by MedImpact)
All drug lists can be found on the PEEHIP website at www.rsa-al.gov.
♦ Participating Pharmacy Copayments:
◊ $6 for 30-day supply of covered generic prescription drug
◊ $40 for 30-day supply of covered preferred brand drug
◊ $60 for 30-day supply of covered non-preferred brand drug
◊ $12 for up to a 90-day supply of approved maintenance drugs
◊ $80 for up to a 90-day supply of approved preferred maintenance drugs
◊ $120 for up to a 90-day supply of approved non-preferred maintenance drugs.
   The drug must be on the approved maintenance list and must be prescribed as a maintenance drug. First fill for a maintenance drug will be a 30-day supply.
♦ Participating pharmacies will file all claims electronically for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP MedImpact prescription drug plan.
♦ The PEEHIP prescription drug plan includes Step Therapy, Prior Authorization, and Quantity Level Limitations for certain medications.
♦ Refills on Retail and Specialty drugs (30-day supply) are allowed only after 75% of the previous prescription has been used (for example, 23 days into a 30-day supply). Refills are allowed for maintenance drugs (90-day supply) only after 75% of the previous prescription has been used (for example, 67 days into a 90-day supply).
♦ Pharmacists must dispense generic drugs unless physician indicates in longhand “Do not substitute.”
♦ Drug benefits for medically necessary fertility drugs are covered at 50% copay for any fertility drug up to a lifetime maximum of $2,500 cost to the PEEHIP plan.
♦ Over the counter (OTC), OTC equivalent drugs and medical foods are not covered even if prescribed by a physician unless mandated by the Affordable Care Act.

Effective August 1, 2015, flu vaccines will be allowed at most participating retail pharmacies at no cost.

Non-Participating Pharmacy (Coverage at a non-participating pharmacy in or outside Alabama)
If members use a non-participating pharmacy they will be required to pay the full cost of the prescription. Members can submit a claim form to MedImpact to be reimbursed at the Participating Pharmacy rate. All PEEHIP copayments and clinical utilization management programs will apply. The member out-of-pocket expenses will be higher when using a non-participating pharmacy.

Step Therapy Prescription Program
The PEEHIP prescription drug program includes Step Therapy for certain medications. The Step Therapy program was implemented to keep PEEHIP sound and to keep premiums and copayments at a reasonable and affordable level. The Step Therapy program applies to “new” prescriptions that have not been purchased in over 130 days. A prescription is considered “new” if the member or covered dependent has not filed and processed the prescription claim through PEEHIP in over 130 days.

Step Therapy is a program especially for people who take prescription drugs regularly to treat ongoing medical conditions such as arthritis/pain, heartburn, diabetes, high blood pressure, etc. It is designed to:
♦ Provide safe and effective treatments for your good health.
♦ Make prescriptions more affordable.
♦ Enable PEEHIP to continue to provide affordable prescription coverage while controlling rising costs.

Step Therapy is organized in a series of “steps” with your doctor approving your medication every step of the way. It is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts. Together, with MedImpact, Inc., they review the most current research on thousands of drugs tested and approved by the Food and Drug Administration (FDA) for safety and effectiveness.
**How it Works**

**First-Step:** Generic drugs are usually in the first-step. These drugs are commonly prescribed, less expensive treatments that are safe and effective in treating many medical conditions. The generic drug copayment is usually the lowest with a first-step drug. It will be necessary for the insured to use first-step drugs before the plan will pay for second-step drugs.

**Second-Step:** If treatment requires more medications, the program advances to the second-step which generally includes brand-name drugs. Brand-name drugs are usually more expensive than generics, so most will have a higher copayment. The first time a pharmacy processes a prescription for a second-step drug the pharmacist will receive a message indicating the PEEHIP plan uses Step Therapy. If you prefer not to try a second-step drug and pay the higher copay, your doctor needs to give you a prescription for a first-step drug. Only your doctor can change a prescription. To receive a first-step drug: **Ask your pharmacist to call your doctor** and request a new prescription or **contact your doctor** to get a new prescription.

If a first-step drug has already been tried, more expensive, brand-name drugs are usually covered in a later step in the program. If there are medical reasons that prevent a first-step drug from being tried, the doctor can call MedImpact at 800.347.5841 to request a “prior authorization” for a second-step drug. If the second-step drug is approved, the higher second-step copayment will be charged. The decision can be appealed through the appeals process outlined in the Blue Cross PEEHIP handbook. For other questions about the Step Therapy program, contact MedImpact Customer Service at 877.606.0727.

Members who are new to PEEHIP or a husband and wife switch from one PEEHIP contract to another may not be subject to the Step Therapy program. For these members to be grandfathered into the Step Therapy program, they will need to provide a prescription history documenting that they have been on the medication(s) 130 days prior to their enrollment date with PEEHIP.

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**This is Only a Summary of Benefits**

Members should refer to the Summary Plan Description for detailed information and limitations.
PEEHIP Supplemental Medical Plan

(Active Members and Non-Medicare-Eligible Retirees)

Blue Cross and Blue Shield of Alabama administers the PEEHIP Supplemental Medical Plan. The PEEHIP Supplemental Medical Plan is designed to only be a supplemental plan to other primary coverage. It does not cover the cost of services excluded by the member's primary group plan.

PEEHIP Supplemental Medical Plan Guidelines:

♦ There is no monthly premium for a single or family plan when the member uses the employer contribution amount for the PEEHIP Supplemental Medical Plan.
♦ The PEEHIP Supplemental Medical Plan provides secondary coverage to the member and covered dependent(s) when primary coverage is provided by another employer.
♦ The PEEHIP Supplemental Medical Plan supplements a primary insurance plan by covering the copayment, deductible, and/or coinsurance of a primary insurance plan or the preferred or participating allowance, whichever is less.
♦ PEEHIP Hospital Medical Plan limitations and exclusions will apply.
♦ The PEEHIP Supplemental Medical Plan will not pay for amounts in excess of the allowed amount for services rendered by a non-preferred provider, amounts in excess of the maximums provided under the primary insurance plan, any services denied by the primary insurance plan, or any penalties or sanctions imposed by the primary insurance plan.
♦ Members enrolled in plans with deductibles greater than $1,450 for individual or $2,700 for family are also not eligible for the PEEHIP Supplemental Medical Plan.
♦ To be eligible for reimbursement under the PEEHIP Supplemental Medical Plan, the primary insurance plan must have either 1) applied the eligible charges to the deductible, or 2) made primary payment for the services rendered.
♦ For inpatient mental health and substance abuse services, there is a maximum allowance of 30 total days per member per plan year.
♦ For outpatient mental health and substance abuse services, there is a maximum allowance of 10 visits per member per plan year.
♦ The annual maximum amount paid from the PEEHIP Supplemental Medical Plan will be limited to $6,600 for individual and $13,200 for family coverage.
♦ Only active employees and non-Medicare-eligible retirees and dependent(s) are eligible to enroll in this plan.
♦ Members can enroll at any time during the year, prospectively.
♦ The PEEHIP Supplemental Medical Plan cannot be used as a supplement to the PEEHIP Hospital Medical Plan, VIVA Health Plan (offered through PEEHIP), Marketplace (Exchange) Plans, State Employees Insurance Board (SEIB), and Local Government Board (LGB). In addition, active members who have Tricare or Champus as their primary coverage cannot enroll in the PEEHIP Supplemental Medical Plan.
♦ The PEEHIP Supplemental Medical Plan cannot be used as a supplement to Medicare (i.e. active members cannot be enrolled in Medicare only).

Members who enroll in the plan will receive more detailed information.
VIVA Health Plan (HMO)

(Active Members and Non-Medicare-Eligible Retirees)

Description of Plan
The VIVA Health Plan is a Hospital Medical plan option available to active employees and non-Medicare-eligible retirees who do not have Medicare-eligible dependents; in addition, the members must live in the VIVA Health service area listed below and use providers in the VIVA Health network. Participating providers can be located at www.vivahealth.com.

In addition to medical benefits, the VIVA Health plan option also includes dental benefits, vision benefits, and an extensive drug formulary. Except in situations described below, all care must be received from Participating Physicians. With VIVA Health, PEEHIP members have access to 70 hospitals and over 7,000 physicians statewide. A brief explanation of benefits is below, and a comparison of the two plan options starts on page 30.

Note: This plan is not available to Medicare-eligible retired members or Medicare-eligible dependents covered on a retired account.

Hospital Benefits
♦ Inpatient Hospitalization: Services are covered in full without a dollar limit.
♦ Copay: $200 for each admission. You are also responsible for the difference between private and semi-private accommodations and other non-medical items such as TV, phone, etc. There will be an additional copay of $50 per day for days 2-5.
♦ Prior Authorization: All inpatient admissions require authorization from VIVA Health prior to receiving services. Emergency admissions must be certified within 24 hours or as soon as reasonably possible for the admission to a covered service.
♦ Inpatient Rehabilitation: Coverage in a rehabilitation facility requires a referral from a Participating Physician and prior approval of the Medical Director. Coverage is limited to 60 days per calendar year and is covered 80% by VIVA Health.
♦ Outpatient Hospital Charges: $150 facility copay for outpatient services at an ambulatory surgical center; outpatient services conducted in the outpatient hospital setting covered at 90% subject to the deductible; and $200 copay for emergency room services. The emergency room copay is waived if admitted to hospital within 24 hours.
♦ Skilled Nursing Facilities, Speech, Occupational and Physical Therapy: member coinsurance is 20%.
♦ Outpatient mental health copay is $40.

Major Medical Benefits
♦ Major medical deductible per calendar year is $300 per person; $900 maximum per family.
♦ Medical and prescription calendar year out-of-pocket combined maximum is $6,600 for an individual and $13,200 for the family per calendar year.
♦ There is no lifetime maximum on this plan.
♦ Covered Services: Physician service for medical and surgical care when you use a Participating Physician; diagnostic, x-ray, and laboratory procedures; ambulance services; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; physical therapy; allergy testing and physician services; semi-private room and other hospital care after basic hospital benefits expire.

Participating Physicians
♦ $7.50 copay per lab test at independent labs; 90% coverage per test at hospital-based labs
♦ $20 copay for Primary Care Physician visit
♦ $40 copay for Specialty Care, Telemedicine consultation and eye exam; No referral required.
♦ $40 copay for Chiropractic Care with a maximum of 25 visits per calendar year
♦ Preventive services are covered at 100% with no copay.

Dental Benefits
♦ Deductible: $50 per person/$150 per family deductible applies to Basic & Major Services
♦ Maximum coverage: $500 Calendar year maximum
♦ Type I Diagnostic/Preventive Services: 100% coverage of maximum plan allowance (MPA). Services include routine oral exams, fluoride treatments (children under 19), cleanings, x-rays (limitations may apply), sealants, and space maintainers.
♦ Type II Basic Services: 50% coverage of MPA. Services include fillings, simple extractions, palliative services, general anesthesia, and non-surgical periodontics.

♦ Type III Major Services: 25% coverage of MPA and a 12 month waiting period. Services include major restorative (crowns, bridges, and dentures), denture repair, endodontics (root canals), surgical periodontics, and surgical oral surgery (includes surgical extractions).

Vision Exam Benefits
♦ Copay: One routine exam per year is covered in full after member pays a $40 copay. Other treatments are covered when medically necessary for the treatment of illness or injury.

Prescription Drug Benefits
♦ When you choose a Participating Pharmacy you pay the following:
  ◆ $5 preferred generic drugs
  ◆ $20 non-preferred generic drugs
  ◆ $60* preferred brand drug
  ◆ $80* non-preferred brand drug
  * When an appropriate grade generic is available and a brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs.

♦ Mail order pharmacy is available.
  ◆ $12 preferred generic drug for 90-day supply through mail order
  ◆ $43 non-preferred generic drug for 90-day supply through mail order
  ◆ $150 preferred brand drug for 90-day supply through mail order
  ◆ $200 non-preferred brand drug for 90-day supply through mail order

♦ Participating pharmacies will file all claims for you.
♦ 70% coverage for self-administered injectibles, bio-technical, biological and specialty drugs

Non-Participating Hospitals and Outpatient Facilities
♦ When choosing a Hospital, Outpatient Facility, or Provider you should first check to see if they are a participating provider/ facility with VIVA Health. Your health plan gives you the freedom to choose your healthcare provider among VIVA Health’s contracted providers/facilities.

♦ To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don’t have to worry about extra out-of-pocket expenses.

♦ Emergency medical care, including Hospital emergency room services and emergency ambulance services will be covered twenty four hours per day, seven days per week, if provided by an appropriate health professional whether in OR out of the Service Area if the following conditions exist:
  1. The member has an emergency medical condition;
  2. Treatment is medically necessary; and
  3. Treatment is sought immediately after the onset of symptoms (within twenty-four hours of occurrence) or referral to a Hospital emergency room is made by a participating physician.

Non-Participating Pharmacy
♦ There are no VIVA benefits if you use a non-participating pharmacy in Alabama.

Excluded Services
♦ Coverage is not provided for cosmetic surgery, hearing aids, or experimental procedures. Other excluded services are listed in the Certificate of Coverage.
Service Area
Coverage with VIVA Health is available in the following areas. You can also find providers in the VIVA Health network on the VIVA website at www.whyviva.com.

Autauga  Butler  Clay  Cullman  Fayette  Jefferson  Madison  Perry  Tallapoosa
Baldwin  Calhoun  Cleburne  Dale  Franklin  Lauderdale  Marion  Pickens  Tuscaloosa
Barbour  Chambers  Colbert  Dallas  Geneva  Lawrence  Mobile  Pike  Walker
Bibb  Cherokee  Conecuh  DeKalb  Hale  Lee  Monroe  St. Clair  Washington
Blount  Chilton  Coosa  Elmore  Henry  Lowndes  Montgomery  Shelby  Wilcox
Bullock  Clarke  Crenshaw  Etowah  Houston  Macon  Morgan  Talladega  Winston

This is Only a Summary of Benefits
Members should refer to the Summary Plan Description for detailed information and limitations.
Optional Coverage Plans

(Active and Retired Members)

Southland Benefit Solutions administers the Optional Plans offered through PEEHIP. Optional Plans in which the member enrolls must be all single or all family, with the exception of the dental plan. In the event that the member’s only dependent wears dentures, the member may carry single dental while other plans remain family. Enrollment in Optional Plans must be retained for the entire plan year (October 1–September 30). New members employed during the Open Enrollment period cannot enroll in the Optional Plans on their date of employment and cancel the plans October 1 of that same year. Members enrolled in family Optional Plans cannot change to single Optional plans outside of the Open Enrollment period unless all dependent(s) become ineligible due to age, death or divorce.

A summary of benefits is listed below. Members who enroll in the Optional Plans should refer to their benefit booklet for detailed information and limitations.

Cancer Plan
- This plan covers cancer disease only.
- Benefits are provided regardless of other insurance.
- Benefits are paid directly to the insured unless assigned.
- Coverage provides $250 per day for the first 90 consecutive days of hospital confinement, $500 per day thereafter.
- Actual surgical charges are paid up to the amounts in the surgical schedule.
- The lifetime maximum benefit for radiation and chemotherapy coverage is $10,000. This benefit covers actual charges for cobalt therapy, x-ray therapy, or chemotherapy injections (excluding diagnostic tests).
- Benefits are also provided for Hospice care, anesthesia, blood and plasma, nursing services, attending physician, prosthetic devices, and ambulance trips.
- Limit of $5,000 per year for blood and plasma for leukemia.
- Added new surgical procedures to the care schedule.
- Plan will allow any physician recommended observation period that is greater than 24 hours to qualify as an inpatient stay.

Dental Plan
- This plan covers diagnostic and preventative services, as well as basic and major dental services.
- Diagnostic and preventative services are not subject to a deductible and are covered at 100% (based on Alabama reasonable and customary charges). These services include: oral examinations, teeth cleaning, fluoride applications for insured children up to age 19, space maintainers, x-rays, and emergency office visits.
- Routine cleaning visits are limited to two times per plan year.
- Basic and major services are covered at 80% for individual coverage and 60% for family coverage with a $25 deductible for family coverage (based on the Usual Customary Rates (UCR) for Alabama). These services include: fillings, general anesthetics, oral surgery not covered under a Group Medical Program, periodontics, endodontics, dentures, bridgework, and crowns.
- The family coverage deductible for basic and major services is applied per person, per plan year with a maximum of three (3) per family.
- All dental services are subject to a maximum of $1,250 per year for individual coverage and $1,000 per person per year for family coverage. Dental coverage does not cover pre-existing dentures or bridgework, nor does it provide orthodontia benefits.
- The dental coverage does not cover the replacement of natural teeth removed before a member’s coverage is effective.
- This plan does not cover temporary partials, implants, or temporary crowns.
- The dental plan administered by Southland Benefit Solutions also offers a money-saving network program known as DentaNet. Under the DentaNet program, members have the opportunity to use network dentists but still have the freedom to use any dentist.
- **Remember:** Dental benefits under this plan will always be paid secondary to other dental plans.

Hospital Indemnity Plan
- This plan provides a per-day benefit when the insured is confined to the hospital.
- The In-Hospital Benefit is $150 per day for individual coverage and $75 per day for family coverage.
- In-hospital benefits are limited to 365 days per covered accident or illness.
- Intensive care benefit is $300 per day for individual coverage; $150 per day for family coverage.
- Convalescent care benefit is $150 per day for individual coverage; $75 per day for family coverage.
Convalescent care benefits are limited to a lifetime benefit of 90 days. This plan does not cover assisted living facilities.

There is a supplemental accident coverage for $1,000. The reimbursement for an accident(s) is limited to a maximum of $1,000 per contract for each covered individual. There is no limit on the number of accident claims that can be filed per contract year.

The plan will allow a physician recommended observation period that is greater than 24 hours to qualify as an inpatient stay.

**Vision Care Plan**

This plan provides coverage for:

- One examination in any 12-month period (actual charges up to $40)
- One new prescription or replacement prescription for lenses per plan year (up to $50 for single vision, $75 for bifocals, $100 for trifocals, and $125 for Lenticular)
- One new prescription or replacement of contacts per plan year (up to $100 for contact lenses)
- Disposable contact lenses
- One new or replacement set of frames per plan year (up to $60)
- Either glasses or contacts, but not both in any plan year
- Vision benefits under this plan will always be paid secondary to other vision plans.

Southland will provide, at no cost, its Vision Choice plan to all PEEHIP members who participate in any of the Optional Plans. Members who use Vision Choice providers will save approximately 20%.

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**This is Only a Summary of Benefits**

Members should refer to the Summary Plan Description for detailed information and limitations.
**Comparison of Benefits**
**Effective October 1, 2015 – September 30, 2016**
*(changes are in bold)*

This is a summary of your group benefits. Please be sure to read the entire “Summary Plan Booklet” for a complete list of benefits, limitations and exclusions.

<table>
<thead>
<tr>
<th>PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers</th>
<th>VIVA Health Plan* (In approved areas only) (Active and Non-Medicare Members Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Medical</td>
<td>$0 copayment then covered in full</td>
</tr>
<tr>
<td>Well Baby Care</td>
<td>Covered at 100% of the allowed amount with no deductible or copayment. See <a href="http://AlabamaBlue.com/preventiveservices">AlabamaBlue.com/preventiveservices</a> for a listing of the specific immunizations and preventive services.</td>
</tr>
<tr>
<td>Routine Immunizations</td>
<td>$0 copayment then covered in full</td>
</tr>
<tr>
<td>Office Care</td>
<td></td>
</tr>
<tr>
<td>Physician’s Care</td>
<td>$30 copayment per visit</td>
</tr>
<tr>
<td>Specialist</td>
<td>$35 copayment per visit</td>
</tr>
<tr>
<td>Lab/Diagnostic Procedures</td>
<td>$5 per test</td>
</tr>
<tr>
<td>Telemedicine Consultation</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient Facility (including Maternity)**</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Physician’s Care</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Inpatient/ Hospital Services</td>
<td>$200 hospital copayment and $25 per day for days 2-5</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$150 copayment</td>
</tr>
<tr>
<td>In-Hospital Care</td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Physician Visits</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Emergency</td>
<td></td>
</tr>
<tr>
<td>In Area/Out of Area Emergency Room Facility Charge</td>
<td>$150 per visit; Members are also responsible for the physician copayment and lab fees. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to calendar year deductible. <strong>Accidents treated as any other illness; all applicable copays will apply.</strong></td>
</tr>
<tr>
<td>Calendar Year Deductible for Major Medical Services</td>
<td>Calendar year deductible $300 per individual; $900 maximum per family.</td>
</tr>
</tbody>
</table>

*VIVA Health Plan: No referral from a primary care physician (PCP) is required. Members must use providers and facilities in the VIVA Access Network.*

**Maternity benefits are not available to children of any age.**
<table>
<thead>
<tr>
<th>Major Medical Services and Coinsurance</th>
</tr>
</thead>
</table>
| **PEEHIP - Traditional Plans**  
(Administered by Blue Cross)  
Preferred Providers | **VIVA Health Plan**  
(In approved areas only)  
(Active and Non-Medicare Members Only) |
| After you pay the $300 deductible, the plan pays 80% of the allowed amount of covered expenses for the first $2,000 and 100% of the allowed amount, thereafter. Therefore, you will have a $400 individual annual out-of-pocket maximum plus the $300 calendar year deductible. Other covered services are the only expenses applicable to the annual out-of-pocket maximum. Members are responsible for expenses above the allowed amount when using out-of-network. | After you pay the $300 deductible, the plan pays 80% of the allowed amount of covered expenses. |

<table>
<thead>
<tr>
<th>Mental Health and Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
</tr>
<tr>
<td>Copayments: $0/day for days 1-9, $15/day for days 10-14, $20/day for days 15-19, $25/day for days 20-24, $30/day for days 25-30. Maximum of 30 days per member per fiscal year at approved facilities. Limit of one substance abuse admission per plan year and two admissions per lifetime. Benefits not provided for substance abuse facility except when provider is a PPO facility.</td>
</tr>
<tr>
<td>Covered in full after $200 copayment and a $25 copayment for days 2-5.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
</tr>
</thead>
</table>
| **(Administered by MedImpact)** | **Preferred Generic - $5 copay, $12 Mail Order 90-day supply**  
Generic - $20 copay, $43 Mail Order 90-day supply |
| **Formulary (preferred brand name) - $40 copayment (30-day supply)** | **Preferred Brand (formulary)- **$60 copay, $150 Mail Order 90-day supply**  
Non-Preferred Brand (non-formulary) - **$80 copay, $200 Mail Order 90-day supply**  
*When an appropriate grade generic is available and a brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs. |
| **Non-formulary (non-preferred brand name) - $60 copayment (30-day supply)** | Mail order pharmacy is available.  
90-day supply available with mail order – 2.5x copay  
90-day supply at retail pharmacy – 3x copay |
| Pharmacists must dispense a generic drug unless the physician indicates in longhand writing on the prescription “Do Not Substitute”, “Medically Necessary”, or “Dispense as Written”.  
Approved Maintenance drugs covered for 90-day supply for one copayment of $12-Generic, $80-Preferred, and $120-Non-preferred. The drug must be on the approved maintenance list and must be prescribed for 90 days. First fill for a new maintenance drug will be a 30-day supply.  
Contraceptives are covered. $0 copay-Generic; applicable copay for brand-name. |  
Contraceptives are covered. $0 copay-Generic; applicable copay for brand-name. |
### Prescription Drugs (cont.)

| **PEEHIP - Traditional Plans**  
| *(Administered by Blue Cross)*  
| **Preferred Providers** | **VIVA Health Plan*  
| *(In approved areas only)*  
| **(Active and Non-Medicare Members Only)** |

- **Flu vaccine covered at no cost when administered by a participating retail pharmacy, beginning August 1, 2015.**

  Certain medications have quantity level limits to comply with the FDA guidelines and to ensure drug safety for our members. Certain medications are subject to Step Therapy. Prior authorizations are required before covered members can receive certain medications.

  In-state and out-of-state non-participating pharmacies: Members must pay the full amount of the prescription and then file the claim to be reimbursed at the participating pharmacy rate. Members pay the difference in cost plus appropriate copayments. All PEEHIP, clinical utilization management programs will apply. Out-of-pocket expenses will be higher if you use a non-participating pharmacy.

  Retired members who are Medicare eligible or have Medicare-eligible dependents are provided prescription drug coverage through the Medicare Part D plan offered by PEEHIP and administered by Medicare GenerationRx.

- **70% coverage for self-administered injectibles, bio-technical and biological drugs and maximum out-of-pocket is combined with the major medical out-of-pocket for a total combined out-of-pocket of $6,600 per member or $13,200 per family per calendar year.**

  Participating pharmacies only.

  VIVA provides no pharmacy benefits when a non-participating pharmacy in Alabama is used.

### Other Services

| **Out-of-state Coverage for Non-PPO Provider** | **Major Medical benefits apply – payable at 80% of the allowed amount after paying the $300 yearly deductible** | **Only Emergency and Urgent Care Services and Prescription Benefits available** |
| **Out-of-state Coverage for PPO Provider** | **$30 copayment per visit. Members must use providers participating in the Blue Cross plan of that state.** | **Only Emergency and Urgent Care Services and Prescription Benefits available.** |
| **Vision Examinations** | **Not Covered** | **Covered in full once each 12 months after a $40 copayment with participating provider** |
| **Dental** | **Not Covered** | *(Administered by Delta Dental)*

The Dental Plan allows you to seek treatment from any licensed dentist. The plan reimburses a percentage of eligible expenses based on usual, customary and reasonable (UCR) fees.

- **Type I – Preventative & Diagnostic – 100% of UCR**
- **Type II – Basic Services – 50% of UCR**
- **Type III – Major Services** – 25% of UCR

Deductible (applies to Basic & Major Services) - $50 per person/$150 per family; Calendar Year Max - $500

**12-month Waiting Period applies to Major Services**
## Comparison of Benefits

### PEEHIP - Traditional Plans (Administered by Blue Cross)
**Preferred Providers**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Service &amp; Chiropractic Services</td>
<td>Participating Chiropractor – Covered at 80% of the allowed amount with no deductible. After 18 visits in a calendar year, services are subject to precertification. Member will owe 20% coinsurance.</td>
<td>Limited to 25 visits per calendar year, $40 copayment per visit</td>
</tr>
<tr>
<td></td>
<td>Non-participating Chiropractor – Covered under major medical at 80% of allowed amount. Member will owe 20% coinsurance, major medical deductible of $300 and charges over allowed amount. Limited to 12 visits in a calendar year per member.</td>
<td></td>
</tr>
</tbody>
</table>

### VIVA Health Plan* (In approved areas only) (Active and Non-Medicare Members Only)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Spinal Service &amp; Chiropractic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td>Benefits for infertility services are limited to a lifetime maximum of 8 artificial insemination attempts (whether successful or not). Benefits are not provided for IVF, ART, or GIFT. Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP per member contract. Members will pay 100% of the cost of the medications after the $2,500 lifetime maximum is reached. Benefits are not provided for IVF, ART, or GIFT.</td>
<td>Coverage for infertility services is limited to initial consultation and one counseling session only. Testing is limited to semen analysis, HSG and endometrial biopsy (covered once during the Member’s lifetime). Treatment for infertility is not a Covered Service.</td>
</tr>
</tbody>
</table>

### Annual Out-Of-Pocket Maximums for In-Network Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered members will pay no more than:</td>
<td>Covered members will pay no more than:</td>
<td></td>
</tr>
<tr>
<td>$6,600 for individual coverage and $13,200 for family coverage. Out-of-pocket maximums apply to in-network combined medical and prescription drugs during the calendar year.</td>
<td>$6,600 for individual coverage and $13,200 for family coverage. Out-of-pocket maximums apply to in-network combined medical and prescription drugs during the calendar year.</td>
<td></td>
</tr>
</tbody>
</table>

*VIVA Health Plan: No referral from a primary care physician (PCP) is required. Members must use providers and facilities in the VIVA Access Network.*

---

**This is Only a Summary of Benefits**

Members should refer to the Summary Plan Description for detailed information and limitations.
Coordination of Benefits (COB)

Members and dependents are legally required to notify PEEHIP of other insurance under which they may be covered to ensure accurate claims processing in the correct payment order of primary and secondary. Members must notify PEEHIP when changes to other insurance coverage occurs. Changes can be submitted online through MOS or by submitting a Coordination of Benefits form to PEEHIP in a timely manner.

In cases where the member needs to inform PEEHIP of other insurance that was in effect during any time-frame in which PEEHIP was also in effect for the member and/or dependent and the other insurance has cancelled, information about that other coverage will still be required. Members must either submit information about that other coverage via MOS or submit a Coordination of Benefits form regarding their other coverage. The member must also send PEEHIP a letter from the other insurer as legal proof of cancellation (i.e. Certificate of Creditable Coverage or Proof of Prior Coverage letter). Documentation must show a cancellation date.

Dental and Vision Plans
If an employee or covered dependent is enrolled in the dental and/or vision plans provided by PEEHIP and is also entitled to any other dental or vision coverage, the total amount that is payable under all plans will not be more than 100% of the covered expenses. PEEHIP will coordinate benefits with other dental and vision coverages.

PEEHIP dental and vision benefits will be secondary to all other dental and vision coverages for the subscriber. Dental and vision claims incurred and filed on the Southland Benefit Solutions plan are always paid secondary to other dental and vision plans. For more information on the COB rules, refer to the PEEHIP Summary Plan Description.

Non-Duplication of Benefits
All PEEHIP members and covered dependents who use their PEEHIP Hospital Medical Plan as their secondary coverage will be required to pay deductibles and copayments imposed by PEEHIP. PEEHIP will cover the portion of the health plan deductibles and copayments that exceed the PEEHIP copayments.
PEEHIP Wellness Programs

(Active Members and Non-Medicare-Eligible Retirees)

Team Up For Health

PEEHIP has Teamed Up For Health with the Alabama Department of Public Health (ADPH) and ActiveHealth as our strategic partners and administrators of PEEHIP’s new and improved Team Up for Health Wellness Program. This program offers FREE services for members and their covered spouse. In accordance with healthcare reform law, there is no required health standard which must be met.

The goals of the program are to:
♦  Help members and their families achieve or maintain good health,
♦  Promote the early detection and identification of chronic disease,
♦  Encourage lifestyle changes that lower the risk of chronic disease and illnesses, and
♦  Enhance wellness and productivity.

This program and its free services are designed to help PEEHIP members live happier, healthier and more satisfying lives. Healthier members typically get sick less often and visit the doctor less frequently. This leads to lower healthcare costs for our members and the plan while providing an invaluable benefit to members.

Wellness Premium Waiver

The following members enrolled in the PEEHIP Hospital Medical Group #14000 Plan administered by Blue Cross Blue Shield are required to complete the applicable wellness activities by the specified deadlines in order to earn a waiver of the new $50 monthly wellness premium effective October 1, 2015.

♦  Members currently employed by a PEEHIP participating system and their covered spouse, regardless of Medicare eligibility
♦  A retired employee who is not Medicare eligible
♦  A non-Medicare-eligible spouse covered on a retiree contract
♦  Members on COBRA, Leave of Absence and surviving spouses who are non-Medicare-eligible

The wellness premium applies separately to the covered member and their covered spouse. The covered member and their covered spouse can each earn the wellness premium waiver of $50 for a potential wellness premium waiver of $100 each month. The wellness premium will be applied to the monthly PEEHIP premium beginning October 2015 for members and spouses who do NOT participate or who do not complete all of the required wellness activities by the deadline. New employees and covered spouses will have 90-days from their date of enrollment to complete all required wellness activities to be eligible to earn the wellness premium waiver. These new members will receive introductory letters to the wellness program and reminder letters of their required activities and specific due dates.

The following members are NOT required to participate in the wellness program:
♦  Children
♦  PEEHIP members or spouses who are only enrolled in the Optional Plans, the PEEHIP Supplemental Medical Plan, or the VIVA Health Plan
♦  Medicare-eligible retirees and Medicare-eligible spouses covered on a retiree contract (even if enrolled in the PEEHIP Hospital Medical Plan Group #14000)

Required Wellness Activities

If you are required to participate in Team Up for Health, you must complete these minimum wellness activities in order to qualify for the $50 monthly wellness premium waiver:
♦  Wellness Screening
♦  Health Questionnaire (HQ)

Participation in the following wellness activity is required only if you and/or your covered spouse is identified as a candidate for these programs and receive an invitation letter from ActiveHealth:
♦  Wellness Coaching
♦  Disease Management Coaching

Participation in the following activity is required only if you and/or your covered spouse is identified as a candidate and receive notification from Blue Cross Blue Shield of Alabama.
♦  Complex Case Management
Wellness Screenings
All PEEHIP members are eligible to receive one **FREE** annual wellness screening by the ADPH nurses at various sites during the year. Visit the ADPH online screening calendar at [www.adph.org/worsitewellness](http://www.adph.org/worsitewellness) to learn when and where screenings will be offered in your area. Members will be required to show their Blue Cross Blue Shield ID card at the screening.

**Wellness Screenings** will measure:
- Blood pressure
- Height, weight, waist and body mass index (BMI)
- Total cholesterol (HDL and LDL)
- Triglycerides
- Blood glucose

Also, **no copay** is required if an ADPH wellness coach give the member and/or covered spouse an **Office Visit Referral** form to take to a physician’s office to follow up with the abnormal results or risk factors identified during the screening process. The **no copay** referral is only good for 60 days from the screening date.

Healthcare Provider Screenings.
If you are required to participate in **Team Up for Health** and prefer for your personal healthcare provider to do your screening, you will need to have your healthcare provider complete the **Healthcare Provider Screening** form which is located on the PEEHIP website at [www.rsa-al.gov/index.php/members/peehip/pubs-forms/](http://www.rsa-al.gov/index.php/members/peehip/pubs-forms/). Your **healthcare provider** must complete and fax or mail it to ADPH. Under the Affordable Care Act (ACA) as part of the federal healthcare reform laws, **no copay** is required for one annual preventive routine office visit obtained through your in-network healthcare provider. The routine lab tests for total cholesterol, triglycerides and blood glucose are covered once a year at no copay through an in-network lab. **You will be responsible for the cost of other elected routine lab tests that are not a covered benefit under PEEHIP, and that are not necessary to complete the PEEHIP screening form.**

All screenings regardless of location must be completed the specified deadline, for those required to participate in order to earn the wellness premium waiver effective October 1, 2015. **Remember that the wellness premium waiver can be applied to the member and their spouse for a total waiver of $100.**

Health Questionnaire (HQ)
The Health Questionnaire (HQ) provides an assessment of your overall health and helps find ways to improve your health and well-being. Log in to [www.MyActiveHealth.com/PEEHIP](http://www.MyActiveHealth.com/PEEHIP) with your self-selected user ID and password to complete the HQ online using your computer, smart phone or tablet. If you do not have access to the Internet, you can call ActiveHealth toll-free at 855.294.6580 to complete the HQ over the phone.

Wellness Coaching
Wellness Coaching, available through ActiveHealth, connects members with registered dieticians, nutritionists, exercise physiologists, or other licensed counselors who can help members to build a plan for achieving healthier lifestyles. Want to eat healthier? Lose weight? Stop smoking? The coaching process offers numerous resources and services to help you maintain or improve upon a healthy lifestyle.

Disease Management
PEEHIP’s Disease Management program is provided by ActiveHealth for members required to participate in **Team Up for Health**. The Disease Management program focuses on five chronic illnesses and the reduction of future complications associated with these diseases: asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease (COPD). ActiveHealth connects you with a licensed nurse to work with you one on one to help manage these long term conditions. You are required to participate in Disease Management only if you receive an invitation letter from ActiveHealth.

Disease Management for children and adult child dependents covered by PEEHIP’s Hospital Medical Plan Group #14000 is provided by Blue Cross Blue Shield of Alabama.
Options to Complete Wellness or Disease Management Coaching

1. **Online:** Log in to www.MyActiveHealth.com/PEEHIP to earn 100 heartbeat units (which equals 1 heartbeat goal) of online coaching to complete required wellness coaching or disease management.

2. **Telephonic:** If you do not have access to the Internet, you may call ActiveHealth toll-free at 855.294.6580 to complete your coaching requirement on the phone.

3. **On-site health coaching clinics:** PEEHIP now offers group health coaching sessions as another option for members to complete their health coaching requirement. Three ActiveHealth wellness coaches are available to travel the state and lead on-site group coaching classes for any PEEHIP member, covered spouse, or retiree that would like to attend. By attending one of these one-hour or less coaching sessions, PEEHIP participants will be given credit for their coaching requirement. These sessions will be held on demand at locations all over the state, so ask your school’s insurance coordinator about requesting a coaching session in your area! Retirees or spouses can call PEEHIP for available locations.

**Complex Case Management**

Complex Case Management is the coordination of care and services provided to members who have experienced a critical event or an acute admission and requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. The situations which place members into qualification for case management are rare, and this program will only apply to a very small percentage of the PEEHIP membership. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client's health and human services needs.

When a member is identified for complex case management, contact is made by a BCBS care coordinator who explains the case management program and obtains verbal consent to open the case management episode. Personalized and ongoing outreach will be made to any PEEHIP members who are identified for needing complex case management. The care coordinator assesses for discharge from the program based on evaluation of goal progression and case closure criteria prior to termination of case management services. **Members who receive notice of their requirement to participate in complex case management must work with their care coordinator in order to earn the $50 monthly wellness premium waiver.** For more information on the complex case management program, please contact Blue Cross Blue Shield of Alabama at 800.327.3994.

**24-Hour Nurse Line**

ActiveHealth provides a 24-hour nurse line for members required to participate in Team Up for Health. Members can speak with a registered nurse 24 hours per day, 7 days per week to inquire about a health related matter. Your personal health facts will be kept private and confidential. To reach the nurse line, call ActiveHealth at 1.855.294.6580.

**Care Considerations**

ActiveHealth continuously analyzes healthcare information to look for opportunities to recommend certain tests, or medications, or treatments. All care considerations encourage members to first speak with their healthcare provider about the recommendation.

**MyActiveHealth Website**

Visit this website at www.MyActiveHealth.com/PEEHIP for tools designed to help you reach your health goals. These include the HQ, a Personal Health Record, Online Health Coaching, videos, quizzes, and other interactive tools.

**Track Your Completion Status of Your Required Wellness Activities**

Your Progress Wheel is available on your “My Wellness Rewards and My Required Activities” web page and shows the percentage of completion of all your required activities. Once you have completed all required wellness activities, your Progress Wheel will show 100% complete. All of your required activities are shown on your action cards on this web page.

If you would like additional confirmation of your wellness premium waiver status, you may also view your status on the PEEHIP member online services web page at https://mso.rsa-al.gov.
**Tobacco Cessation Programs**

ActiveHealth offers a free tobacco cessation program with live and online counseling to those members listed above who are eligible for their services. For more information visit [www.MyActiveHealth.com/PEEHIP](http://www.MyActiveHealth.com/PEEHIP) or call 855.294.6580. The ADPH also offers Alabama Tobacco Quitline, a free service for all Alabamians. Alabama Tobacco Quitline offers live and online counseling, and is available toll free at 1.800.QUIT.NOW (800.784.8669) or online at [www.quitnowalabama.com](http://www.quitnowalabama.com). For more information on the services provided by the PEEHIP Team Up for Health Wellness Program, visit [www.rsa-al.gov/index.php/members/peehip/health-wellness/](http://www.rsa-al.gov/index.php/members/peehip/health-wellness/).

**Non-Tobacco User Discount**

All PEEHIP members and covered spouses enrolled in the PEEHIP Hospital Medical or VIVA Health Plan are each charged a $50 per month tobacco premium. Non-tobacco users can have the $50 premium waived by certifying that they and/or their covered spouse have not used tobacco products within the last 12 months. The tobacco premium does not apply to the PEEHIP Optional Coverage Plans or the PEEHIP Supplemental Medical Plan.

Members are required to re-certify tobacco usage status for themselves and/or their covered spouse if there is a tobacco status change during the year, when members make changes to their coverages, and at the time of the wellness screening. The update can be made throughout the plan year either online through Member Online Services (MOS) or by submitting a completed New Enrollment and Status Change form. The change in premium will be applied prospectively.

Non-tobacco user discounts are part of our automated premium invoice generation, and these discounts are prospectively applied to member accounts beginning with the first full month after PEEHIP has received certification that a member and/or covered spouse has been a non-tobacco user for the previous consecutive 12 months.

If you and/or your covered spouse are tobacco users and do not qualify for the non-tobacco user discount, you and/or your covered spouse can become eligible to have your tobacco premium waived if you complete the tobacco cessation program. Removal of the tobacco premium is not automatic upon completion of this program. To seek the premium discount, you must contact PEEHIP once you have received your tobacco cessation program completion certificate. You will then have to provide the certificate to PEEHIP along with a written request to waive the tobacco premium. Once you have completed all the necessary steps, you may qualify to receive the non-tobacco user discount from the time you began the tobacco cessation program until the end of the plan year. Additionally, your physician may recommend an alternative method for you and/or your covered spouse to qualify for the discount, if you or your covered spouse is medically unable to participate in the tobacco cessation program. Members and/or covered spouses who receive the discount by means of completing the PEEHIP tobacco cessation program are required to complete the program again each plan year in order to continue receiving their discount, if their status remains tobacco free. If you would like to receive more information about the tobacco cessation program, you can contact the PEEHIP Wellness Coordinator toll free at 877.517.0020.

New employees who enroll in the PEEHIP Hospital Medical or VIVA Health Plan must certify their tobacco status (and their spouse’s tobacco status, if covered as a dependent) by answering the tobacco questions through Member Online Services (MOS) at the time of enrollment.

**Baby Yourself Program**

*Baby Yourself* is a prenatal wellness program, administered by Blue Cross and Blue Shield of Alabama, for expectant mothers. This program is part of your PEEHIP Hospital Medical coverage and is available at no cost to you. PEEHIP strongly encourages all expectant mothers covered under the PEEHIP Hospital Medical plan to sign up for *Baby Yourself* today. If you are a soon-to-be expectant mother, please sign up as soon as you confirm your pregnancy. PEEHIP encourages you to sign up for the program with each pregnancy even if you have already participated. When you sign up, you will receive:

- Support from an experienced Blue Cross registered nurse
- Educational information by telephone and email during your pregnancy
- Useful gifts that encourage healthy habits, proper prenatal care, and help you understand the changes and challenges of pregnancy

PEEHIP will waive the $200 copayment for the delivery of your baby for those members enrolling in the first trimester and who complete the program. The $25 per day copayment for days 2 through 5 will apply (maximum of $100 copayment). The vast majority of mothers who delivered premature babies did not participate in the PEEHIP Baby Yourself program. The goal of Baby Yourself is to have healthy mothers and babies at delivery.

If you are pregnant, please enroll today in *Baby Yourself* by calling 800.222.4379 or registering online at [www.bcbsal.com/baby](http://www.bcbsal.com/baby).
Premium Rates

(Active, LOA, and COBRA Members)

October 1, 2015 – September 30, 2016

The following health insurance premiums are the base rates set by the PEEHIP Board. Base rates are before the wellness and tobacco premiums are applied, if applicable.

Insurance premiums and enrollments are handled by PEEHIP, not by the employer. If the payroll deduction is incorrect, members need to contact PEEHIP instead of the employer. Premiums for PEEHIP medical, dental, vision, cancer, and indemnity will be paid with pre-tax dollars and are excludable from federal and state income taxes under Sections 105(b) or 106 of the Internal Revenue Code for active employees.

PEEHP premiums are deducted in the month prior to the month of coverage (i.e. the premium for October’s insurance coverage is deducted in September). Flexible Spending Account contributions are deducted in the current month (i.e. the contribution for October is deducted in October).

### PEEHIP Hospital/Medical & VIVA Health Plan

#### Active Member

<table>
<thead>
<tr>
<th></th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$15</td>
</tr>
<tr>
<td>Family without Spouse</td>
<td>$177</td>
</tr>
<tr>
<td>Family with Spouse* (includes spousal surcharge)</td>
<td>$202</td>
</tr>
</tbody>
</table>

#### Member on LOA/COBRA

<table>
<thead>
<tr>
<th></th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$444</td>
</tr>
<tr>
<td>Family without Spouse</td>
<td>$1,131</td>
</tr>
<tr>
<td>Family with Spouse* (includes spousal surcharge)</td>
<td>$1,156</td>
</tr>
</tbody>
</table>

*Effective October 1, 2015, the spousal surcharge will be phased in over 3 years beginning with $25 per month the first year, $50 per month the second year, and $75 per month the third year. **Note:** The spousal surcharge will not apply to spouses who are independently eligible for PEEHIP.

### PEEHIP Supplemental Medical Plan

#### Active Member

<table>
<thead>
<tr>
<th></th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single or Family</td>
<td>$0</td>
</tr>
</tbody>
</table>

#### Member on LOA/COBRA

<table>
<thead>
<tr>
<th></th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single or Family</td>
<td>$164</td>
</tr>
</tbody>
</table>

### Tobacco Premium

**Active/Retired Member, LOA/COBRA, Surviving Dependent and Covered Spouses**

<table>
<thead>
<tr>
<th></th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>$50</td>
</tr>
<tr>
<td>Spouse</td>
<td>$50</td>
</tr>
</tbody>
</table>

The tobacco premium applies only to the PEEHIP Hospital Medical and VIVA Health plans. A premium discount can be obtained if the member and/or spouse each certify having not used tobacco products in the past 12 months. See page 38 to learn how you and/or your spouse can receive the non-tobacco user discount.
Wellness Premium
(Non-Medicare-Eligible) Active/Retired Member, LOA/COBRA, Surviving Dependent & Covered Spouses

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>$ 50</td>
</tr>
<tr>
<td>Spouse</td>
<td>$ 50</td>
</tr>
</tbody>
</table>

The wellness premium applies only to the Blue Cross Blue Shield Hospital Medical Group #14000 plan for non-Medicare-eligible active and retired members, non-Medicare-eligible members on LOA or COBRA, and non-Medicare-eligible spouses on active or retired contracts. See page 35 to learn how you and/or your spouse can receive a wellness premium waiver.

Optional Coverage Plan Premiums

<table>
<thead>
<tr>
<th>Coverage Column</th>
<th>Single or Family</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer, Indemnity, and Vision</td>
<td>Single or Family</td>
<td>$ 38</td>
</tr>
<tr>
<td>Dental</td>
<td>Single</td>
<td>$ 38</td>
</tr>
<tr>
<td>Dental</td>
<td>Family</td>
<td>$ 50</td>
</tr>
</tbody>
</table>
ALL Kids Children’s Health Insurance Program (CHIP)

(Active Members)

The Federal Health Care Reform legislation allows public education employees to participate in the ALL Kids CHIP program administered by the Alabama Department of Public Health (ADPH).

Members must re-apply for ALL Kids each year to continue to receive coverage.

Children may be eligible if they are:
- An Alabama resident,
- Under age 19,
- A U.S. Citizen or an eligible immigrant,
- Not covered or eligible for Medicaid,
- Not a resident in an institution,
- Not covered by other group health insurance for 30 days, and
- Within the income ranges established for participation (see income guidelines)

How to apply:
- Complete an application online at www.adph.org or download a paper application from the ADPH website. You can also call 888.373.KIDS (5437) to have an application mailed to you.
- ALL Kids will determine eligibility for your children and will let you know if:
  ◊ your child is eligible and is being enrolled in ALL Kids,
  ◊ your child is under income and your application is being forwarded to Medicaid, or
  ◊ your child is over income and not otherwise eligible.

<table>
<thead>
<tr>
<th>Monthly Gross Income Guidelines for Medicaid and ALL Kids</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children Under 19 Years</strong></td>
</tr>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

Becoming eligible for ALL Kids is not a Qualifying Life Event to drop children from PEEHIP coverage outside of Open Enrollment. If you wish to enroll your eligible children in ALL Kids, you will need to cancel their PEEHIP coverage during Open Enrollment and apply for ALL Kids for an October 1 effective date.

For more information about ALL Kids, go to www.adph.org or call 888.373.KIDS (5437).
Federal Poverty Level Assistance Program (FPL)

*(Active and Retired Members)*

PEEHIP provides assistance to PEEHIP members with a total combined family income of less than or equal to 300% of the Federal Poverty Level (FPL), as defined by federal law, by giving a discount on hospital/medical premiums. To qualify for the FPL premium discount, PEEHIP members must submit the Federal Poverty Level Assistance Application and furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Active and retired employees may apply and the FPL premium discount will be effective the first day of the second month after the receipt and approval of the application. Certification of income level will be effective for the current plan year only. The premium reduction does not renew each year.

**Members are required to submit a new application annually during Open Enrollment.**

The premium discount will apply only to the PEEHIP Hospital Medical premium or VIVA Health Plan premium and only applies to active and retired members. The premium discount does not apply to the Tobacco Premium or the Wellness Premium for those who are subject to these premiums. The FPL premium discount is not available to members who are on a Leave of Absence, COBRA, or surviving dependent contract. The FPL application can be received and/or postmarked after the close of Open Enrollment (September 1), but the premium reduction will not be effective until the first day of the second month after receipt and approval of the application.

**Federal Poverty Level Premium Discount**

<table>
<thead>
<tr>
<th>Over 300% of the FPL</th>
<th>member pays 100% of the member contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>equal to or less than 300% but more than 250% of the FPL</td>
<td>member contribution reduced 10% Member pays 90%</td>
</tr>
<tr>
<td>equal to or less than 250% but more than 200% of the FPL</td>
<td>member contribution reduced 20% Member pays 80%</td>
</tr>
<tr>
<td>equal to or less than 200% but more than 150% of the FPL</td>
<td>member contribution reduced 30% Member pays 70%</td>
</tr>
<tr>
<td>equal to or less than 150% but more than 100% of the FPL</td>
<td>member contribution reduced 40% Member pays 60%</td>
</tr>
<tr>
<td>equal to or less than 100% of the FPL</td>
<td>member contribution reduced 50% Member pays 50%</td>
</tr>
</tbody>
</table>

**2015 Federal Poverty Levels (FPL)**

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100% of FPL</th>
<th>150% of FPL</th>
<th>200% of FPL</th>
<th>250% of FPL</th>
<th>300% of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 member</td>
<td>$11,770</td>
<td>$17,655</td>
<td>$23,540</td>
<td>$29,425</td>
<td>$35,310</td>
</tr>
<tr>
<td>2 members</td>
<td>$15,930</td>
<td>$23,895</td>
<td>$31,860</td>
<td>$39,825</td>
<td>$47,790</td>
</tr>
<tr>
<td>3 members</td>
<td>$20,090</td>
<td>$30,135</td>
<td>$40,180</td>
<td>$50,225</td>
<td>$60,270</td>
</tr>
<tr>
<td>4 members</td>
<td>$24,250</td>
<td>$36,375</td>
<td>$48,500</td>
<td>$60,625</td>
<td>$72,750</td>
</tr>
<tr>
<td>5 members</td>
<td>$28,410</td>
<td>$42,615</td>
<td>$56,820</td>
<td>$71,025</td>
<td>$85,230</td>
</tr>
<tr>
<td>6 members</td>
<td>$32,570</td>
<td>$48,855</td>
<td>$65,140</td>
<td>$81,425</td>
<td>$97,710</td>
</tr>
<tr>
<td>7 members</td>
<td>$36,730</td>
<td>$55,095</td>
<td>$73,460</td>
<td>$91,825</td>
<td>$110,190</td>
</tr>
<tr>
<td>8 members</td>
<td>$40,890</td>
<td>$61,335</td>
<td>$81,780</td>
<td>$102,225</td>
<td>$122,670</td>
</tr>
</tbody>
</table>

The FPL application can be downloaded from the PEEHIP website at [www.rsa-al.gov](http://www.rsa-al.gov). If you do not have access to the Internet, the application is also included at the back of this handbook. Members are not able to apply for the FPL discount online through MOS.
Flexible Spending Accounts (FSA)  
(Active Members Only)  

PEEHIP Flexible Spending Accounts are administered by Blue Cross Blue Shield of Alabama and are available to all actively employed members of PEEHIP. Participation in a Flexible Spending Account allows members to save tax dollars on money that they will spend on copays, deductibles and other covered services each plan year.

The PEEHIP Flexible Spending Accounts consist of the following three programs:

1. **Premium Conversion Plan** requires all active members to pay premiums for PEEHIP using pre-tax dollars. This plan is strictly a function of the payroll system in which the member does not have to pay federal and state of Alabama income taxes on their health insurance premium.

2. **Dependent Care Flexible Spending Account (DCA)** allows active members to set aside up to a maximum of $5,000 in pre-tax contributions each year to pay for dependent day care expenses so the member (and spouse, if married) can work outside of the home or attend school full time. If the member and spouse file separate tax returns, the maximum contribution amount for each is $2,500. The minimum annual election to participate in this plan is $120.

3. **Health Care Flexible Spending Account (Health FSA)** allows active members to set aside up to a maximum of **$2,550** of pre-tax contributions each year to pay themselves back for eligible health care expenses incurred by them and their dependents. The minimum annual election to participate in this plan is $120.

Listed below are some of the eligible expenses that can be paid from your Flexible Benefits Accounts for you and your dependents as defined by IRS Section 152:

**Dependent Care Flexible Spending Account:**
- Licensed nursery school and day care facilities for children
- Child care in or outside the home
- Day care for elderly or disabled dependents

**Health Care Flexible Spending Account:**
- Physician office copayments
- Prescription drug copayments
- Dental copayments
- Orthodontia
- Deductibles
- Vision care including Lasik and Prelex surgery
- Hearing care
- OTC medications (only with a prescription)


**Flex Enrollment and Cancellation**

The Open Enrollment period for the Flexible Spending Accounts begins July 1 and extends through September 30. Accounts become effective at the start of the plan year, October 1. **Participation in the PEEHIP Flexible Spending Accounts program does not automatically renew each year.** Members currently enrolled in the PEEHIP Flexible Spending Accounts must re-enroll every year to continue participation. Members can enroll online at [https://mso.rsa-al.gov](https://mso.rsa-al.gov) or complete a **Flexible Spending Account Enrollment Application**.

New employees are allowed to enroll in the Flexible Spending Accounts within 30 days of their date of hire. Members who are currently enrolled in a Flexible Spending Account through their employer are allowed to enroll in the PEEHIP Flexible Spending Accounts at the end of their employer’s plan year.

All Flexible Spending Accounts cancel at the end of the plan year, September 30. If the member terminates employment or retires before the end of the plan year, the Flexible Spending Account will cancel the first day of the following month or when the member has exhausted their employer paid insurance contributions. Any unused funds will remain in the account and will be forfeited by the member. Early cancellation or change in the elected amount before the end of the plan year is only permitted when a member has experienced a Qualifying Life Event (QLE). A **Flexible Spending Account Status Change form** must be submitted within 45 days of the date of the QLE.
**Elected Amount and Reimbursement**
The member can only be reimbursed for eligible expenses outlined in the plan. Refunds are not permitted. Funds assigned to one account cannot be transferred to the other account under any circumstances. Therefore, members should carefully plan the annual amount they elect to contribute to each Flexible Spending Account. A Tax Savings Calculator is available at [www.rsa-al.gov](http://www.rsa-al.gov) and [www.bcbsal.org/peehip/preferredblue](http://www.bcbsal.org/peehip/preferredblue) to assist in determining the contribution amount. The annual contribution amount selected is divided equally based on the number of remaining months in the plan year to determine the monthly contribution amount.

**Traditional Bump Reimbursement:** This method is available only for the Health FSA. The Health FSA is linked to the member’s PEEHIP hospital/medical or optional dental plan. When the member pays eligible expenses not covered by their insurance, the funds are automatically reimbursed to the member.

**Manual Reimbursement:** This method is available for the DCA and Health FSA. The member must submit a Request for Reimbursement form along with an itemized receipt indicating the charges that were incurred. To be reimbursed from the DCA, the member must submit a Request for Reimbursement form with a copy of the receipt for expenses indicating the dates of service. Funds for reimbursement from the DCA become available only after contributions have been withheld from the member’s paycheck. Health FSA funds are available for reimbursement up to the annual amount elected as of the first effective day of the plan. If a member is covered by another insurance company who pays primary benefits, the member must submit a copy of the Explanation of Benefits showing what the other carrier paid.

**Effective October 1, 2015, the Flex Debit Card will no longer be available as a reimbursement method option under the PEEHIP Health Flexible Spending Account. Members will continue to have the automatic bump and the manual reimbursement method options.**

**Timely Filing Period Deadline/Funds Roll-Over**
The Flexible Spending Account plan year ends September 30. Members have until January 15 to submit a Request for Reimbursement form along with receipts for eligible expenses that occurred during the plan year (October through September). No reimbursement will be allowed for funds remaining in the DCA after the deadline of January 15. Remaining funds will be forfeited.

$500 Carryover Provision (Applicable to Health FSA Only)
PEEHIP allows members up to $500 of unused funds remaining in a Health FSA at the end of the plan year to be carried over and used for eligible Health FSA expenses in the following plan year. The carry over funds do not affect the annual maximum contribution amount nor is it cumulative. The carry over provision will apply to all plan participants that are in active employed status at the beginning of the following plan year. This provision is in accordance with guidelines set by The Department of Treasury Notice 2013-7 issued by the Internal Revenue Service on October 31, 2013. Any funds remaining in the Health FSA, after all claims received by Blue Cross Blue Shield, in excess of $500 at the end of the plan year will be forfeited.

**Retired Members**
Retired members are not eligible to participate in the Flexible Spending Accounts due to the fact that their premiums are not pre-taxed.
Leave of Absence (LOA) & Family Medical Leave Act (FMLA)

Leave of Absence (LOA)
The beginning date of the leave of absence should be the date any accrued leave is exhausted (sick leave, donated leave, annual leave or personal days).

The employer must enter the leave of absence status and beginning date in the Employer Portal when an employee is granted an official leave of absence. Upon return to work, employees who paid for their insurance while on an authorized leave of absence cannot pick up new insurance coverage that they did not have while on leave. (See Exception)

Employees who do not pay for their insurance while on an official leave of absence or have a break in coverage can enroll as new employees within 30 days and choose the effective date of the day they return to work, the first day of the month after they return to work, or can enroll during Open Enrollment for an October 1 effective date.

PEEHIP must receive an online enrollment request before the member can be enrolled.

Employees who continue insurance coverage while on leave must wait until the Open Enrollment period to make insurance changes for an October 1 effective date.

Exception: Employees enrolled in one or more Optional Plan while on leave of absence can add the remaining Optional Plans when he or she returns to work and becomes eligible for a full employer contribution. However, employees enrolled in one or more Optional Plan while on leave cannot enroll in a Hospital Medical Plan until Open Enrollment.

When the employee returns to work, the employer must update the Employer Portal and enter the hire status as the date the leave of absence terminated.

Family and Medical Leave Act (FMLA)
The Family and Medical Leave Act of 1993 requires employers to continue health benefits to employees taking FMLA Leave.

Eligibility
Employees are eligible for leave under FMLA if they have worked 1,250 hours over the prior 12 months and if they have worked for a covered employer for at least one year. (Although bus drivers are classified as full-time, normally they do not work 1,250 hours.)

Conditions
♦ Leave earned under FMLA is for a maximum of 12 weeks not 3 months.
♦ Employees must provide a 30-day notice for foreseeable leave. Leave under FMLA cannot be granted retroactively.
♦ Leave granted under FMLA cannot and should not be applied to the summer months for 9-month employees or during any time that the employee is not required to be at work. FMLA should begin when member is required to be at work.
♦ Employees on FMLA do accrue extra months of coverage while on leave under FMLA. Therefore, the 3-1 Rule does apply while an employee is on FMLA. If extra months of coverage are earned for the summer months, the months should be applied to the end of the 12 weeks that were granted under FMLA.
♦ An employee cannot earn extra months of coverage under FMLA if he or she is retiring or not returning to work unless the reason for not returning to work is a serious health condition or circumstance beyond the control of the employee.
♦ The school system will collect premiums while the employee is on leave under FMLA and should collect premiums for any extra months earned under the 3-1 Rule.
♦ Employers must enter the FMLA status and beginning date in the Employer Portal when an employee is granted FMLA.
♦ Employers must enter the new status and FMLA ending date in the Employer Portal when the FMLA benefit ends.
COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires PEEHIP and most other group health plans to offer employees and their families the opportunity for a temporary extension of health coverage. The continuation of coverage is offered at group rates in certain instances where coverage under PEEHIP would otherwise end.

All public education employees of the state of Alabama who are covered under the PEEHIP group health insurance have the right to choose continuation of coverage if the employee loses group health coverage due to a reduction in hours of employment or because of a resignation or termination of employment (for reasons other than gross misconduct on the part of the employee).

Each public education institution has the responsibility by law to notify the PEEHIP office immediately when an employee loses group health coverage due to the employee’s:

- Death,
- Termination of employment, or
- Reduction in hours.

COBRA also provides that you may have other health coverage alternatives for you and your family that may be available to you through the Health Insurance Marketplace at www.healthcare.gov or by calling 800.318.2596. You may be able to buy coverage through the Health Insurance Marketplace and could be eligible for a new kind of tax credit that lowers your monthly premiums right away. You can see what your premiums, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you will also learn if you qualify for free or low cost coverage through Medicaid or the CHIP.

Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

An individual who elects COBRA coverage will be eligible for Marketplace coverage during the annual Marketplace Open Enrollment, upon experiencing an event that creates another Marketplace special enrollment opportunity, such as marriage or the birth of a child, or upon exhausting COBRA coverage. In the absence of another special enrollment event, an individual who terminates COBRA coverage before the end of the maximum COBRA period will have to wait until Open Enrollment to enroll in Marketplace coverage. An individual who enrolls in Marketplace coverage relinquishes his or her COBRA rights.

COBRA Compliance and PEEHIP Notification

The sanctions imposed under the auspices of COBRA can be quite severe, making a determination of compliance greatly important. It is the employer’s responsibility to notify PEEHIP within a maximum of 30 days of an employee’s termination, death or reduction in hours. The employer must notify the PEEHIP office by entering a termination date in the employer portal before the next payroll cycle. Employers must key the termination date in the employer portal for each employee who loses insurance coverage due to termination or resignation of employment or reduction in hours or for an employee who does not earn the employer contribution, even if the employee does not want to continue the coverage.

Employers are subject to a penalty of $100 per day for every day that they are past the 30 day notification deadline. It is the employee’s or dependent’s responsibility to notify PEEHIP within a maximum of 60 days when the dependent needs continuation coverage under COBRA.

Termination for Gross Misconduct

If an employer terminates an employee for gross misconduct, PEEHIP is not required to provide continuation of coverage under the provisions of COBRA. However, the employer must still notify the PEEHIP office of the termination by entering the termination information via the employer portal.

COBRA Eligibility

Under COBRA, the employee, ex-spouse or dependent family member has the responsibility to inform PEEHIP within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan and must obtain a Continuation of Coverage application form. PEEHIP may be notified by phone or in writing.
**Authorized Leave of Absence**
A member who goes on an authorized leave of absence without pay can continue group health coverage for up to two years of authorized leave before he or she would be required to enroll in continuation of coverage under the COBRA provisions. A member on an approved leave of absence can continue the health insurance coverage for two years and then can continue the health insurance coverage for an additional 18 months under the COBRA provisions.

A dependent’s coverage ends on the last day of the month in which the dependent becomes ineligible by turning age 26 or by divorce, or legal separation.

When PEEHIP is notified of a qualifying event, PEEHIP will in turn notify the eligible member that he or she has the right to choose continuation of coverage. **It is important to note that the eligible member has 60 days from the date he or she would lose coverage because of one of the qualifying events to inform PEEHIP that he or she wants continuation of coverage.**

If the eligible member does not choose continuation of coverage, his or her PEEHIP group health insurance coverage will end the last day of the month in which the member becomes ineligible.

If a member and/or dependent become entitled to Medicare after electing COBRA coverage, he or she is no longer eligible to continue the COBRA coverage. However, dependents on the contract will be allowed to continue COBRA coverage up to a total of 36 months from the date of the original qualifying event.

**Continuation of Coverage**
If the eligible member chooses continuation of coverage, PEEHIP is required to give the member coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members and is the same coverage he or she had prior to the qualifying event.

COBRA requires that the eligible member be afforded the opportunity to maintain continuation of coverage for 18 months due to a termination of employment or reduction in hours. COBRA requires that eligible dependents who become eligible for COBRA for reasons such as aging out or divorce be afforded an opportunity to maintain coverage for 36 months.

COBRA members have the same rights such as adding a newborn child or a new spouse within 45 days of the date of birth or marriage as other employed or retired members.

COBRA also provides that a member’s continuation of coverage may be cut short for any of the following five reasons:
- PEEHIP no longer provides group health coverage to any of its employees.
- The premium for continuation of coverage is not paid by the member when payment is due, or the premium payment is insufficient.
- The member becomes covered under another group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition.
- The member or dependent becomes entitled to Medicare after COBRA benefits begin.
- The member becomes divorced from a covered employee and subsequently remarries and is covered under the new spouse’s group health plan, which does not contain any exclusions or limitations with respect to pre-existing conditions.

An eligible member does not have to show that he or she is insurable to choose continuation of coverage. However, under COBRA, he or she is required to pay the full COBRA monthly premium for continuation of coverage.

If a member who is on COBRA dies before the 18 months have lapsed and the member’s family is covered under COBRA, the eligible covered family members can continue the COBRA coverage up to a total of 36 months from the date of the original qualifying event.

**Dependent Coverage**
A spouse of an employee covered by PEEHIP has the right to choose continuation of coverage if the spouse loses group health coverage under the Plan for any of the following reasons:
- Death of the employee
- Termination of the employee’s employment (for reasons other than gross misconduct) or reduction in the employee’s hours of employment
- Divorce or legal separation
- Employee’s eligibility for Medicare
In the case of a dependent child of an employee covered by PEEHIP, he or she has the right to continuation of coverage if group health coverage under the Plan is lost for any of the following reasons:

♦ Death of a parent
♦ Termination of a parent’s employment (for reasons other than gross misconduct) or reduction in a parent’s hours of employment with the employer
♦ Parents’ divorce or legal separation
♦ Parent becomes eligible for Medicare
♦ Dependent ceases to be an eligible child under the Plan

Members on COBRA Who Return to Work
When a member who is enrolled in PEEHIP under COBRA returns to work and does not have a break in coverage, the member is not allowed to change coverage until the Open Enrollment period.

If a member chooses not to continue their insurance coverage under COBRA and has a break in coverage, the member must complete a new enrollment application when he or she is re-employed in public education.

Exception: Employees enrolled in one or more Optional Plans while on COBRA can add the remaining Optional Plans when he or she becomes eligible for a full employer contribution. However, employees enrolled in one or more Optional Plans while on COBRA cannot enroll in a Hospital Medical Plan until Open Enrollment.

COBRA Extension for Covered Members Who Have Become Disabled
In certain circumstances, COBRA can be extended for covered members who become disabled. If a covered member becomes disabled under Title 11 (OASDI) or Title XVI (SSI) of the Social Security Act during the first 60 days after the employee’s termination of employment or reduction in hours, the 18-month period may be extended to 29 months on the date the disabled individual becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverages, regardless of whether the disabled individual elects the 29-month period for him or herself.

In order for this disability extension to apply, you must notify the PEEHIP office of Social Security’s determination within 60 days after the date of the determination and before the expiration of the 18-month period. You must also notify PEEHIP within 30 days of any revocation of Social Security disability benefits.

The cost for COBRA coverage after the 18th month will be 150% of the full COBRA cost of coverage under the plan, assuming that the disabled individual 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 spouses 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. The 36-month period will run from the original date of the termination of employment or reduction in hours.
Health Insurance Policies for Retired Members

**Form 10 – Application for Retirement**
In order to file for retirement benefits, a member must complete a Form 10 - Application for Retirement. The law provides that an application for retirement must be filed with the Teachers’ Retirement System Board of Control no less than thirty (30) days or more than ninety (90) days before the first of the month in which retirement is to be effective.

The member must complete the PEEHIP Insurance Authorization section on the back of Form 10 to authorize health insurance coverage. However, this section cannot be used as a PEEHIP enrollment form.

If a member is enrolled in the PEEHIP Hospital Medical Plan and one or more Optional Plan, he or she cannot drop the Optional Plan(s) until the Open Enrollment period.

The insurance contribution for retired members will pay the premium for two of the Optional Plans without a payroll deduction for those retired members enrolled in only the optional plan(s). The member must indicate which optional plan(s) he or she wants to keep on his or her date of retirement.

**A Member Retiring from a Non-Participating System**
A member who retires from a non-participating system is eligible to enroll in the PEEHIP Hospital Medical Plan or the PEEHIP Supplemental Medical Plan on the date of retirement. If the member did not have a Hospital Medical Plan with his or her school system, or only had single coverage, he or she can only enroll in single coverage on the date of retirement and must wait until the Open Enrollment period to add family coverage. The school system must certify if the member had a Hospital Medical Plan and whether the plan was for single or family coverage.

**Vested Members Not Currently Enrolled**
A retiring employee who has had a break in his or her employment and retires outside of the Open Enrollment period (vested retiree) can only enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Plan and not the Optional Plans on his or her date of retirement.

A vested retiring employee can wait to enroll in the PEEHIP Hospital Medical Plan during Open Enrollment and can enroll in the Optional Plans for an effective date of October 1.

**A Member Retiring from a Participating System**
If a member retires from a participating system and was enrolled in the four Optional Plans on his or her date of retirement, the member can continue coverage under all four Optional Plans or may reduce coverage to two plans on his or her date of retirement. The member cannot reduce to three Optional Plans outside of Open Enrollment.

If a member has the PEEHIP Hospital Medical Plan and one or more Optional Plans, he or she cannot drop the Optional Plan(s) until the Open Enrollment period. Also, a member cannot add Optional Plans on the date of retirement. The insurance contribution will cover the full cost of two Optional Plans for retirees.

A member who is retiring from a participating system and is only enrolled in the Optional Plans on the date of retirement cannot add the Hospital Medical Plan until the Open Enrollment period.

**Example 1:**
Mr. Smith retired from Jefferson County school system on January 1. Mr. Smith was enrolled in the four individual Optional Plans on his date of retirement. Mr. Smith can drop two of the Optional Plans on January 1, or Mr. Smith can retain all four Optional Plans and pay $76.00 for the Optional Plans. Mr. Smith cannot add the PEEHIP Hospital Medical Plan nor is he allowed to drop only one Optional Plan until the Open Enrollment period.

**Example 2:**
Mrs. Scott retired from the University of Alabama (a non-participating system) on January 1. Mrs. Scott was enrolled in the Blue Cross and Blue Shield Health Insurance Plan with the University of Alabama. Therefore, Mrs. Scott can enroll in the PEEHIP plan on January 1. If Mrs. Scott was enrolled in the family Blue Cross and Blue Shield plan with the University of Alabama, Mrs. Scott could add her dependents. However, if Mrs. Scott only had the single Blue Cross plan, Mrs. Scott could not enroll her family in the PEEHIP plan until the Open Enrollment period.
Example 3:
Mr. Johnson was employed with Birmingham City and retired on March 1. Mr. Johnson was enrolled in the family Dental and family Hospital Medical Plan with Birmingham City. On his date of retirement, Mr. Johnson would be required to continue his Dental Plan until the Open Enrollment period. Mr. Johnson could drop his PEEHIP Hospital Medical Plan on his date of retirement or at any other time by notifying PEEHIP in writing and the change would be effective the first day of the month following the notification.

Example 4:
When Mrs. Sellers was age 55, she terminated her employment with Auburn University with 11 years of service. When she turned age 60, she began drawing a retirement check and became eligible for the PEEHIP Hospital Medical Plan. Mrs. Sellers is eligible to enroll in the PEEHIP Hospital Medical Plan or PEEHIP Supplemental Plan effective the date of her retirement or she could wait until the Open Enrollment period. Mrs. Sellers must wait until the Open Enrollment period to enroll in any of the PEEHIP Optional Plans.

A Medicare-Eligible Retiree
If a member or dependent is Medicare-eligible due to age or disability at the time of his or her retirement, Medicare will become the primary payer and PEEHIP the secondary payer effective on the member’s date of retirement. The PEEHIP Hospital Medical Plan will supplement the Medicare coverage.

It is extremely important for the Medicare-eligible member and/or dependent to have Medicare Part A and Part B to assure adequate coverage with PEEHIP. **In addition, the member should notify Medicare of his or her retirement date and request Medicare to change their records to reflect that Medicare should be the primary payer and PEEHIP the secondary payer effective on the member’s date of retirement.** Medicare-eligible members and dependents should not enroll in a separate Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. PEEHIP automatically enrolls all Medicare-eligible members and Medicare-eligible dependents in the Medicare GenerationRx Medicare Part D Employer Group Waiver Program (EGWP) offered by PEEHIP unless already enrolled in a separate Medicare Part D plan or they choose not to participate/opt out.

A Retired Member with a Medicare-Eligible Dependent
If the retired member is carrying family coverage and has a Medicare-eligible dependent, Medicare will become the primary payer for the dependent and PEEHIP will be the secondary payer at the time of retirement. The member must notify Medicare and PEEHIP. The dependent must have Medicare Part A and Part B effective on the member’s date of retirement. Medicare-eligible members and dependents should not enroll in a separate Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. PEEHIP automatically enrolls all Medicare-eligible members and covered Medicare-eligible dependents in the PEEHIP Medicare GenerationRx Medicare Part D program unless already enrolled in a Medicare Part D plan or they choose not to participate/opt out.

Non-Medicare-Eligible Dependents
The Medicare-eligible retiree’s spouse or other covered dependents who are not Medicare eligible will remain in the PEEHIP (non-Medicare) prescription drug plan. For more detailed information about the EGWP, refer to the Retirees with Medicare handbook.

Insurance Coverage Periods and System Contributions
Retiring members are eligible to receive the extra coverage months under the 3-1 Rule.

Examples:
♦ A June 1 retiree who works 9 months during the school year may receive coverage through August 31.
♦ A July 1 retiree who works the entire school year may receive coverage through September 30.

The school system will continue to provide the appropriate insurance contribution earned under the 3-1 Rule. **However, the member must have Medicare Part A and Medicare Part B effective the date of retirement.** The PEEHIP office assumes that the system will not pay the September contribution for the June 1 retirees.
PEEHIP Medicare Plus

*(Medicare-Eligible Retirees)*

This plan is a supplement to hospital and medical benefits provided under Medicare Parts A and B and is available to Medicare-eligible retirees. This coverage is similar in nature to C-Plus and other Medicare supplemental insurance plans. It provides hospital and non-hospital benefits as outlined below. This plan does not provide benefits for custodial care such as help in walking, eating, bathing and dressing.

**Members must have Medicare Part A and Part B, and Medicare must be your primary payer for claims.** Medicare-eligible members and covered Medicare-eligible dependents should not enroll in a separate Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. Beginning January 1, 2013, all Medicare-eligible retired members and Medicare-eligible dependents on a retired contract who are enrolled in the PEEHIP Hospital Medical plan are moved into the Medicare GenerationRx Medicare Part D Employer Group Waiver Program (EGWP) offered by PEEHIP unless they are already enrolled in a separate Medicare Part D plan or they choose not to participate/opt out.

♦ There are no pharmacy benefits for retired Medicare members and covered Medicare-eligible spouses if the retired member or spouse is enrolled in a separate Medicare Part D drug plan.

### PEEHIP Hospital Benefits *(Administered by Blue Cross and Blue Shield of Alabama)*

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medicare Pays</th>
<th>PEEHIP Pays</th>
<th>Retiree Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Charges</td>
<td>All but the Part A deductible per admission. All but applicable coinsurance after 60 days.</td>
<td>All but $200 copay per admission. Applicable coinsurance after 60 days.</td>
<td>A $200 copay, $25 per day copay for days 2-5, (maximum $300 copay), and any personal charges (such as private room, telephone, TV, etc.).</td>
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### PEEHIP Non-Hospital Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medicare Pays</th>
<th>PEEHIP Pays</th>
<th>Retiree Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital Charges</td>
<td>80% of Medicare’s approved amount after the Medicare Part B deductible.</td>
<td>20% of Medicare’s approved amount after the member meets Medicare Part B deductible and the $30 copay for physician visit.</td>
<td>The Part B deductible, a $30 copay for physician visits, any charges not covered by Medicare or PEEHIP, and charges above the Medicare allowed amount when using unassigned providers.</td>
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### Excluded Services

♦ Coverage is not provided for nursing home costs, charges in excess of Medicare allowed charges, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids, and experimental procedures.

♦ Medicare Part B covered medications are excluded from primary coverage under the PEEHIP prescription drug benefit but will be covered under the Medicare Part B benefit. PEEHIP will pay secondary to Medicare.

♦ **Certain prescription drugs may be excluded to drive utilization to lower cost therapeutic alternative drugs.**

♦ **Effective August 1, 2015, bulk chemical powders will no longer be covered under PEEHIP for Medicare-eligible retirees and covered dependents.**

♦ Over the counter (OTC), OTC equivalent drugs and medical foods are not covered even if prescribed by a physician unless mandated by the Affordable Care Act.
Pharmacy Program (Administered by MedImpact)
♦ Participating Pharmacy - When using a Participating Pharmacy you pay the following:
  ◊ $6 for any covered generic prescription drug (30-day supply)
  ◊ $40 for any covered preferred brand drug (The preferred brand drug list can be found on the PEEHIP Medicare GenerationRx website at www.medicaregenerationrx.com/peehip.) (30-day supply)
  ◊ $60 for any covered non-preferred brand drug (30-day supply)Approved maintenance drugs can be purchased up to a 90-day supply for one copayment of $12 for generic, $80 for preferred and $120 for non-preferred. The drug must be on the approved maintenance list and must be prescribed as a maintenance drug. First fill for a maintenance drug will be a 30-day supply.
♦ Refills on Retail and Specialty medications (30-day supply) are allowed only after 75% of the previous prescription has been used (for example, 23 days into a 30-day supply). For maintenance medications (90-day supply), refills are allowed only after 75% of the previous prescription has been used (for example, 67 days into a 90-day supply).
♦ Pharmacists must dispense generic drugs unless physician indicates in longhand “Do not substitute.”
♦ Participating pharmacies will file all claims electronically for you. Most major pharmacy chains in-state and out-of-state participate with the PEEHIP MedImpact prescription drug plan.
♦ The PEEHIP prescription drug plan includes Step Therapy, Prior Authorization, and Quantity Level Limitations for certain medications.

Medicare Part D Prescription Drug Coverage
Medicare-eligible retirees and Medicare-eligible dependents covered under PEEHIP are automatically enrolled in the Medicare GenerationRx Part D Prescription Drug Program (Employer PDP) offered by PEEHIP. This change did not affect PEEHIP active members, non-Medicare-eligible members, or members already enrolled in another Medicare Part D plan. Medicare GenerationRx is a Medicare approved Part D plan and is sponsored by Stonebridge Life Insurance Company.

Non-Participating Pharmacy
♦ Coverage at a non-participating pharmacy in or outside Alabama: If you use a non-participating pharmacy, you will pay the full amount of the prescription. Then you can submit a claim form to MedImpact to be reimbursed at the Participating Pharmacy rate. All PEEHIP copays and clinical utilization management programs will apply. Your out-of-pocket expenses will be higher if you use a non-participating pharmacy.

Out-of-State Coverage
♦ When you receive medical treatment outside Alabama, Medicare of that state is responsible for the payment of the claim. When you receive the Explanation of Medicare Benefits statement from that state, you must send Blue Cross a copy of the statement attached to a completed claim form in order for Blue Cross to consider the charges for payment. Always list your identification number on the claim form. Claim forms can be found on the PEEHIP website at www.rsa-al.gov.

Out-of-Country Coverage
♦ If you receive medical treatment outside the United States, Medicare may not make payment. In this situation, if the services are medically necessary, PEEHIP will pay primary under the major medical benefits. All PEEHIP deductible and coinsurance amounts and contract limitations will apply. The claims must be stated in U.S. dollars and filed with Blue Cross of Alabama.

Non-Participating Hospitals and Outpatient Facilities
♦ Currently there are no non-participating inpatient or outpatient facilities in Alabama. However, when choosing a hospital or outpatient facility located outside Alabama, you may want to consider checking with the facility first to determine if they are Blue Cross and Blue Shield participating providers. With your health plan benefits, you have the freedom to choose your health care provider.
♦ To maximize your coverage and minimize your out-of-pocket expenses, you should always use network providers for services covered by your health plan. Your out-of-pocket expenses will be significantly higher in a non-participating hospital or facility. When you choose a network provider, you don’t have to worry about extra out-of-pocket expenses.

This is Only a Summary of Benefits
Members should refer to the Summary Plan Description for detailed information and limitations.
Retiree Other Employer Group Health Insurance Coverage
Legislation requires certain members who retired after September 30, 2005, to take other employer health insurance. PEEHIP members who (1) retired after September 30, 2005, (2) become employed by another employer and (3) the other employer provides at least 50% of the cost of single health insurance coverage, and (4) are eligible to receive the other employer group health insurance coverage, must use the other employer’s health benefit plan for primary coverage.

PEEHIP retirees must drop the PEEHIP coverage as their primary coverage and enroll in the new health plan through their new employer. The retiree may enroll in the PEEHIP Supplemental Medical Plan within 30 days of eligibility for other group health insurance coverage. Failure by a retiree to enroll in the other employer’s group health plan under the terms of the Act will result in the termination of coverage in PEEHIP.

PEEHIP requires all retired members to complete a Retiree Employment Verification form.
Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it with your other important documents. This notice has information about your current prescription drug coverage with PEEHIP and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a standard Medicare drug plan or keep your PEEHIP drug coverage.

The PEEHIP prescription drug benefit for Medicare retirees and Medicare covered dependents is an Employer Group Waiver Plan (EGWP), which is PEEHIP’s Medicare Prescription Part D Drug Plan called Medicare GenerationRx. All PEEHIP covered Medicare-eligible retirees and Medicare covered dependents are automatically enrolled in Medicare GenerationRx unless you are enrolled in another Part D plan or choose to opt-out. If you opt-out of this plan, you will have no prescription coverage from PEEHIP.

If you are considering joining a standard Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. However, if you choose to enroll in a standard Medicare Part D drug plan, you will lose the PEEHIP prescription drug coverage.

There are two important things you need to know about your current coverage and Medicare’s standard prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a standard Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All standard Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. PEEHIP has determined that the prescription drug coverage offered by the PEEHIP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing PEEHIP coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a standard Medicare drug plan.

Medicare Drug Plan Enrollment Period
You can join a standard Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. If you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a standard Medicare drug plan.

Standard Medicare Drug Plan and PEEHIP Drug Plan
If you decide to join a standard Medicare drug plan and drop your PEEHIP drug plan, your current PEEHIP drug coverage will terminate on the date that you enroll in a standard Medicare drug plan. Please be aware that you will lose the PEEHIP drug coverage and will not be able to get this coverage back until you drop the other standard Medicare Part D coverage. You cannot have PEEHIP prescription drug coverage and a standard Part D coverage plan at the same time. If you enroll in a standard Medicare drug plan, you will still be eligible for your current PEEHIP health benefits but will have no prescription drug coverage under PEEHIP.

Medicare Drug Plan Penalty when Joining Outside of the Enrollment Period
You should also know that if you drop or lose your current coverage with PEEHIP and do not join a standard Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

Example: If you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.
For More Information About Options Under Medicare Prescription Drug Coverage

More detailed information about standard Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by standard Medicare drug plans.

For more information about standard Medicare prescription drug coverage:
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 800-Medicar (800.633.4227). TTY users should call 877.486.2048.

An exception may apply to certain “low-income” individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and standard Part D (two separate steps). For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 800.772.1213 (TTY 800.325.0778).

For More Information About This Notice Or Current Prescription Drug Coverage

Contact the PEEHIP office at 877.517.0020 for further information. You will receive this notice each year and you may request a copy of this notice at any time.

Keep this important notice because if you decide to join one of the standard Medicare drug plans, you may be required to provide a copy of this notice to show whether or not you have maintained creditable coverage.

<table>
<thead>
<tr>
<th>Medicare Part D Prescription Drug Benefit Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TelephoneNumber</strong></td>
</tr>
<tr>
<td>Medicare 800-MEDICAR; 800.633.4227</td>
</tr>
<tr>
<td>Social Security Administration 800.772.1213</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare <a href="http://www.medicare.gov">www.medicare.gov</a></td>
<td>Provides access to information about Medicare and Medicare health plans.</td>
</tr>
<tr>
<td>Social Security Administration <a href="http://www.ssa.gov">www.ssa.gov</a></td>
<td>Link to the Social Security Administration’s site for information on low-income subsidies and other resources.</td>
</tr>
<tr>
<td>AARP <a href="http://www.aarp.com/bulletin">www.aarp.com/bulletin</a></td>
<td>Access the Medicare Benefit Drug Calculator, which illustrates what the Medicare drug benefit means to you.</td>
</tr>
<tr>
<td>Aging Parents and Elder Care <a href="http://www.todaysseniors.com">www.todaysseniors.com</a></td>
<td>Senior Solutions is an independent organization providing information on issues to help seniors get the most out of retirement.</td>
</tr>
<tr>
<td>Benefits Check Up <a href="https://benefitscheckup.org">https://benefitscheckup.org</a></td>
<td>A service of the National Council on Aging; helps find programs for people ages 55 and over that may pay some costs of prescription drugs, health care, utilities, and other essential items or services.</td>
</tr>
<tr>
<td>Destination Rx <a href="http://www.destinationrx.com">www.destinationrx.com</a></td>
<td>Provides a pharmacy discount buying service.</td>
</tr>
<tr>
<td>Medicare Rights Center <a href="http://www.medicarerights.org">www.medicarerights.org</a></td>
<td>Medicare Rights Center (MRC) is the largest independent U.S. source of health information and assistance for people with Medicare.</td>
</tr>
<tr>
<td>Needymeds.com <a href="http://www.needymeds.com">www.needymeds.com</a></td>
<td>Find information on patient assistance programs that provide no cost prescription medications to eligible participants.</td>
</tr>
<tr>
<td>Rxaminer.com <a href="http://www.rxaminer.com">www.rxaminer.com</a></td>
<td>Use this prescription drug comparison tool to find lower-cost prescription drugs.</td>
</tr>
<tr>
<td>Together Rx <a href="http://www.togetherrx.com">www.togetherrx.com</a></td>
<td>Offers a prescription drug savings program.</td>
</tr>
</tbody>
</table>
### Premium Rates

*(Retired Members)*

The following health insurance premiums are the base rates set by the PEEHIP Board. Base rates are before the wellness premiums, tobacco premiums, and the retiree sliding scale adjustments are applied, if applicable. The monthly premiums for members who retired prior to October 1, 2005, or members who retired on or after October 1, 2005, and before January 1, 2012, with 25 years of service are listed in the chart below and show a retiree’s out-of-pocket cost after subtracting the retiree insurance contribution.

<table>
<thead>
<tr>
<th>Type of Contract</th>
<th>*Retiree Monthly Out-of-Pocket Premium</th>
<th>Family Premium with Covered Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Coverage/Non-Medicare-eligible Retired Member</td>
<td>$151</td>
<td>N/A</td>
</tr>
<tr>
<td>Family Coverage/Non-Medicare-eligible Retired Member and Non-Medicare-eligible Dependent(s)</td>
<td>$391</td>
<td>$416</td>
</tr>
<tr>
<td>Family Coverage/Non-Medicare-eligible Retired Member and Only Dependent Medicare-eligible</td>
<td>$250</td>
<td>$260</td>
</tr>
<tr>
<td>Individual Coverage/Medicare-eligible Retired Member</td>
<td>$10</td>
<td>N/A</td>
</tr>
<tr>
<td>Family Coverage/Medicare-eligible Retired Member and Non-Medicare-eligible Dependent(s)</td>
<td>$250</td>
<td>$275</td>
</tr>
<tr>
<td>Family Coverage/Medicare-eligible Retired Member and Only Dependent Medicare-eligible</td>
<td>$109</td>
<td>$119</td>
</tr>
</tbody>
</table>

*This rate applies to the PEEHIP Hospital Medical or the VIVA Health Plan and is the monthly amount that will be deducted from a retiree’s check. The VIVA Health Plan is not available to retired members who are Medicare-eligible or retired members with dependents who are Medicare-eligible.

### Retiree Sliding Scale Premium

The premium for retiree coverage is broken down into the employer share (what PEEHIP pays) and the retiree share. Under the sliding scale, the retiree is still responsible for the retiree share; however, the employer share will increase or decrease based upon a retiree’s years of service. The sliding scale premium rates can be found on the PEEHIP website at [www.rsa-al.gov](http://www.rsa-al.gov). A retiree premium calculator is available for your review on our website at [http://www.rsa-al.gov/index.php/members/peehip/calculators/peehip-premium-calculator](http://www.rsa-al.gov/index.php/members/peehip/calculators/peehip-premium-calculator).

- **Members who retired before October 1, 2005** are not affected by the Retiree Sliding Scale Premium.
- **Members who retired on or after October 1, 2005**: are subject to the Retiree Sliding Scale premium based on years of service. Members who retire on disability and are also eligible for service retirement are subject to the sliding scale.
- **Members who retired on or after October 1, 2005, with 25 years of service**, PEEHIP will pay 100% of the employer share of the premium. The member will only be responsible for the employee share of the premium.
- **Members who retired on or after October 1, 2005, with more than 25 years of service**, for each year of service above 25, the employer (PEEHIP) share increases by 2% and the retiree share is reduced accordingly.
- **Members who retired prior to January 1, 2012 with less than 25 years of service**, the PEEHIP share of the premium is reduced by 2% of the cost for each year less than 25 and the retiree share is increased accordingly.
- **Members who retired on disability prior to January 1, 2012**, are not affected by the sliding scale premiums for twenty-four (24) months from the member’s date of retirement, provided the member submits to PEEHIP proof of application for Social Security Disability benefits. The exemption from the sliding scale premium can be extended beyond twenty-four (24) months from the member’s date of retirement if the member qualifies for Social Security Disability benefits during the twenty-four (24) months following the member’s date of retirement and proof of the Social Security Disability is provided to PEEHIP. For those qualifying, the premium adjustment will be made effective the first day of the second month following receipt of the Social Security notification by PEEHIP. It is important to send in your proof of application for Social Security disability and subsequent approval for Social Security disability as soon as you receive it in order to receive a premium reduction.
- **Members who retired on disability on or after January 1, 2012**, are subject to the age and subsidy component prior to becoming Medicare eligible even if they are not affected by the years of service component.
- **Members who retired on or after January 1, 2012**, are subject to the sliding scale premiums which are based on age at retirement, years of service, and the cost of the insurance program. See pages 57-58.

### Optional Coverage Plan Premium

Optional Coverage Plan premiums are the same for retirees as for full-time active employees.
Retiree Sliding Scale Legislation Effective January 1, 2012

On June 14, 2011, Senate Bill 319 (Act 2011-704) was signed into law. The law was enacted primarily to address the inequity in the funding of health care benefits for non-Medicare retirees.

The law changed the retiree sliding scale premium calculation so that by 2016 the funding level for active and non-Medicare would be equal; thereby removing the inequity in funding that currently exists for non-Medicare retirees.

The major provisions of Act 2011-704 are summarized below. A retiree premium calculator is available for your review on the PEEHIP website at www.rsa-al.gov.

Changes to the Retiree Sliding Scale Premium Calculation
It is important to note that the changes in the retiree sliding scale premium calculation due to Act 2011-704 only apply to those who retired on or after January 1, 2012.

The law has the greatest effect on employees who retire with minimal years of service (for example, someone with 10 years of service at age 60). The effect on employees who retire with 25 or more years of service is less dramatic.

A retiree’s cost of coverage is equal to the employer’s contribution (state funding amount) plus the employee’s contribution (premium). Under the sliding scale premium calculation, the employer contribution is adjusted up or down by a percentage based on years of service. If the employer contribution is reduced then the employee contribution (premium) will be increased and vice versa.

Under the law there are three major changes to the retiree sliding scale premium. These changes are related to a retiree’s years of service (Service Premium Component), age at the time of retirement (Age Component), and subsidy premium (Subsidy Component).

1. Change in the Service Premium Component:
   ✦ Employees who retired before January 1, 2012 - the amount the state contributes to the cost of retiree health care (employer contribution) is decreased by 2% for each year of service less than 25 and increased by 2% for each year of service more than 25.
   ✦ Employees who retired on or after January 1, 2012 (regardless of age) - the amount the state contributes to the cost of retiree health care (employer contribution) is decreased by 4% for each year of service under 25 years and increased by 2% for each year of service more than 25 (Service Premium Component).
   ✦ Employees who retired on or after January 1, 2012 – will see no change in the service component of the sliding scale premium and will continue to receive a 2% bonus for each year of service over 25 years.

   Example:
   If you retire with 10 years of service, you are 15 years away from having 25 years of service and the employer contribution will be reduced by 60% (15 years x 4%). The employee contribution (or premium) will increase by an amount equal to 60% of the employer contribution.

2. Addition of an Age Premium Component:
   ✦ Employees who retired before January 1, 2012 - there is no age component that is taken into account in the sliding scale premium.
   ✦ Employees who retired on or after January 1, 2012 - state contribution for the sliding scale premium will be reduced by 1% for each year of age of the employee at retirement less than the Medicare entitlement age (age component). Upon Medicare entitlement, the age component will be removed.

   This component applies only to employees who retired without Medicare on or after January 1, 2012. These retirees will have 1% deducted from the employer contribution for each year that they are not entitled to Medicare. Age at retirement is what is used to calculate the age premium component.

3. Addition of a Subsidy Premium Component:
   ✦ Employees who retired before January 1, 2012 - subsidy component is not applicable.
   ✦ Employees who retired on or after January 1, 2012 - a subsidy premium is applicable. The subsidy premium is the net difference in the active employee's subsidy and the non-Medicare retiree subsidy. For Fiscal Year 2016, the subsidy component is $147.52. Upon Medicare entitlement, the subsidy will be removed.

Note: The total of the additional service premium, age premium, and subsidy premium resulting from the new law will be phased-in over a 5-year period until 2016. Upon becoming Medicare-eligible, the age and subsidy premium components are no longer applicable.
**Act 2011-704 and DROP**

The sliding scale premium does not apply to employees who were participating in the Deferred Retirement Option Plan (DROP) at the time the law was passed unless the DROP participant:

1. Voluntarily terminates participation in the DROP within the first three years, or
2. Does not withdraw from service at the end of the DROP participation period.

This will exempt employees who entered the DROP from being subject to the new legislation if they fulfill their DROP obligation and withdraw from service at the end of the DROP participation period.
Retired employees are not affected by the TEFRA amendment to the Age Discrimination in Employment Act; therefore, upon retirement and Medicare eligibility the member’s coverage under PEEHIP will complement his or her Medicare coverage. Medicare will be the primary payer and PEEHIP will be the secondary payer for retirees and dependents eligible for Medicare. Medicare approved admissions will not be subject to the Preadmission Certification requirements.

PEEHIP remains primary for retirees until the retiree is Medicare eligible. A Medicare-eligible retiree and/or Medicare-eligible spouse must have both Medicare Part A and Part B to have adequate coverage with PEEHIP. Medicare-eligible members and dependents should not enroll in a separate Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage. Beginning January 1, 2013, PEEHIP automatically enrolls all Medicare-eligible members and Medicare-eligible dependents in the Medicare GenerationRx Medicare Part D Employer Group Waiver Program (EGWP) offered by PEEHIP unless already enrolled in a separate Medicare Part D plan or they choose not to participate/opt out.

After Medicare pays 80% of the approved amount after the Part B deductible, PEEHIP will pay the remainder of the Medicare approved amount without a Major Medical deductible (subject to a $30 copay on office visits, emergency room visits and outpatient consultations) on PEEHIP approved services. In rare situations some services are covered by Medicare and are not by PEEHIP. In the rare situation that a service is not covered by Medicare but is covered by PEEHIP, PEEHIP will be primary and all PEEHIP deductible and copayment amounts will apply as will all PEEHIP precertification requirements.

Note: If a member or dependent is under age 65 and eligible for Medicare coverage due to a disability, the PEEHIP office must receive a copy of the Medicare card before the premiums can be reduced. Refunds will not be processed for retroactive premiums. However, PEEHIP will pay secondary to Medicare once PEEHIP becomes aware of your Medicare eligibility regardless of whether or not PEEHIP has received your Medicare card. Medicare-eligible members and dependents must have Medicare Part A and Part B to have adequate coverage with PEEHIP.
Surviving Dependent Benefits

PEEHIP law allows covered surviving dependents to be able to continue the PEEHIP insurance plans that they are covered on at the time of the member’s death. The insurance plan(s) can be continued as long as the surviving dependents pay the monthly premium by the due date each month.

Survivor policies are as follows:

♦ New dependents who are not covered on the PEEHIP policies at the time of the member’s death cannot be added to the plan at a later date.
♦ Surviving dependents do not have Open Enrollment rights.
♦ Once the insurance is cancelled by a surviving dependent, no reinstatement is allowed, and coverage cannot be picked up at a later date.
♦ Surviving dependents cannot enroll in new PEEHIP plans that they were not covered on at the time of the member’s death.
♦ The eligible surviving dependent who wants to continue the PEEHIP coverage should notify PEEHIP as soon as possible from the member’s date of death to enroll in coverage and avoid a lapse in coverage.

PEEHIP law also requires surviving dependents to pay the full cost of the monthly premium without financial assistance from the state.

Surviving Dependent Premiums
Effective October 1, 2015 - September 30, 2016

The following health insurance premiums are the base rates set by law and approved by the PEEHIP Board. Base rates are before the wellness and tobacco premiums are applied, if applicable.

<table>
<thead>
<tr>
<th>Type of Contract</th>
<th>Monthly Premium for PEEHIP Hospital Medical or VIVA Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Coverage/Non-Medicare-eligible (NME) Survivor</td>
<td>$ 740</td>
</tr>
<tr>
<td>Family Coverage/NME Survivor &amp; NME Dependents</td>
<td>$ 987</td>
</tr>
<tr>
<td>Family Coverage/NME Survivor &amp; Only Dependent ME</td>
<td>$1,033</td>
</tr>
<tr>
<td>Individual Coverage/ME Survivor</td>
<td>$ 425</td>
</tr>
<tr>
<td>Family Coverage/ME Survivor &amp; NME Dependent(s)</td>
<td>$ 679</td>
</tr>
<tr>
<td>Family Coverage/Medicare-eligible Survivor &amp; Only Dependent ME</td>
<td>$ 725</td>
</tr>
<tr>
<td>Optional (Each) - Cancer, Indemnity, Vision, and Single Dental</td>
<td>$ 38</td>
</tr>
<tr>
<td>Optional - Family Dental Premium</td>
<td>$ 50</td>
</tr>
<tr>
<td>Tobacco Premium for Survivor enrolling in Hospital Medical</td>
<td>$ 50</td>
</tr>
<tr>
<td>Wellness Premium/NME Survivor</td>
<td>$ 50</td>
</tr>
</tbody>
</table>

If a member or dependent is under age 65 and eligible for Medicare coverage due to a disability, the PEEHIP office must receive a copy of the Medicare card before the premiums can be reduced. Refunds will not be processed for retroactive premiums. However, PEEHIP will pay secondary to Medicare once PEEHIP becomes aware of your Medicare eligibility regardless of whether PEEHIP has received your Medicare card. Medicare-eligible members and dependents must have Medicare Part A and Part B to have adequate coverage with PEEHIP.
Updating Personal Contact Information

(Active and Retired Members)

Name and Social Security Number
Peehip determines a member’s name for insurance purposes from the TRS Form 100 Enrollment form, enrollment through Member Online Services (MOS), or the New Enrollment and Status Change form. Peehip updates names from information received from the Social Security office. The name on all insurance enrollments and TRS forms must be the same as the name on the Social Security card.

Peehip requires a copy of the member’s Social Security card before a name or Social Security number can be changed. Active employees must provide a copy of their current Social Security card to their employer for the employer to correct their Peehip and TRS accounts. Your Social Security number will be used by Peehip for the purpose of Coordination of Benefits. The disclosure of your Social Security number is mandatory for Peehip coverage so that Peehip may ensure compliance with the federal Medicare Secondary Payee rules created by 42 USC 1395y(b).

Address Changes
It is imperative that Peehip have the member’s correct mailing address to ensure that the member receives important information regarding their insurance coverage(s). A member may update their address online through the secure Member Online Services (MOS) login from the RSA website www.rsa-al.gov. An address changed in MOS will automatically transmit to the insurance carriers, the Teachers’ Retirement System, and RSA-1 accounts, if the member is participating in those accounts.

All address changes should be made online, on the U.S. Postal Service address change cards, or the Address Change Notification form provided by RSA. The card must be mailed to Peehip for the change to occur. Peehip cannot accept an address change by phone or email. The MOS address change does not change an address with the employer. A member must contact their employer to change the address in their system.
Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

The notice describes how medical information about you may be used and disclosed and how you can get access to this information.

The Public Education Employees’ 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 is required by law to take reasonable steps to ensure the privacy of your health information and to inform you about:

♦ The Plan’s uses and disclosures of your health information.
♦ Your privacy rights with respect to your health information.
♦ The Plan’s obligations with respect to your health information.
♦ A breach of your PHI.
♦ Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services.
♦ The person or office to contact for further information about the Plan’s privacy practices.

Effective Date of Notice: This notice was effective as of September 23, 2013.

How the Plan Uses and Discloses 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, Healthcare Operations and Treatment

The Plan and its business associates may use your health information without your permission to carry out payment or healthcare operations. The Plan may also disclose health information to the Plan Sponsor, PEEHIP, 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. 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. However, in no event will Benefit Staff use PHI that is genetic information for underwriting purposes.

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 or if it:

♦ Constitutes summary health information and 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.
♦ Constitutes de-identified information.
♦ Relates to workers’ compensation programs.
♦ Is for judicial and administrative proceedings.
♦ Is about decedents.
♦ Is for law enforcement purposes.
♦ Is for public health activities.
♦ Is for health oversight activities.
♦ Is about victims of abuse, neglect or domestic violence.
♦ Is for cadaveric organ, eye or tissue donation purposes.
♦ Is for certain limited research purposes.
♦ Is to avert a serious threat to health or safety.
♦ Is for specialized government functions.
♦ 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 Official.

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 Official.

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. To exercise your rights, you must contact the Plan’s Privacy Official at 877.517.0020.

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.

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. The Plan must accommodate your reasonable request to receive communication of PHI by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of the information through normal processes could endanger you in some way.

Copy of Health Information
You have a right to 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. 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.” 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 not accurate and complete.
Right to Access Electronic Records
You may request access to electronic copies of your PHI, or you may request in writing or electronically that another person receive an electronic copy of the records. The electronic PHI 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 a copy of the electronic PHI.

List of Certain Disclosures
You have the right to receive a list of certain disclosures of your health information. The Plan or its business associates will provide you with one free accounting each year. For subsequent requests, you may be charged a reasonable fee.

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. You will not be penalized for filing a complaint.

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 follow the terms of the notice currently in effect.

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 PEEHIP’s Privacy Official at 877.517.0020.
Important Notices

Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirement listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from the requirements for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy. The Public Education Employees’ Health Insurance Board has elected to exempt the PEEHIP from the following requirement:

♦ Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from this federal requirement has been in effect since October 1, 2005. The election has been renewed every subsequent plan year.

For more information regarding this notice, please contact PEEHIP.

Women’s Health and Cancer Rights Act of 1988

PEEHIP, as required to the Women’s Health and Cancer Rights Act of 1988, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call Blue Cross Blue Shield of Alabama at 800.327.3994 for more information.

Newborns’ and Mothers’ Health Protection Act of 1996

The Newborns’ and Mothers’ Health Protection Act of 1996 and its regulations provide that health plans and health insurance issuers may not restrict a mother’s or newborn’s benefits for a hospital length of stay that is connected with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother and newborn child earlier. Plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Access to Obstetrical and Gynecological (OBGYN) Care Notice

You do not need prior authorization from the Plan or from any other person (including a Primary Care Provider (PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Blue Cross and Blue Shield of Alabama network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to the Blue Cross and Blue Shield of Alabama website [www.AlabamaBlue.com](http://www.AlabamaBlue.com).
Medicaid & the Children’s Health Insurance Program (CHIP)  
Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can contact your state Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of April 16, 2010. You should contact your state for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Contact Information (Website; Phone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Medicaid</td>
<td><a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a>; 800.362.1504</td>
</tr>
<tr>
<td>Alaska</td>
<td>Medicaid</td>
<td><a href="http://www.health.hss.state.ak.us/dpa/programs/medicaid/">www.health.hss.state.ak.us/dpa/programs/medicaid/</a>; (Outside of Anchorage) 888.318.8890; (Anchorage) 907.269.6529</td>
</tr>
<tr>
<td>Arizona</td>
<td>CHIP</td>
<td><a href="http://www.azahcccs.gov/applicants/default.aspx">www.azahcccs.gov/applicants/default.aspx</a>; 877.764.5437</td>
</tr>
<tr>
<td>Arkansas</td>
<td>CHIP</td>
<td><a href="http://www.arkidsfirst.com/">www.arkidsfirst.com/</a>; 888.474.8275</td>
</tr>
<tr>
<td>California</td>
<td>Medicaid</td>
<td><a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a>; 866.298.8443</td>
</tr>
<tr>
<td>Colorado</td>
<td>Medicaid and CHIP</td>
<td>Medicaid: <a href="http://www.colorado.gov/">www.colorado.gov/</a>; 800.866.3513 CHIP: <a href="http://www.CHPplus.org">www.CHPplus.org</a>; 303.866.3243</td>
</tr>
<tr>
<td>Florida</td>
<td>Medicaid</td>
<td><a href="http://www.fdhe.state.fl.us/Medicaid/index.shtml">www.fdhe.state.fl.us/Medicaid/index.shtml</a>; 866.762.2237</td>
</tr>
<tr>
<td>Georgia</td>
<td>Medicaid</td>
<td><a href="http://www.dch.georgia.gov/">www.dch.georgia.gov/</a> (Click on Programs, then Medicaid); 800.869.1150</td>
</tr>
<tr>
<td>Idaho</td>
<td>Medicaid and CHIP</td>
<td>Medicaid: <a href="http://www.acessstohealthinsurance.idaho.gov">www.acessstohealthinsurance.idaho.gov</a>; 800.926.2588 CHIP: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a>; 800.926.2588</td>
</tr>
<tr>
<td>Indiana</td>
<td>Medicaid</td>
<td><a href="http://www.in.gov/fssa/2408.htm">www.in.gov/fssa/2408.htm</a>; 877.438.4479</td>
</tr>
<tr>
<td>Iowa</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a>; 888.346.9562</td>
</tr>
<tr>
<td>Kansas</td>
<td>Medicaid</td>
<td><a href="http://www.khpa.ks.gov">www.khpa.ks.gov</a>; 800.766.9012</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Medicaid</td>
<td><a href="http://www.chfs.ky.gov/dms/default.htm">www.chfs.ky.gov/dms/default.htm</a>; 800.635.2570</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Medicaid</td>
<td><a href="http://www.la.hipp.dhh.louisiana.gov">www.la.hipp.dhh.louisiana.gov</a>; 888.342.6207</td>
</tr>
<tr>
<td>Maine</td>
<td>Medicaid</td>
<td><a href="http://www.maine.gov/dhhs/oms/">www.maine.gov/dhhs/oms/</a>; 800.321.5557</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/MassHealth">www.mass.gov/MassHealth</a>; 800.462.1120</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.state.mn.us/">www.dhs.state.mn.us/</a> (Click on Health Care, then Medical Assistance); 800.657.3739</td>
</tr>
<tr>
<td>Missouri</td>
<td>Medicaid</td>
<td><a href="http://www.dss.mn.gov/mhd/index.htm">www.dss.mn.gov/mhd/index.htm</a>; 573.751.6944</td>
</tr>
<tr>
<td>Montana</td>
<td>Medicaid</td>
<td><a href="http://www.medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">www.medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a>; 800.694.3084</td>
</tr>
<tr>
<td>State</td>
<td>Program</td>
<td>Contact Information (Website; Phone)</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Medicaid</td>
<td><a href="http://www.dhhs.ne.gov/med/medindex.htm">www.dhhs.ne.gov/med/medindex.htm</a>; 877.255.3092</td>
</tr>
<tr>
<td>Nevada</td>
<td>Medicaid and CHIP</td>
<td>Medicaid: <a href="http://www.dwss.nv.gov/">www.dwss.nv.gov/</a>; 800.992.0900; CHIP: <a href="http://www.nevadacheckup.nv.org/">www.nevadacheckup.nv.org/</a>; 877.543.7669</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Medicaid</td>
<td><a href="http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm">www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm</a>; 800.852.3345 x5254</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Medicaid and CHIP</td>
<td>Medicaid: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>; 800-356-1561 CHIP: <a href="http://www.njfamilycare.org/index.html">www.njfamilycare.org/index.html</a>; 800.701.0710</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Medicaid and CHIP</td>
<td>Medicaid: <a href="http://www.hsd.state.nm.us/mad/index.html">www.hsd.state.nm.us/mad/index.html</a>; 888.997.2583 CHIP: <a href="http://www.hsd.state.nm.us/mad/index.html">www.hsd.state.nm.us/mad/index.html</a> (Click on Insure New Mexico); 888.997.2583</td>
</tr>
<tr>
<td>New York</td>
<td>Medicaid</td>
<td><a href="http://www.nyhealth.gov/health_care/medicaid/">www.nyhealth.gov/health_care/medicaid/</a>; 800.541.2831</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Medicaid</td>
<td><a href="http://www.nc.gov">www.nc.gov</a>; 919.855.4100</td>
</tr>
<tr>
<td>North Dakota</td>
<td>Medicaid</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">www.nd.gov/dhs/services/medicalserv/medicaid/</a>; 800.755.2604</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Medicaid</td>
<td><a href="http://www.insureoklahoma.org/">www.insureoklahoma.org/</a>; 888.365.3742</td>
</tr>
<tr>
<td>Oregon</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.oregonhealthykids.gov">www.oregonhealthykids.gov</a>; 877.314.5678</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Medicaid</td>
<td><a href="http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm">www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm</a>; 800.644.7730</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.ri.gov/">www.dhs.ri.gov/</a>; 401.462.5300</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Medicaid</td>
<td><a href="http://www.scdhhs.gov">www.scdhhs.gov</a>; 888.549.0820</td>
</tr>
<tr>
<td>Texas</td>
<td>Medicaid</td>
<td><a href="http://www.gethipptexas.com/">www.gethipptexas.com/</a>; 800.440.0493</td>
</tr>
<tr>
<td>Utah</td>
<td>Medicaid</td>
<td><a href="http://www.health.utah.gov/medicaid/">www.health.utah.gov/medicaid/</a>; 866.435.7414</td>
</tr>
<tr>
<td>Vermont</td>
<td>Medicaid</td>
<td><a href="http://www.ovha.vermont.gov/">www.ovha.vermont.gov/</a>; 800.250.8427</td>
</tr>
<tr>
<td>Washington</td>
<td>Medicaid</td>
<td><a href="http://www.hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">www.hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a>; 877.543.7669</td>
</tr>
<tr>
<td>West Virginia</td>
<td>Medicaid</td>
<td><a href="http://www.wvrecovery.com/hipp.htm">www.wvrecovery.com/hipp.htm</a>; 304.342.1604</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.wisconsin.gov/medicaid/publications/p-10095.htm">www.dhs.wisconsin.gov/medicaid/publications/p-10095.htm</a>; 800.362.3002</td>
</tr>
</tbody>
</table>

To see if any more states have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Ext. 61565
Forms

Mail forms to: Public Education Employees’ Health Insurance Plan
P.O. Box 302150
Montgomery, AL 36130-2150

Please do not send any forms to Blue Cross Blue Shield, VIVA, or Southland National. When completing these forms, make sure the name of the subscriber and dependents is the same as the name on their Social Security card. Forms can also be downloaded from our website at www.rsa-al.gov. In lieu of using a paper form, the preferred method of enrolling or changing coverage is online at https://mso.rsa-al.gov.

New Enrollment and Status Change – This form is to be used if you are: an active or retired member who is not enrolled in any coverage; or an active or retired member who wants to enroll in one or more Optional Coverage Plans that you are not enrolled in, or are not enrolled in a Hospital Medical Plan and want to enroll.

This form is to be used if you are an active or retired member currently enrolled in PEEHIP and you want to make changes to your existing coverage, and/or to certify or change your or your spouse’s tobacco status. Examples: change from single to family coverage or vice-versa; cancel coverage; change your Hospital Medical Plan; add or cancel a dependent to or from family coverage. You must provide the Requested Effective Date or the form will be returned to you.

Flexible Spending Account Enrollment Application – This form is to be used if you are an active member and you wish to enroll or re-enroll in the Health Care and/or Dependent Care Flexible Spending Accounts. Important: You must re-enroll in these programs every year as these programs will not automatically renew each year without a new enrollment application. The Health Care Account allows members to pay for non-covered health care expenses with pre-tax dollars. The Dependent Care Account allows members to pay for dependent care expenses with pre-tax dollars.

Flexible Spending Account Status Change – This form is to be used if you are an active member and you enrolled or re-enrolled in a Flexible Spending Account(s) during Open Enrollment and subsequently wish to make a change to the annual contribution amount of your Flexible Spending Account(s) before the end of Open Enrollment or during the year if you have a qualifying life event.

Federal Poverty Level Assistance (FPL) Application – This form is to be used by eligible active and retired members to apply for the FPL premium discount. Members must re-enroll in this program every year. This program will not automatically renew each year without a new application. This form cannot be completed online through MOS. You must submit the paper form.

Coordination of Benefits (COB) Form – This form is to be used by an active or retired member if you, your spouse, and/or dependent children are covered under PEEHIP and have any other hospital/medical/prescription coverage or dental or vision insurance coverage. This form is a request for other coverage information PEEHIP must have in order to provide proper coverage.

Retiree Employment Verification – This form is to be used by a retired member who is currently employed to verify employer health insurance benefits offered to its employees.

Important for New Employees

Enrollment in PEEHIP coverage must be completed within 30 days of the member’s employment date. The required method of enrollment for new employees is through Member Online Services (MOS) at https://mso.rsa-al.gov.
**NEW ENROLLMENT AND STATUS CHANGE**

Public Education Employees’ Health Insurance Plan
P. O. Box 302150  Montgomery, Alabama 36130-2150
334.517.7000 or 877-517-0020; Fax: 334.517.7001 or 877.517.0021
You may submit information online at https://mso.rsa-al.gov

**PEEHIP Subscriber Information**
Name must be entered as shown on your Social Security card.

<table>
<thead>
<tr>
<th>Social Security # or PID</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
</table>

Marital Status
- Single
- Married
- Divorced
- Legally Separated
- Widowed

Date Married: __/__/____

Is your spouse employed? Yes No
Does your spouse have other health insurance coverage? Yes No

Mailing Address
City State ZIP Code

Is this a change of address? Yes No
Home Phone Work Phone

Cell Phone

Email Address

Date of Employment

Employer/School System

Have you or your spouse used tobacco products within the last 12 months? Yes No

**PEEHIP Coverage Information**
(You will be billed for prorata premiums or premiums that are not deducted from your payroll or retirement check.)

**Section A. New Enrollment**
(PEEHIP plans are administered by Blue Cross and Blue Shield of AL)

<table>
<thead>
<tr>
<th>Coverage Type: (Select only one of the three plans)</th>
<th>Optional Coverage Plans (administered by Southland National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEEHIP Hospital/Medical</td>
<td>Note: Optional plans must be all Single or all Family Coverage Type(s):</td>
</tr>
<tr>
<td>VIVA Health Plan (HMO) (Primary Care Physician ________________)</td>
<td>Cancer Dental Indemnity Vision</td>
</tr>
<tr>
<td>PEEHIP Hospital/Medical Supplemental* (Secondary Medical)</td>
<td>Single or Family (Complete Section C)</td>
</tr>
</tbody>
</table>

**Complete Primary Insurance Information in Section D if choosing this plan.**
This plan is not a Medicare supplement & differs from Optional Plans.

Member Spouse

Requested Effective Date ___/___/____ (required)

**Section B. PEEHIP Coverage Information**
(Only check boxes requiring a change to existing coverage.)

<table>
<thead>
<tr>
<th>Coverage Type:</th>
<th>PEEHIP Hosp/Med</th>
<th><strong>PEEHIP Supplemental</strong></th>
<th>VIVA HMO</th>
<th>Cancer</th>
<th>Dental</th>
<th>Indemnity</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change from Single to Family Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add dependent(s) listed in Section C to Family Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancel Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change from Family to Single Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancel dependent(s) listed in Section C from Family Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Requested Effective Date ___/___/____ (required) QLE changes must be submitted within 45 days of the QLE.

Reason for Status Change(s) (check all that apply)
Changes cannot be processed without the appropriate documentation as explained in the Member Handbook for starred (*) items.

Date change occurred (Required) ___/___/____

- Open Enrollment – Change effective October 1st
- Adoption of a child* (need adoption papers)
- Birth of a child* (need birth certificate)
- Death of spouse/dependent* (need death certificate)
- Qualifying loss of coverage* (need proof of loss of coverage)
- Divorce/Annulment/Legal Separation* (need divorce decree)
- FMLA/LOA

Legal custody of a child* (need legal custody papers)
Marriage* (need marriage certificate & add'l proof of marriage)
Marriage of dependent child* (need marriage certificate)
Termination of spouse/dependent employment*
Commencement of spouse/dependent employment*
Medicare/Medicaid entitlement* (need copy of card)

Note: Active members must have an IRS qualifying life event (QLE) to cancel their Hospital Medical or change their coverage outside of Open Enrollment because their premiums are pre-taxed. QLE changes must be submitted within 45 days of the QLE.
Section C. Dependent Information (only required for family coverage)

Social Security Number is required for all dependents. Name must be entered as it appears on the Social Security card. Appropriate eligibility documents are required for all dependents: All children – birth certificates; spouses – marriage certificate & additional current marriage document; adopted children – certificate of adoption or papers from adoption agency showing intent to adopt; step children – also required is the marriage certificate showing member’s spouse is married to member; foster and other children – also required is the placement authorization signed by a judge or final court order with judge’s signature and seal. (See handbook for more detail.)

<table>
<thead>
<tr>
<th>Name of Dependent (First, Middle, Last)</th>
<th>Social Security #</th>
<th>Date of Birth</th>
<th>Relation to Subscriber</th>
<th>Sex</th>
<th>Handicapped</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Spouse</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Biological</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Adopted</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Step</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

Section D. Primary Insurance Information** (Must be completed if choosing PEEHIP Hospital/Medical Supplemental)

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>Phone Number</th>
<th>Contract/Policy #</th>
<th>Effective Date of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section E. Other Health Insurance Information (Must be completed for enrollment)

Are you, your spouse, or dependent children covered under any other Hospital, Medical, Dental, or Vision plan(s)?    Yes* No

*If you answered yes, you must complete a separate COORDINATION OF BENEFITS (COB) form, available at www rsa-al.gov.

Section F. Retiree Other Employer Information (Must be completed if you retired after September 30, 2005)

Are you a retiree and employed by another employer?    Yes* No

*If you answered yes and you retired after September 30, 2005, and became employed by another employer, you must complete a separate RETIREE EMPLOYMENT VERIFICATION form available at www rsa-al.gov.

Section G. Medicare Information

Are you or your covered dependent(s) eligible for Medicare?    Yes* No

*If you answered yes, you must complete this section and provide a copy of the Medicare card(s) to PEEHIP before your monthly retiree premium can be reduced. **Note: As a retiree or a dependent on a retired account, you MUST have BOTH Part A and Part B to have adequate coverage with PEEHIP. If you fail to timely enroll in Part A and B, you will have a lapse in coverage if your effective date for Part A and B is after your date of retirement. You are financially liable for medical costs incurred as PEEHIP will only pay 20% of the Medicare allowable fees.

<table>
<thead>
<tr>
<th>Name</th>
<th>Medicare Card Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check the Medicare Part(s) for which you are eligible:

- Part A-Effective: ______/_____/______
- Part B-Effective: ______/_____/______
- Part D**-Effective: ______/_____/______

<table>
<thead>
<tr>
<th>Name</th>
<th>Medicare Card Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check the Medicare Part(s) for which you are eligible:

- Part A-Effective: ______/_____/______
- Part B-Effective: ______/_____/______
- Part D**-Effective: ______/_____/______

**If you are enrolled in another Medicare Part D plan (other than PEEHIP’s Medicare GenerationRx), you are not eligible for the PEEHIP prescription drug plan coverage.

Section H. PEEHIP Subscriber Certification

Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. I further understand that there is mandatory utilization review, and I do hereby release any information necessary to evaluate, administer and process claims for benefits to any person, entity or representative acting on the Plan’s behalf. I also agree to periodic tobacco usage testing and agree to notify the PEEHIP office if my or my spouse’s tobacco status changes or if my employment status changes. I also agree to have premiums deducted from my retirement check or paycheck for any prior months that are due but were not deducted at the proper time.

Member Signature ____________________________ Date Signed ______/_____/______

Please mail the completed form to the address located on the front of this form.
# FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION

Public Education Employees’ Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334.517.7000 or 877.517.0020; Fax: 334.517.7001 or 877.517.0021
Website: www.rsa-al.gov
You can enroll online at https://mso.rsa-al.gov

## PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

<table>
<thead>
<tr>
<th>Social Security Number or PID Number</th>
<th>First Name</th>
<th>Middle Name/Initial</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>/</strong>/_______</td>
<td><strong>-</strong>-____</td>
<td><strong>-</strong>-____</td>
<td>☐ Male</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Employer/School System</th>
<th>Email Address</th>
<th>Date of Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Single</td>
<td></td>
<td></td>
<td><strong>/</strong>/_______</td>
</tr>
<tr>
<td>☐ Married</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Divorced</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Legally Separated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Widowed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Healthcare Flexible Spending Account Information

☐ I wish to enroll in the Health Care Flexible Spending Account for an Annual Contribution Amount of $___________.

Choose One: ☐ Traditional Reimbursement (bump) OR ☐ Manual Reimbursement

I understand that:
- The minimum annual contribution cannot be less than $120 and the maximum cannot exceed $2,550.
- The annual amount will be divided by the number of months remaining in this plan year (Oct. 1 – Sep. 30) and my pay will be reduced by this amount each month. If I sign up during Open Enrollment the annual amount will be divided by 12.
- Funds cannot be used to pay for health insurance premiums.
- Non-prescription over-the-counter medications are not eligible for reimbursement.

## Dependent Care Flexible Spending Account Information

☐ I wish to enroll in the Dependent Day Care Flexible Spending Account for an Annual Contribution Amount of $___________.

I understand that:
- The minimum annual contribution cannot be less than $120 and the maximum cannot exceed $5,000 ($2,500 for married filing separate tax returns).
- The annual amount will be divided by the number of months remaining in this plan year (Oct. 1 – Sep. 30) and my pay will be reduced by this amount each month. If I sign up during Open Enrollment the annual amount will be divided by 12.
- This account cannot be used for reimbursement of medical, dental or vision expenses for me or my dependents.
- This account is for reimbursement of dependent (daycare) expenses so I (and spouse) can work outside of the home or attend school (i.e., licensed nursery school or daycare for children under 13, or daycare for elderly or disabled dependents).

## PEEHIP Subscriber Certification

I certify that I have completely read and fully understand the terms and conditions of the Flexible Spending Account and all information furnished is true and complete.

Employee Signature ___________________________ Date Signed __/__/_______
## Flexible Spending Account Status Change

**Public Education Employees’ Health Insurance Plan**  
P. O. Box 302150  
Montgomery, Alabama 36130-2150  
334.517.7000 or 877.517.0020; Fax: 334.517.7001 or 877.517.0021  
Website: www.rsa-al.gov

### PEEHIP Subscriber Information

Name must be entered as shown on your Social Security card.

<table>
<thead>
<tr>
<th>Social Security Number or PID Number</th>
<th>First Name</th>
<th>Middle Name/Initial</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Legally Separated
- [ ] Widowed

### Reason for Status Change

I certify that I have incurred the following change in status:

- [ ] Marriage
- [ ] Marriage of dependent
- [ ] Birth of a child
- [ ] Adoption of a child
- [ ] Legal custody of a child
- [ ] Divorce/annulment
- [ ] Death of spouse/dependent
- [ ] Dependent loss of coverage
- [ ] Dependent no longer in daycare *(Dependent Care FSA only)*
- [ ] Significant change in medical benefits or premiums
- [ ] Termination of spouse/dependent employment
- [ ] Commencement of spouse/dependent employment
- [ ] Taking leave under the Family and Medical Leave Act
- [ ] Medicare/Medicaid entitlement
- [ ] Unpaid Leave of Absence
- [ ] Short plan year

**Date qualifying event occurred (Required) [__] [____] [____]**

*Note: PEEHIP must be notified within 45 days of the occurrence of the qualifying event.*

### Healthcare Flexible Spending Account Information

Healthcare Flexible Spending Account Change Request: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

- [ ] New Annual Election Amount $ ____________

**Maximum amount cannot exceed $2,550 and the minimum annual amount is $120.** New monthly contribution amount will be determined by dividing the remaining election amount by the total months remaining in this plan year.

- [ ] Stop Payroll Deductions

Reimbursement Option Change can only be made by calling BCBS Flex at 800.213.7930.

### Dependent Care Flexible Spending Account Information

Dependent Care Flexible Spending Account Change Requested: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

- [ ] New Annual Election Amount $ ____________

**Maximum amount cannot exceed $5,000 if single or married filing a joint return, $2,500 if married filing separate returns.** The minimum annual amount is $120. New monthly contribution amount will be determined by dividing the remaining election amount by the total months remaining in this plan year.

- [ ] Stop Payroll Deductions

### PEEHIP Subscriber Certification

I understand that Federal regulations prohibit me from changing the election I have made after the beginning of the plan year, except under special circumstances. I understand that the change in my benefit election must be necessary or appropriate as a result of the status change under the regulations issued by the Department of the Treasury. I hereby certify under penalties of perjury that the information furnished in this form is true and complete to the best of my knowledge.

Employee Signature ___________________________ Date Signed [____]/[____]/[____]
This form is to be used to apply for the Federal Poverty Level Premium Assistance.

### PEEHIP Subscriber Information - Required

**Name must be entered as shown on your Social Security card.**

<table>
<thead>
<tr>
<th>Social Security Number or PID Number</th>
<th>First Name</th>
<th>Middle Name/Initial</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Date Received (For internal use only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Martial Status**

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Legally Separated
- [ ] Widowed

### Instructions

1. A signed copy of your prior year’s Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099’s and W-2’s must be attached. If you were married and did not file a joint return, you must also file a copy of your spouse’s prior year’s Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099’s and W-2’s in order for this application to be processed.

2. You must reapply for this assistance every year during Open Enrollment.

3. Any Federal Poverty Level assistance application received and/or postmarked after the close of Open Enrollment (September 1) will be effective for the first day of the second month after the receipt and approval of the application.

### PEEHIP Subscriber Certification - Required

I declare that the above information and the accompanying tax returns and supporting 1099’s and W-2’s are true, complete, and accurate. I understand that submitting false or misleading information on this application is a crime punishable under state and federal law. I also understand that if any statements or accompanying tax returns and supporting 1099’s and W-2’s are found to be incorrect, incomplete, false, or misleading, I will be required to repay all discounts plus interest. This certification authorizes the Alabama Department of Revenue (or corresponding agency of the state of member’s residency) to release to PEEHIP all of the member’s and his/her spouse’s tax returns in the agency’s records for the current and prior tax year.

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>/</strong>/____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>/</strong>/____</td>
</tr>
</tbody>
</table>

PEEHIP provides premium assistance to PEEHIP members with a total combined family income of less than or equal to 300% of the Federal Poverty Level (FPL) as defined by Federal Law. To qualify for the FPL assistance, PEEHIP members must furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Certification of Income Level will be effective for the plan year only, and re-certification will be required annually during Open Enrollment. The premium reduction does not automatically renew each year. The premium reduction will apply only to the hospital medical premium or HMO premium and only applies to active and retired members. The FPL premium discount is not available to members who are on a Leave of Absence, COBRA or surviving spouse contract.

### Federal Poverty Level Premium Discount:

<table>
<thead>
<tr>
<th>Over 300% of the FPL</th>
<th>member pays 100% of the member contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>equal to or less than 300% but more than 250% of the FPL</td>
<td>member contribution reduced 10%</td>
</tr>
<tr>
<td>equal to or less than 250% but more than 200% of the FPL</td>
<td>member contribution reduced 20%</td>
</tr>
<tr>
<td>equal to or less than 200% but more than 150% of the FPL</td>
<td>member contribution reduced 30%</td>
</tr>
<tr>
<td>equal to or less than 150% but more than 100% of the FPL</td>
<td>member contribution reduced 40%</td>
</tr>
<tr>
<td>equal to or less than 100% of the FPL</td>
<td>member contribution reduced 50%</td>
</tr>
</tbody>
</table>

Please mail the completed form to the address located on the top of this form. See reverse for FPL levels.
### 2015 Federal Poverty Levels (FPL)

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100% of FPL</th>
<th>150% of FPL</th>
<th>200% of FPL</th>
<th>250% of FPL</th>
<th>300% of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,770</td>
<td>$17,655</td>
<td>$23,540</td>
<td>$29,425</td>
<td>$35,310</td>
</tr>
<tr>
<td>2</td>
<td>$15,930</td>
<td>$23,895</td>
<td>$31,860</td>
<td>$39,825</td>
<td>$47,790</td>
</tr>
<tr>
<td>3</td>
<td>$20,090</td>
<td>$30,135</td>
<td>$40,180</td>
<td>$50,225</td>
<td>$60,270</td>
</tr>
<tr>
<td>4</td>
<td>$24,250</td>
<td>$36,375</td>
<td>$48,500</td>
<td>$60,625</td>
<td>$72,750</td>
</tr>
<tr>
<td>5</td>
<td>$28,410</td>
<td>$42,615</td>
<td>$56,820</td>
<td>$71,025</td>
<td>$85,230</td>
</tr>
<tr>
<td>6</td>
<td>$32,570</td>
<td>$48,855</td>
<td>$65,140</td>
<td>$81,425</td>
<td>$97,710</td>
</tr>
<tr>
<td>7</td>
<td>$36,730</td>
<td>$55,095</td>
<td>$73,460</td>
<td>$91,825</td>
<td>$110,190</td>
</tr>
<tr>
<td>8</td>
<td>$40,890</td>
<td>$61,335</td>
<td>$81,780</td>
<td>$102,225</td>
<td>$122,670</td>
</tr>
</tbody>
</table>
**COORDINATION OF BENEFITS (COB) FORM**

Request for Other Coverage Information

This form is a request for other coverage information we must have in order to update your insurance information and provide proper coverage.

**INSTRUCTIONS:** Print clearly in black ink. Complete the form in full, sign, and return it to PEEHIP using one of the following methods:

- **Online:** [https://mso.rsa-al.gov/](https://mso.rsa-al.gov/) *(the fastest, preferred method)*
- **Fax:** 877-517-0021 *(toll-free)* *(Please fax front and back of form)*
- **Mail:** PEEHIP, P.O. Box 302150, Montgomery, AL 36130
- **Email:** peehipinfo@rsa-al.gov *(Scan front and back)*

If you, your spouse and/or dependent children are covered under PEEHIP and have any other insurance coverage, **EXCLUDING MEDICARE AND PEEHIP**, please indicate the other coverage on this form or **online** at [https://mso.rsa-al.gov/](https://mso.rsa-al.gov/). Failure to timely submit this form will result in your account being placed on claim hold and may cause a denial of medical and prescription claims.

### SECTION A. PEEHIP SUBSCRIBER INFORMATION

<table>
<thead>
<tr>
<th>SSN or PID:</th>
<th>First and Last Name:</th>
<th>Telephone Number:</th>
<th>Cell Phone Number:</th>
<th>Email Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### SECTION B. OTHER INSURANCE COVERAGE INFORMATION, EXCLUDING MEDICARE AND PEEHIP (Check all that apply)

- Yes ☐ No - I have/had other insurance coverage while covered by PEEHIP.
- Yes ☐ No - My spouse has/had other insurance coverage while covered by PEEHIP.
- Yes ☐ No - My dependent child(ren) has/had other insurance coverage provided by my spouse and/or other insurer while covered by PEEHIP.

If you answered "Yes" to any of the above, you must complete the Insurance Company information below. If you answered "No" to all of the above, skip to Section C.

**LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)**

<table>
<thead>
<tr>
<th>Name of Policy Holder</th>
<th>Date of Birth</th>
<th>Contract/Policy No.</th>
<th>Effective Date of Coverage</th>
<th>Termination Date (if applicable)</th>
<th>Insurance Co. Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Name of Insurance Company (check one)**

- Aetna ☐ Blue Cross Blue Shield ☐ Cigna ☐
- Tricare ☐ United Health Care ☐ VA ☐
- SEIB/Local Govt. ☐ Other: __________________________

**Coverage Provided Through**

- ☐ Current Employer
- ☐ Former Employer
- ☐ Other

**Type(s) of coverage (check all that apply)**

- ☐ Hospital/Medical with Prescription Drug
- ☐ Dental
- ☐ Hospital/Medical without Prescription Drug
- ☐ Vision
- ☐ Prescription Drug Only

**Note:** HSA, HDHP, and HRA Plans are considered Hospital/Medical with Prescription Drug Coverage

Are you or any of your PEEHIP dependents covered as **dependents** on this insurance policy? ☐ Yes-- List each dependent below ☐ No

### Dependents Name(s)

<table>
<thead>
<tr>
<th>Dependent(s) Name(s)</th>
<th>Effective Date(s) of Coverage</th>
<th>Relationship to Policy Holder</th>
<th>Are both parents married or living together?</th>
<th>Based on court decree, who is responsible for healthcare expenses? (check first that applies)** Copy of Divorce Decree Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Spouse</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ You (PEEHIP Subscriber) or Spouse is responsible</td>
<td>☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Joint custody or no court decree</td>
</tr>
<tr>
<td>☐ Child→ ☐ Stepchild→</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ You (PEEHIP Subscriber) or Spouse is responsible</td>
<td>☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Joint custody or no court decree</td>
</tr>
<tr>
<td>☐ Spouse</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ You (PEEHIP Subscriber) or Spouse is responsible</td>
<td>☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Joint custody or no court decree</td>
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<tr>
<td>☐ Child→ ☐ Stepchild→</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
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<td>☐ Spouse</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
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<td>☐ Yes ☐ No</td>
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<td>☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Joint custody or no court decree</td>
</tr>
</tbody>
</table>

**SEE REVERSE SIDE – THIS FORM CONTAINS MORE INFORMATION**
### SECTION C. SUBSCRIBER CERTIFICATION

**Statement:** Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. It is fraudulent to submit information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse PEEHIP for any money it was induced to pay as a result of the information I provided. Receipt and/or completion of this form is not a guarantee of eligibility. I further authorize the release of any pertinent information from any source available to PEEHIP to verify the status of my employment.

**Subscriber Signature** date

HELPING YOU UNDERSTAND WHY THE INFORMATION IS NEEDED

**COORDINATION OF BENEFITS. WHAT IS IT?** Coordination of Benefits is designed to keep your rates as low as possible by eliminating excess payments. It keeps the cost of your medical care down without affecting the way you receive care. Oftentimes, members and their dependents are covered by two insurance plans. Working spouses cover each other and children are often covered on both parents’ plans. When a PEEHIP member is covered by more than one health plan, the payment of his/her benefits is coordinated between the two plans.

**HOW COORDINATION WORKS.** If you have more than one plan and you receive services or supplies that are covered under both plans, this is how your benefits are coordinated:

1. The benefits of the plan that covers you as an employee will be paid before the plan that covers you as a dependent. However, if you are eligible for Medicare coverage and Medicare is primary to your plan and your spouse has active coverage through an employer, then your plan pays third.
2. For claims on dependent children, the benefits of the parent’s plan whose birthday falls earlier in the calendar year will be primary (this is known as the birthday rule) unless the parents are separated or divorced, in which case:
   a. If a court decree specifies one parent cover the child’s medical care, that parent’s plan is primary.
   b. If there is no court decree specifying coverage, the plan covering the parent with custody will be primary.
   c. However, if the parent with custody remarries, the plan covering that parent will be primary, the plan covering the step-parent will be secondary, and the plan covering the parent without custody will be third.
   d. If a court decree specifies joint custody but does not say which parent covers the child’s medical care, then the birthday rule is used.
3. If you are the subscriber on an active contract and the subscriber on a retired contract, the benefits of the plan covering you as an active employee are primary over the benefits of a plan covering you as a retired employee.
4. If you are the policy holder on two active or retired contracts, the plan that has covered you longer is primary.

**Helping You Understand Why the Information Is Needed**

**ACTION REQUIRED:** If you have indicated that you, your spouse, or your dependent child is insured under another insurance plan, you are required to provide a copy of the front and back of the insurance card for each card.

**If applicable, you must provide a copy of the section of the Court Order/Divorce Decree pertaining to health coverage or other documents to support your response.**

---

### LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)

<table>
<thead>
<tr>
<th>Name of Policy Holder</th>
<th>Date of Birth</th>
<th>Contract/Policy No.</th>
<th>Effective Date of Coverage</th>
<th>Termination Date (if applicable)</th>
<th>Insurance Co. Phone No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Insurance Company (check one)</th>
<th>Coverage Provided Through</th>
<th>Type(s) of coverage (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Current Employer</td>
<td>Hospital/Medical with Prescription Drug</td>
</tr>
<tr>
<td>Blue Cross Blue Shield</td>
<td>Former Employer</td>
<td>Dental</td>
</tr>
<tr>
<td>Cigna</td>
<td>Other</td>
<td>Hospital/Medical without Prescription Drug</td>
</tr>
<tr>
<td>Tricare</td>
<td></td>
<td>Vision</td>
</tr>
<tr>
<td>United Health Care</td>
<td></td>
<td>Prescription Drug Only</td>
</tr>
<tr>
<td>VA</td>
<td></td>
<td>Note: HSA, HDHP, and HRA Plans are considered</td>
</tr>
<tr>
<td>SEIB/Local Govt.</td>
<td></td>
<td>Hospital/Medical with Prescription Drug Coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you or any of your PEEHIP dependents covered as dependents on this insurance policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent(s) Name(s)</th>
<th>Effective Date(s) of Coverage</th>
<th>Relationship to Policy Holder</th>
<th>Are both parents married or living together?</th>
<th>Based on court decree, who is responsible for health care expenses? (check first that applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>No</td>
<td>You (PEEHIP Subscriber) or Spouse is responsible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td>Yes</td>
<td>Policy Holder or their Spouse is responsible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stepchild</td>
<td></td>
<td>You (PEEHIP Subscriber) or your Spouse has custody</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>No</td>
<td>Policy Holder or their Spouse has custody</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td>Yes</td>
<td>Joint custody or no court decree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stepchild</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>You (PEEHIP Subscriber) or Spouse is responsible</td>
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<td>Child</td>
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<td>Policy Holder or their Spouse is responsible</td>
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<td>You (PEEHIP Subscriber) or your Spouse has custody</td>
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<td></td>
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<tr>
<td>Child</td>
<td>Yes</td>
<td>Joint custody or no court decree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stepchild</td>
<td></td>
<td></td>
<td><strong>Copy of Divorce Decree Required</strong></td>
<td></td>
</tr>
</tbody>
</table>

| Action Required: | If you have indicated that you, your spouse, or your dependent child is insured under another insurance plan, you are required to provide a copy of the front and back of the insurance card for each card. |

**If applicable, you must provide a copy of the section of the Court Order/Divorce Decree pertaining to health coverage or other documents to support your response.**
**SECTION A. PEEHIP RETIREE INFORMATION**

<table>
<thead>
<tr>
<th>Retiree's Name:</th>
<th>Social Security Number or PID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently employed?</td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

You must select “Yes” or “No.” *(If No,* skip to Section B)*

<table>
<thead>
<tr>
<th>Name of Retiree's Employer: (After date of retirement)</th>
<th>Employer's Address 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer's Address 2:</td>
<td>Employer's Telephone #:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Hire (MM/DD/YYYY)</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>ZIP Code</td>
</tr>
</tbody>
</table>

1. Does your current employer offer health insurance coverage? Yes  No *(If No,* skip to Section B)*
2. Are you currently eligible, or will become eligible after a specified waiting period, for health insurance benefits through your current employer? Yes  No*
   - If you are eligible for your employer's health insurance, you must indicate the date you became/will become eligible for benefits (MM/DD/YYYY):
3. Does your employer contribute at least 50% or more of the cost of single health insurance coverage? Yes  No*

**ACTION REQUIRED:** If you answered "No" to questions 2 or 3, you must have your current employer complete Section C and D before submitting the completed, signed, and dated form to PEEHIP.

**SECTION B. PEEHIP RETIREE SIGNATURE**

Statement: Under penalties of perjury, I declare that I have examined this form and statements, and to the best of my knowledge and belief, they are true and correct. It is fraudulent to submit information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse PEEHIP for any money it was induced to pay as a result of the information I provided. Receipt and/or completion of this form is not a guarantee of eligibility. I further authorize the release of any pertinent information from any source available to PEEHIP to verify the status of my employment.

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**SECTION C. EMPLOYER INFORMATION (To be completed by Current Employer only)**

<table>
<thead>
<tr>
<th>Employee Hire Date: (MM/DD/YYYY)</th>
<th>Employee Status:</th>
<th>Full-time</th>
<th>Part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the person, named above as the Employee, eligible for your company’s Health Insurance Coverage?</td>
<td>Yes  No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If "Yes," please provide the Single Employee monthly premium contribution information below:**

**Important Note:** If your company pays for, reimburses, or intends to pay or reimburse the person, named above as the Employee, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan), that amount should be reflected in the monthly premiums.


**If "No," please indicate why employee is not eligible:**

- Benefits not offered
- Part-time employee (not eligible for benefit)
- Other, please explain:

**SECTION D. EMPLOYER SIGNATURE (To be completed and signed by Current Employer only)**

Statement: Under penalties of perjury, I hereby certify that the above answers are true and correct. I further understand that omission of important facts, of a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Public Education Employees' Health Insurance Plan (PEEHIP), for a person who is ineligible for such plan, is a violation of the anti-fraud provision of the Health Insurance Portability and Accountability Act, to which civil and criminal penalties, including imprisonment, can apply.

Printed Name of Company Representative Providing Verification

Title

Signature of Company Representative Providing Verification

Date

**EMPLOYER:** Please return this Employment Verification Form to your Employee. The Employee must submit this form to PEEHIP. Thank you for your cooperation.

**SEE REVERSE SIDE FOR INSTRUCTIONS**
Under Alabama law, Section 16-25A-5.2(1), Code of Alabama, 1975, employees who retire after September 30, 2005, and who become employed by an employer that provides employees at least 50 percent of the cost of single health insurance coverage and that qualify to receive other employer group health insurance coverage through that employer shall be required to use the employer’s health benefit plan for primary coverage and the Public Education Employees’ Health Insurance Plan may provide supplemental secondary coverage. If you are required to take your new employer’s health insurance, the Public Education Employees’ Health Insurance Plan (PEEHIP) offers supplemental and optional coverages at little to no cost. Please visit the PEEHIP website, www.rsa-al.gov, or contact PEEHIP for more information on the supplemental and optional coverages.

You can re-enroll in PEEHIP without a break in coverage if your new employer stops paying at least 50% of the cost of single coverage or if you should lose your other employer’s health insurance coverage due to termination or ineligibility.

All employees who retired after September 30, 2005, are required to complete the form on the reverse side of this letter and return it to PEEHIP (forms should be faxed to 877.517.0021 or mailed to PEEHIP, P O BOX 302150, Montgomery, AL 36130). Your employer must also complete the Employer Information Sections C and D of the Retiree Employment Verification form (on back) if applicable. You must also contact PEEHIP about subsequent employment changes if other group health insurance coverage is made available to you.

Any employee or retiree who knowingly and willfully submits materially false information to PEEHIP shall repay all claims and other expenses incurred by the plan related to false or misleading information submitted by the employee or retiree, in addition to a charge based on the applicable interest rate (Section 16-25A-20, Code of Alabama, 1975).

If you or your covered dependents are under age 65 and Medicare eligible, it is imperative that you notify the PEEHIP office and provide a copy of your or your dependent’s Medicare card to ensure that medical and prescription drug claims are being processed correctly and you are paying the lower PEEHIP premium.

Thank you for your cooperation.