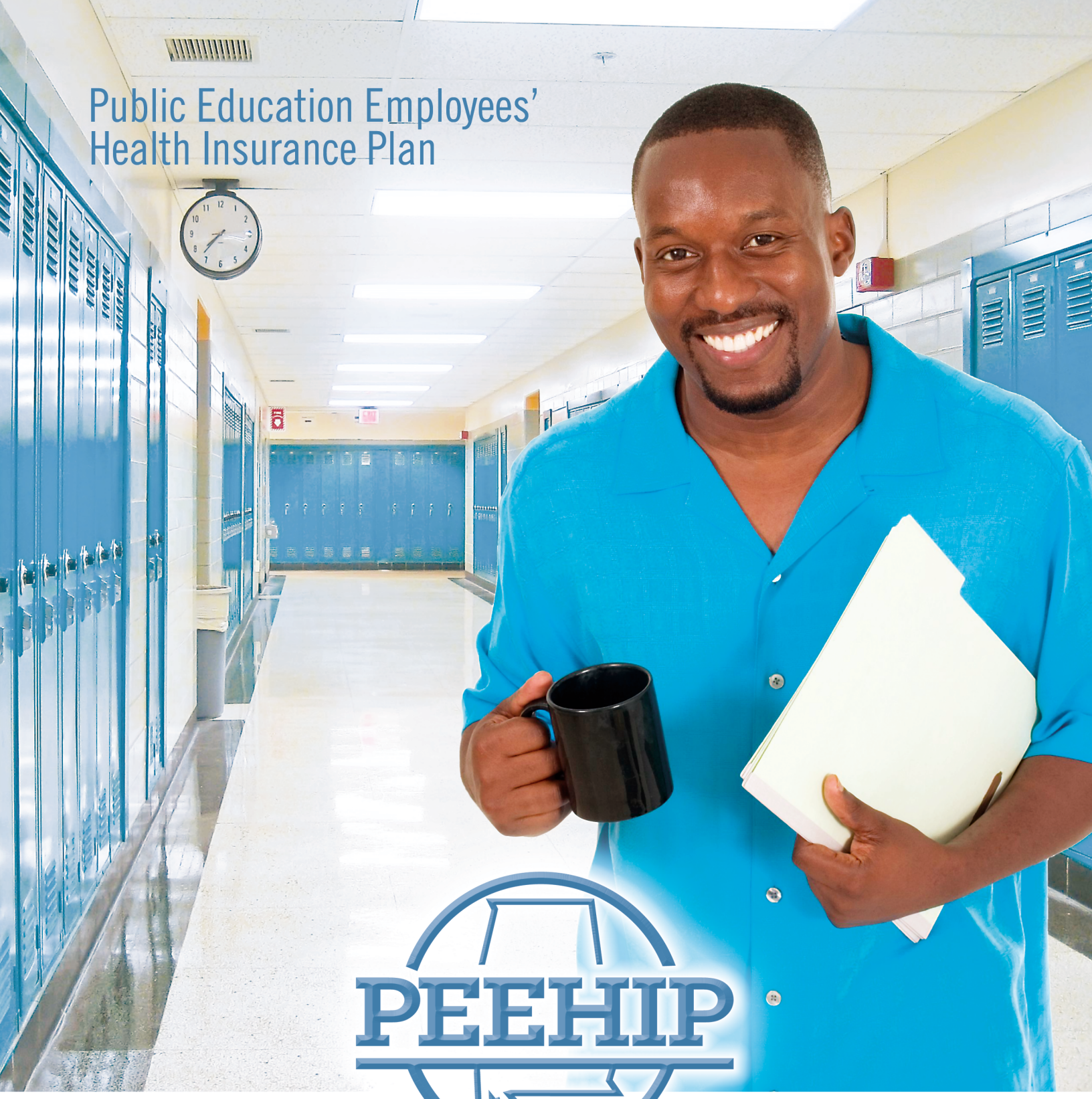
Public Education Employees'
Health Insurance Plan



PEEHIP

Member Handbook

with ***Open Enrollment*** *information*

THE RETIREMENT SYSTEMS OF ALABAMA

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
www.rsa-al.gov/index.php/members/peehip/flex-account/

Business Hours

8:00 a.m. - 5:00 p.m.
Monday - Friday

Additional Contact Information

Wellness Program and ALL Kids *(Administered by the Department of Public Health)*

201 Monroe St, Suite 986
Montgomery, AL 36104
www.adph.org/worksitewellness
800.252.1818

Tobacco Cessation Quitline
800.QUIT.NOW
800.784.8669
www.alabamaquitnow.com

ALL Kids
P.O. Box 304839
Montgomery, AL 36130-4839
888.373.5437
www.adph.org/allkids

Blue Cross Blue Shield of Alabama *(Administrator of Hospital/Medical, Flexible Spending Accounts, & Supplemental Plans)*

450 Riverchase Parkway East
P.O. Box 995
Birmingham, AL 35298
www.bcbsal.org/peehip/

Customer Service
800.327.3994

Preadmission Certification
800.248.2342

Rapid Response to order ID cards, directories & claim forms
800.248.5123

Flexible Spending Accounts
800.213.7930

Baby Yourself (Prenatal Wellness Program)
800.222.4379

Fraud Hot Line
800.824.4391

MedImpact - *Administrator of Core Pharmacy, Specialty, and EGWP Pharmacy Programs*

10680 Treena Street
San Diego, CA 92131
https://mp.medimpact.com/ala

Customer Service
(Available 24 hours/day)
877.606.0727

Pharmacy Help Desk
(Available 24 hours/day)
800.788.2949

Step Therapy Prior Authorization
(For Physician Use)
800.347.5841
Fax: 877.606.0728

Medicare GenerationRx Pharmacy and Provider Help Desk
888.678.7789
Customer Service 877.633.7943 *(Available 24 hours a day)*
https://www.medicaregenerationrx.com/peehip

VIVA Health Plan

417 20th Street North
Suite 1100
Birmingham, AL 35203
www.vivahealth.com/PEEHIP

Customer Service
205.558.7474
800.294.7780

Delta Dental Customer Service
(Dental provider for Viva Health Plan)
800.521.2651

Southland Benefit Solutions - *Administrator of Cancer, Dental, Indemnity, & Vision Optional Plans*

2200 Jack Warner Pkwy, Ste 150
P.O. Box 1250
Tuscaloosa, AL 35403

Customer Service
800.476.0677
www.southlandpeehip.com

Common PEEHIP Acronyms

PEEHIP	Public Education Employees' Health Insurance Plan	HIPAA	Health Insurance Portability and Accountability Act
BCBS	Blue Cross Blue Shield	ADPH	Alabama Department of Public Health
HMO	Health Maintenance Organization	CHIP	ALL Kids Children's Health Insurance Program
PPO	Preferred Provider Organization	SEIB	State Employees' Insurance Board
OE	Open Enrollment	FSA	Flexible Spending Accounts
OTC	Over the Counter	FPL	Federal Poverty Level
PMD	Preferred Medical Doctor	UCR	Usual Customary Rates
MOS	Member Online Services		

PEEHIP Member Handbook
with Open Enrollment Information

Introduction

The Retirement Systems of Alabama (RSA) is pleased to provide you with the 2014-2015 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.

Contents

General Information

The Public Education Employees' Health Insurance Plan (PEEHIP) was established in 1983 to provide quality health care insurance benefits for members employed in any public institution of education in the state of Alabama.

PEEHIP Plan Administrators

Blue Cross Blue Shield of Alabama (www.bcbsal.org/peehip/) administers the PEEHIP Hospital Medical, Flexible Spending Accounts and Supplemental Plans. See the *PEEHIP Hospital Medical Matrix of Benefits, Supplemental Coverage Plan,* and *Flexible Spending Account* brochures on our website for more information.

Viva Health (www.vivahealth.com/peehip) administers an alternative Hospital Medical Plan. See the *Viva Health Summary of Benefits* brochure for more information. Visit the Benefits and Policies page on our website to view the Comparison of Benefits between Blue Cross and Viva Health.

MedImpact (www.mp.medimpact.com/ala) administers the Core Pharmacy, Specialty Pharmacy, and EGWP Pharmacy Plans. See the *PEEHIP Hospital Medical Matrix of Benefits* brochure on our website for more information.

Southland Benefit Solutions (www.southlandpeehip.com) administers the Cancer, Dental, Indemnity, and Vision Optional Plans. See the Optional Plan brochure on our website for more information.

Member Online Services (MOS)

https://mso.rsa-al.gov

PEEHIP's Member Online Services offers a simple, convenient way to enroll in and make changes to your benefits electronically. The online system is fast, free, secure and accurate and operates in real-time.

By the time you receive your Confirmation page, your enrollment elections are already processed and in our system. Your Confirmation page confirms the date and time that your elections were saved and submitted to PEEHIP; gives a recap of your elections; displays your actual PEEHIP coverages; and provides your premium calculation so that you will know what your monthly out-of-pocket premium will be!

No paper forms, envelopes, stamps or last minute runs to the post office when you use the RSA's Member Online Services system! RSA and PEEHIP continually strive to improve the services we provide to our members. Use the electronic Member Online Services system and we all benefit in terms of greater efficiency and effectiveness as well as savings in time and costs!

PEEHIP Members Can Do the Following Online

New Employees

- 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 pay their initial premiums at the time of enrollment and are required to enroll using the online system. Subsequent premiums will be payroll deducted.

Year Round

- View your Current Coverages
- View and/or Update your Contact Information (address, phone number, email and marital status)
- View the history of your confirmation pages and other important documents mailed to you by PEEHIP
- Update member or spouse tobacco status
- Add or Update other (non-PEEHIP) insurance coverage information
- Members who retired on or after October 1, 2005, can update Retiree Employment Information

During Open Enrollment (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 form)
- Enroll or Re-enroll in Flexible Spending Accounts (not available to retirees)
- Add or Update Retiree Employment Information
- Update your and your Spouse's Tobacco Usage Status
- Add Dependent(s) to Coverage such as a child or spouse
- Cancel Dependent(s) from Coverage

Special Enrollment Outside of Open Enrollment

Coverage for new dependents can be added through the online system for the following four 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.

New PEEHIP Policies, Benefit and Premium Changes Effective October 1, 2014

Premium Rate Changes

The PEEHIP Board met in April and voted no increases in premiums, copays and deductibles for fiscal year 2015. An increase in PEEHIP's funding allocation by the legislature, the board's approval of changing the plan language to address issues raised by the federal healthcare reform laws and authorization of the use of funds from the Alabama Retired Education Employee's Health Care Trust as necessary to cover retiree health care costs, and other cost-savings initiatives and careful management of the PEEHIP program helped prevent increases in these rates.

As mandated by Federal COBRA Law and state law related to Surviving Spouses paying the cost of their coverage, there will be increases to these rates. Also, members who retired on or after October 1, 2005, may experience rate adjustments because their premiums are subject to the sliding scale law and are based on years of services and the cost of the insurance program. An age and subsidy component may also apply for members retiring on or after January 1, 2012. The PEEHIP retiree premium calculators with the new rates will be available on the RSA website prior to October 1, 2014.

PEEHIP Prescription Drug Changes

The PEEHIP Board approved some changes to the prescription drug formulary and added prior authorizations (PA) and quantity level limits (QLL) on certain medications and made minor changes in the Step Therapy program. Any members affected by these changes will be sent a letter from PEEHIP before October 1. More detailed information about the prescription drug changes can be found in the June edition of the *PEEHIP Advisor*.

VIVA Health Plan Benefit Changes

- Primary care physician copay - $20
- Specialist visit copay and eye exam - $40
- Surgical, diagnostic services and other outpatient care copay - $150
- Mental health copay - $40
- Emergency care copay - $175
- Chiropractic copay - $40
- Added $5 copay per lab test
- Telemedicine consultation will be added at a copay of $40 per consultation
- Specialty drug coinsurance - 20% with an increase in the out-of-pocket maximum from $1,000 per member per calendar year to $6,350 per member or $12,700 per family

Annual Out-of-Pocket Maximums

Effective October 1, 2014, the Affordable Care Act (ACA) requires all non-grandfathered health plans to comply with the annual limitation on out-of-pocket (OOP) maximums for in-network services: $6,350 for single coverage and $12,700 for family coverage. The PEEHIP Board approved a change to the plan language

to comply with the ACA annual limits. PEEHIP covered members with hospital medical coverage will pay no more than the annual OOP maximums for in-network medical expenses (excludes drug copays) during the PEEHIP fiscal plan year (not calendar year). Effective October 1, 2015, PEEHIP will be required to also include drug copays in the annual OOP maximums. This is an enhanced benefit for our members.

PEEHIP's New and Improved Wellness Program will Launch August 1, 2014

For information about the new and improved *Team Up For Health* Wellness Program and requirements, please see page 29.

Who is eligible to enroll in PEEHIP coverages?

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.

An eligible permanent, part-time employee is not a substitute or a transient employee. 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.

Eligible Dependents

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. Excludes a divorced spouse, common law spouse, and same sex partner.

Children

PEEHIP offers dependent coverage to children up to age 26. Appropriate documentation will be required by PEEHIP before dependents can be enrolled as explained on pages 9-11. 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 any child 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.

   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.**

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 hospital medical 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 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.

Who is not eligible to enroll?

Ineligible employees

- 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.

Ineligible family members (dependents)

- An ex-spouse regardless of what the divorce decree may state
- Ex-stepchildren regardless of what the divorce decree may state
- A common law spouse or same-sex partner
- Children age 26 and older
- Disabled children over 26 who were never enrolled or were deleted from coverage
- An employee who is eligible for PEEHIP as a subscriber cannot be covered as a dependent child on another PEEHIP policy.
- 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 you by blood or marriage for which you do 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

How do I enroll or make changes in coverages?

This section provides you with information on how to enroll yourself and your eligible dependents in PEEHIP Hospital Medical Plans or Optional Coverage Plans, and Flexible Spending Accounts, or make changes in your coverages. Enrollments and changes in coverage are handled by PEEHIP and not by the employer.

The preferred method of enrollment is online through Member Online Services (MOS) at https://mso.rsa-al.gov. Instructions are given below.

Alternatively, enrollments or changes in coverage can be made by submitting a completed New Enrollment and Status Change form to PEEHIP if you do not have access to a computer or the Internet. The form is in the back of this handbook and on the PEEHIP web site, or can be obtained upon request by calling Member Services at 877.517.0020.

Enrolling in or changing coverage online

1. Go to www.rsa-al.gov and click the MOS Login at the top of the page. You can also go to https://mso.rsa-al.gov.

2. Enter your User ID and Password.

3. If you do not have a User ID and Password, click "Register Now" and follow the on screen prompts to create your own User ID and Password. You will need your personal identification number (PID). The PID has replaced your social security number as your identifying number to use with the TRS and PEEHIP. Current and new members who do not know their PID can request a PID letter when registering online.

4. Once you successfully log in, click the link "Enroll or Change PEEHIP Coverages" from the PEEHIP menu found at the left of your screen.

5. Select the "New Enrollment" link (available for new employees who are within 30 days of their hire date), or "Open Enrollment" (available during the Open Enrollment period), or "Qualifying Life Event" (to add a newly acquired dependent if within 45 days of QLE). Click Continue and follow the onscreen prompts until you receive your Confirmation page.

Items needed during the enrollment process:

1. Social Security numbers for you and your eligible dependents

2. Other health insurance information you and your dependents are covered under

Enrollment Documentation Required by PEEHIP

Every member who enrolls dependent(s) on his or her PEEHIP coverage(s) is required to certify to PEEHIP their dependent's eligibility. Certification will require appropriate documents to support your dependent's 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.

Please mail, email, or fax your documents to PEEHIP.

Enrollments cannot be processed without the appropriate documentation. PEEHIP is not bound by a court order to insure dependents who do not meet PEEHIP guidelines. **To avoid enrollment deadlines, submit your enrollment even if you do not have all of the appropriate documentation at the time of enrollment.**

Spouse

A spouse is defined as a member of the opposite sex to whom you are currently and legally married. Ex-spouses and common-law 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 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, or 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 the spouse at the same address as the member

"Current" is defined as within the last six months.

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 under age 26 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 residing 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 step child showing member's spouse's name

AND

- Marriage certificate showing step child'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 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 hospital medical 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 document(s) for one of the dependent categories as noted above to show the child is your biological child, adopted, or step child

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

Dependent Eligibility Audit

PEEHIP has limited funds to cover the high cost of claims and coverage of its eligible members and their dependents who are enrolled in PEEHIP coverages. PEEHIP must use its limited funds appropriately and this entails monitoring compliance with eligibility policies to prevent fraud, waste and abuse. Therefore, in 2011 PEEHIP conducted a 100% dependent eligibility audit to ensure compliance with its dependent eligibility policies, and PEEHIP continues to monitor compliance.

If you are covering an ineligible dependent, you must notify PEEHIP and disenroll the dependent immediately. If you know of someone who is covering an ineligible dependent, please notify PEEHIP by phone 877.517.0020, fax 877.517.0021, email peehipinfo@rsa-al.gov or mail PEEHIP, P.O. Box 302150, Montgomery, AL 36130-2150.

Covering ineligible dependents unnecessarily raises costs for all eligible PEEHIP members. Help PEEHIP prevent fraud, waste and abuse through compliance with its dependent eligibility policies.

When can I enroll or make changes in coverages?

Open Enrollment

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 the coverages the members are currently enrolled in, including their current tobacco status on fi le with PEEHIP.

In addition, the complete PEEHIP Member Handbook with Open Enrollment Information is available on the PEEHIP Open Enrollment web page by July 1 every year and provides information about any changes effective for the upcoming plan year.

Open Enrollment begins July 1 and will end 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 30**. Any paper forms or faxes postmarked after August 30 will not be accepted.
- The deadline for enrollment or re-enrolling in a **Flexible Spending Account** online or on paper is **September 30**.

No Open Enrollment changes can be made after these deadlines.

Effective Date of Coverage: All Open Enrollment elections approved by PEEHIP during the Open Enrollment period will have an effective date of October 1.

Open Enrollment Web Page

PEEHIP created an Open Enrollment web page designed to make it easy for you to find all the information you need to make informed decisions about your health plan elections. You will find the open enrollment deadlines, the PEEHIP Member Handbook with the Open Enrollment information, and other pertinent information about Open Enrollment. Go to **www.rsa-al.gov/index.php/members/peehip/open-enrollment/**.

During Open Enrollment, You Can

- Enroll, Change or Cancel your Hospital Medical Plan
- Enroll, Change or Cancel your Optional Coverage Plans (cancer, dental, indemnity and vision)
- Add, Update or Cancel your Other (non-PEEHIP) Health Insurance Coverage Information
- Enroll or Re-enroll in Flexible Spending Accounts
- Enroll or Re-enroll in the Federal Poverty Level Discount Program (paper form only)
- Add or Update your Medicare Information
- Add or Update Retiree Employer Information
- Update your and your Spouse's Tobacco Usage Status
- Add Dependent(s) to Coverage such as a newborn child or new spouse
- Enroll your child(ren) (under the age of 26) to any PEEHIP plan or the VIVA Health Plan
- Cancel Dependent(s) from Coverage

Optional Plans (Cancer, Dental, Hospital Indemnity and Vision)

- The state allocation will pay in full for the four Optional Plans for a full-time active employee who is not enrolled in one of the Hospital Medical Plans.
- If an employee wants to apply the state allocation to the PEEHIP Hospital Medical Plan or the HMO Plan, he or she may purchase one or more Optional Plans. The cost is $38/month for each plan. The monthly premium for family dental is $45.

- Optional Plans must be all "Single" or all "Family" plans.
- The Optional Plans must be retained for the entire insurance year, i.e., through September 30.
- New employees 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 Plan(s) cannot change to single Optional Plan(s) outside the Open Enrollment period unless all dependents become ineligible due to age, death or divorce.

Helpful information about Open Enrollment

- **If you do not wish to make changes to your PEEHIP coverage, you do not need to complete the enrollment form or use Member Online Services. You will remain enrolled in the same or existing plan(s), and the appropriate premium will continue to be deducted.**
- **Exception**: Eligible members who want to enroll or renew their **Flexible Spending Accounts** or the **Federal Poverty Level Premium Discount**, must re-enroll each year. These two programs do not automatically renew each year without a new application. To re-enroll in the Flex plan, the preferred method to enroll is online through MOS at www.rsa-al.gov or you can use the form in the back of this handbook. Retired members are not eligible to enroll in the Flexible Spending plans. To enroll or re-enroll in the FPL program, you must complete the FPL application in the back of this handbook. FPL enrollment cannot be done online.
- Members enrolling in new insurance plans should receive their new ID cards no later than the last week in September.
- The new payroll deduction for changes made to your PEEHIP insurance coverage during Open Enrollment will be reflected in your 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.
- Active members electing to enroll in the Flexible Spending Accounts will have their first Flex contribution amount deducted from their October paycheck.
- The preferred method of enrolling or changing coverages is online through https://mso.rsa-al.gov. The Open Enrollment forms are also in the back of this packet, and a self-addressed envelope is provided for your convenience.
- You are not required to certify your tobacco usage status every year unless you or your spouse have a change in your tobacco usage status. You can certify changes in tobacco usage status online through https://mso.rsa-al.gov or by completing the tobacco usage questions on the New Enrollment and Status Change form and mailing the form to PEEHIP.
- **Pursuant to the federal healthcare reform laws, all members and dependents regardless of age that are added to PEEHIP coverage on or after October 1, 2014, will not have waiting periods applied on pre-existing conditions.**

New Employees

New employees must enroll online through MOS within 30 days of hire date. The effective date of coverage can be the date of employment or the first of the month following date of employment.

If online enrollment is not completed within 30 days:

- The New Employee enrollment link within MOS is only available until the 30th day after your employment date, and then it is removed.
- If online enrollment is not completed within the deadline, the new employee is only permitted to enroll in single Hospital Medical coverage. The new employee must then submit a New Employee and Status Change form to PEEHIP and the effective

date will be the date the form is completed and 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 Payment

Premiums are due one month prior to the coverage period and will be payroll deducted. Because new employees will not yet have a paycheck for payroll deduction of the first month's premium, the first month's premium must be paid at the time of enrollment and can be paid online. Failure to timely pay will result in your enrollment not processing and a claim hold on your account.

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.

Pre-Existing Conditions

Prior to October 1, 2014, new employees and dependents with effective dates of coverage on or after July 1 and before October 1 are given waivers on the waiting periods for pre-existing conditions. All children under the age of 19 are given waivers on waiting periods for pre-existing conditions regardless of effective date of coverage.

Beginning October 1, 2014 and pursuant to the federal healthcare reform laws, all members and dependents regardless of age that are added to PEEHIP coverage on or after October 1, 2014, will no longer have waiting periods applied on pre-existing conditions.

Family Coverage

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

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 46 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.

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.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects Americans who move from one job to another, and have a loss of coverage. HIPAA applies to the PEEHIP Hospital Medical Plan and the VIVA plan. HIPAA does not apply to the four Optional Plans administered by Southland Benefit Solutions Insurance Corporation.

HIPAA provides for increased health coverage portability for our members and special enrollment periods. HIPAA provides for other benefits such as guaranteed availability and renewability of health insurance coverage.

Pre-Existing Conditions

Beginning October 1, 2014 and pursuant to the federal healthcare reform laws, all members and dependents regardless of age that are added to PEEHIP coverage on or after October 1, 2014, will no longer have waiting periods applied on pre-existing conditions.

Credit Must Be Given for Creditable Coverage

When medical coverage is cancelled on a PEEHIP member or dependent, Blue Cross and Blue Shield of Alabama or VIVA Health Plan will mail the Certificate of Creditable Coverage to the member's address on file. This certificate provides evidence of prior health coverage and can be used to demonstrate creditable coverage to the member's new plan or issuer. The certificate can be furnished automatically to members and upon request by an individual within 24 months after coverage ends.

PEEHIP and the VIVA plan will accept the Certificates of Creditable Coverage from other plans.

Special Enrollment Outside of Open Enrollment

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 coverage loss situations that qualify for special enrollment:

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

These individuals are not required to wait until the Open Enrollment period to enroll in the Hospital Medical Plan. 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 continuation of coverage, the special enrollment can only be requested after exhausting COBRA continuation of coverage.
- If the other coverage is not COBRA

continuation of coverage, special enrollment can only be requested after losing eligibility for the other coverage or after cessation of employer contributions for the other coverage. In each case, the employee has 45 days to request special enrollment.

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.

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

The special enrollment for new dependents can occur if a person has a new dependent by birth, marriage, adoption or placement for adoption or legal custody. The election to enroll must be made within 45 days following the qualifying life event and can be made online.

If the request is not made within 45 days of the loss of coverage, the special enrollment benefit does not apply. In addition, the coverage effective date must be within 45 days of the loss of coverage.

When requesting special enrollment in Hospital Medical coverage due to loss of coverage, the member must submit to PEEHIP a completed New Enrollment and Status Change form and attach a letter on company letterhead from the employer through which coverage was lost and the letter must state the reason for the loss of coverage, the employment and termination dates, and the date the coverage ended. The New Enrollment and Status Change form can be downloaded from the PEEHIP website. Special enrollment due to loss of coverage cannot be made online.

If the loss of coverage is due to divorce, the member must indicate on the form and give the exact date of divorce 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, the member is required to wait and enroll during the Open Enrollment period of July 1 – August 31 for an October 1 effective date of coverage. Members are only allowed to enroll in the Hospital Medical plan when there has been a loss of coverage and must wait until Open Enrollment to enroll in the Optional Plans. The member cannot enroll in dental or vision coverage 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 he or she enrolls in Hospital Medical coverage due to a loss of previous coverage if he or she had the Optional Plan(s) for at least one year.

Newly Acquired Dependents and Single Coverage

Marriage

A member enrolled in single coverage who marries and wishes to acquire family coverage can request coverage within 45 days of the marriage. You must mail a copy of the marriage certificate to PEEHIP after adding the new spouse to coverage through Member Online Services at www.rsa-al.gov. The effective date of coverage can be the date of marriage or the first day of the following month. Prior notification is not required.

If you do not enroll your new spouse through the online system or in writing within 45 days of the date of marriage, the policy cannot be changed to family and the new spouse cannot be added until the Open Enrollment Period.

Members will be required to make payment for the additional family premium at time of enrollment.

Birth, Adoption, or Legal Custody of a Child

Members enrolled in single coverage who desire family coverage due to the birth, adoption, or legal custody of a child can request coverage within 45 days of the qualifying life event. You must provide a copy of the birth certificate, adoption or custody papers and the child's Social Security number after adding your child through the Member Online Services (MOS) system at www.rsa-al.gov. Click the QLE link after logging into MOS. You can also submit written notification to PEEHIP within 45 days of the date of qualifying life event. The effective date of coverage can be the date of birth or the first day of the following month.

If PEEHIP does not receive your online enrollment or written notification within 45 days of the qualifying life event, the policy cannot be changed to family and the new dependent cannot be added until the Open Enrollment period. If a newborn is not covered on the date of birth, claims for the newborn at the time of birth will not be paid.

When adding family coverage, a member can add all eligible dependents to the policy. A member who is only enrolled in the four Optional Plans cannot enroll in the Hospital Medical Plan due to any of these qualifying life events.

Members will be required to make payment for the additional family premium at time of enrollment.

Newly Acquired Dependents and Family Coverage

If a member is enrolled in family coverage, the member can enroll a new dependent(s) by using the Member Online System at www.rsa-al.gov or by completing and mailing a New Enrollment and Status Change form to PEEHIP within 45 days of acquiring the dependent(s). Prior notification is not required. Application for dependent coverage must be made by the employee and approved and processed by PEEHIP prior to the payment of any claims.

Cancelling or Changing Coverage Outside of Open Enrollment

Active Members

On October 1, 2005, all active members began paying 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 their coverage, or drop/add dependents outside of the Open Enrollment period. Also, the request to cancel or change coverage must be within 45 days of the IRS qualifying event.

Examples of IRS qualifying events are:

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

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

A member is not eligible to drop the medical plan when they change from full-time to part-time status.

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. When a policy is cancelled, the coverage remains in effect through the last day of the month. Policies cannot be cancelled in the middle of a month.

Retired Members

A retired member's premiums are not paid with pre-taxed dollars; therefore, a retired member can drop the hospital medical coverage, drop a dependent(s) from hospital medical coverage, or change from family to single hospital medical coverage outside of Open Enrollment on a prospective basis, by submitting a written request to PEEHIP. The cancellation of coverage will be the first day of the month following receipt of the written notification. A retired member cannot make changes to the optional coverage plans until the Open Enrollment period.

An 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 deleted 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.

Active and retired members can use the online system to report a divorce and 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 box, and then 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 a computer, you must timely notify PEEHIP of your divorce by completing and mailing or faxing a New Enrollment and Status Change form and a copy of your divorce decree to PEEHIP.

Coordination of Benefits

To ensure claims are properly processed, PEEHIP conducted a Coordination of Benefits (COB) audit in July 2013. The audit collected other health, dental and vision insurance information on our members and their covered dependents, and verified retiree employment information for members who retired on or after October 1, 2005.

A member must correctly complete the Other Health Insurance Coverage information section online or on the New Enrollment and Status Change form, and update PEEHIP when changes are made. Members and dependents are legally required to notify PEEHIP of other coverage. Also, employers must inform PEEHIP when other insurance coverage of any kind is provided to employees by their system.

Dental and Vision Plans

If an active or retired 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. In addition, 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. Claims incurred and filed on the PEEHIP dental and vision plans administered by Southland Benefit Solutions 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 plan will still be required to pay any copays or deductibles imposed by PEEHIP. PEEHIP will cover the portion of the health plan deductibles and copays that exceed the PEEHIP copays.

PEEHIP Hospital Medical Coverage

(Coverage for Active Members and Non-Medicare-eligible Retirees)

Hospital Benefits *(Administered by Blue Cross)*

- Inpatient Hospitalization: Services are covered in full for 365 days without a dollar limit.
- Deductible: $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 $25 for days 2-5.
- Preadmission Certification (PAC): All admissions will be subject to Preadmission Certification by completing a Blue Cross and Blue Shield of Alabama Preadmission Certification form. Emergency admissions must be certified by the first business day following the admission by calling 800.354.7412.
- Inpatient Rehabilitation: Coverage in a rehabilitation facility limited to one admission per illness or accident; one per lifetime with a 60-day maximum. Precertification is required.
- Outpatient Hospital Charges: $150 facility copay for outpatient surgery and $150 facility copay for medical emergencies and hemodialysis. There is no copay required for accident related services rendered within 72 hours after the accident.
- Non-medical emergencies will be paid under major medical at 80% of the allowable charge after a $300 calendar year deductible.

Major Medical Benefits *(Administered by Blue Cross)*

- Deductible: $300 deductible per person per calendar year; maximum of 3 deductibles per family per year or $900.
- Coinsurance: After you pay the $300 deductible, the plan pays 80% of the Usual Customary Rates (UCR) of covered expenses for the first $2,000 and 100% UCR thereafter.
- Covered Services: Physician services for medical and surgical care when you do not use a PMD physician; laboratory and X-rays, (outpatient MRI's must be precertified); ambulance service; blood and blood plasma; oxygen, casts, splints and dressings; prosthetic appliances and braces; podiatrist services; physical therapy; allergy testing and treatments; semi-private room and other hospital care after basic hospital benefits expire.
- Sleep Studies will be covered in an approved Blue Cross sleep disorder facility with the following copays:
  - Freestanding clinic: $10 facility copay
  - Hospital outpatient facility: $150 facility copay for adults and $10 copay for children 18 and under

Preferred Medical Doctor (PMD)

- $5 Copay Per Test: Outpatient diagnostic lab and pathology (including pap smears).
- $30 Copay Per Visit: Doctor's office visits and consultations; one routine preventive visit each year for adults age 19 and over.

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

- Coverage is not provided for nursing home costs, vision and dental care (except accidental injuries), cosmetic surgery, hearing aids and experimental procedures.

Pharmacy Program *(Administered by MedImpact)*

- Participating Pharmacy: When you choose 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 website at www.rsa-al.gov.) (30-day supply)
  - $60 for any covered non-preferred brand drug (30-day supply)
  - Approved maintenance drugs may 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.
- 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 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."
- 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.

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.

Remember, this is only a summary of benefits. Members should refer to the Summary Plan Description for detailed information and limitations.

Step Therapy 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 U.S. Food and Drug Administration (FDA) for safety and effectiveness.

How does Step Therapy work?

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. Your copayment is usually the lowest with a first-step drug. It will be necessary for you to use the first-step drugs before the plan will pay for second-step drugs.

Second Step: If your treatment path requires more medications, then the program moves you along to this step, which generally includes brand-name drugs. Brand-name drugs are usually more expensive than generics, so most have a higher copayment.

When a prescription for a second-step drug is processed at your pharmacy for the first time, your pharmacist will receive a message indicating the PEEHIP plan uses Step Therapy. If you would rather not pay full price for your prescription drug, your doctor needs to give you a prescription for a first-step drug. Only your doctor can change your current prescription to a first-step drug covered by your program. 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.

With Step Therapy, more expensive, brand-name drugs are usually covered in a later step in the program if you have already tried the first-step drug. If your doctor decides you need a different drug for medical reasons before you have tried a first-step drug, then your doctor can call MedImpact to request a "prior authorization." If the second-step drug is approved, you will pay a higher copayment than for a first-step drug. If the drug is not approved, you will need to pay the full price for the drug. You can appeal the decision through the appeals process outlined in the Blue Cross PEEHIP handbook.

If you have medical reasons that prevent you from trying a first-step drug, your physician can contact MedImpact to request a prior authorization by calling 800.347.5841. For other questions about the Step Therapy program, contact MedImpact Customer Service at 877.606.0727.

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

VIVA Health Plan

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 36.

The VIVA Health plan is not available to retired members who are Medicare-eligible 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 $25 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 surgery and $175 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%.

Major Medical Benefits

- Major medical deductible per calendar year is $300 per person; $900 maximum per family.
- **Calendar year out-of-pocket maximum increases to $6,350 per member or $12,700 per family.**
- 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

- **$5 copay per test for lab procedures.**
- **$20 copay for Primary Care Physician visit.**
- **$40 copay for Specialty Care and eye exam. No referral required.**
- 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.

Pharmacy Program

- Participating Pharmacy: When you choose a Participating Pharmacy you pay the following:
  - $5 preferred generic drugs
  - $20 non-preferred generic drugs
  - *$40 for any covered preferred brand drug
  - *$65 for any covered 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.
- 90-day supply is available through mail order for 2.5 copays.
- 90-day supply is available at the retail pharmacy for 3 copays.
- Participating pharmacies will file all claims for you.
- **80% coverage for self-administered injectibles, bio-technical, biological and specialty drugs and maximum out-of-pocket is $6,350 per member or $12,700 per family per calendar year for these 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 benefits 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.

Other Benefits Effective October 1, 2014

- Telemedicine consultation at a copay of $40 per consultation.
- Chiropractic copay increases to $40 up to 25 visits per calendar year.
- New $5 copayment per lab test.
- Outpatient mental health copay increases from $30 to $40.

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: Also, you can go to the VIVA website at **www.whyviva.com** to find providers in the VIVA Health network.

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

Remember, this is only a summary of benefits. Members should refer to the Summary Plan Description for detailed information and limitations.

Optional Plans

(Cancer, Dental, Hospital Indemnity, Vision Care)

There are four Optional plans offered through PEEHIP. A synopsis of these plans is provided below. More detailed information will be provided to those who enroll in the plan(s). Claims administration is provided through Southland Benefit Solutions. All Optional plans must be retained for the entire insurance year, i.e. until September 30. New employees 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.

If a member is enrolled in more than one of the Optional plans, the contracts must be all family or all single plans. 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. Listed below are merely summaries of benefits for the Optional plans. Members should refer to the 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.
- 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.
- Cancer and maternity admissions are covered as any other illness.
- There is supplemental accident coverage for $1,000. The reimbursement for an accident(s) is limited to a maximum of $1,000 per contract year for each covered individual. There is no limit on the number of accident claims that can be filed per contract year.
- Plan will allow any physician recommended observation period that is great 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)
- One new or replacement set of frames per plan year (up to $60)
- Either glasses or contacts, but not both in any plan year
- Disposable contact lenses
- 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%.

Remember, this is only a summary of benefits. Members should refer to the appropriate benefit booklet for detailed information and limitations.

PEEHIP Supplemental Coverage Plan

PEEHIP members may opt to elect the PEEHIP Supplemental Plan as their Hospital Medical coverage in lieu of the PEEHIP Hospital Medical Plan. The PEEHIP Supplemental Plan will provide secondary benefits to the member's primary plan provided by another employer. Only active and non-Medicare retiree members and dependents are eligible for the PEEHIP Supplemental Plan. There is no premium required for this plan, and the plan covers most out-of-pocket expenses not covered by the primary plan.

The PEEHIP Supplemental Plan imposes the same exclusions and limitations that are in the PEEHIP primary Hospital Medical Plan. Additionally, the PEEHIP Supplemental Plan does not pick up services excluded by the other group plan. Blue Cross and Blue Shield of Alabama is the administrator for the PEEHIP Supplemental Plan. The PEEHIP Supplemental Plan cannot be used as a supplement to Medicare, the PEEHIP Hospital Medical Plan, or the State or Local Governmental Plans administered by the State Employees' Insurance Board (SEIB). In addition, active members who have TriCare or Champus as their primary coverage cannot enroll in the PEEHIP Supplemental Plan.

The supplemental Hospital Medical Plan:

- Provides secondary coverage to the members and covered dependent(s) when primary coverage is provided by another employer.
- Only active and non-Medicare-eligible retiree members and dependents are eligible to enroll in the Supplemental Plan.
- An annual maximum amount paid from the PEEHIP Supplemental Hospital Medical Plan will be limited to $6,250 for individual and $12,500 for family coverage. Members who enroll in a Marketplace (Exchange) plan for their primary coverage cannot enroll in PEEHIP's Supplemental Plan. Members enrolled in high deductible plans with deductibles greater than $1,250 for individual or $2,500 for family are also not eligible for the PEEHIP Supplemental Plan.
- There is no premium cost for the plan when the member uses the state allocation for the Supplemental Plan.
- The Supplemental Plan covers most deductibles, copayments, and coinsurance not covered by the primary plan.
- Participants may elect individual or family coverage.
- PEEHIP Hospital Medical Plan exclusions and limitations will continue to be imposed such as exclusions for dental coverage, cosmetic surgery, limitation on infertility treatment, etc.
- The Supplemental Plan will not cover or pick up any cost of services excluded by the primary plan because the plan is strictly a supplemental plan.
- The Supplemental Plan cannot be used as a supplement to Medicare, the PEEHIP Hospital Medical Plan, or the State or Local Governmental plans administered by the State Employees' Insurance Board (SEIB).
- The Supplemental Plan only supplements your primary insurance plan by covering the copay, deductible and/or coinsurance of your primary insurance plan or the preferred or participating allowance, whichever is less.
- To be eligible for reimbursement under the PEEHIP Supplemental Coverage Plan, the primary insurance plan must have either 1) applied the eligible charges to the deductible, or 2) made primary payment for the services rendered.
- For 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 PEEHIP Supplemental Coverage Plan will not pay for amounts in excess of the allowed amount for services rendered by a non-preferred provider, amounts in excess of the maximums provided under the primary insurance plan, any services

denied by the primary insurance plan, or any penalties or sanctions imposed by the primary insurance plan.

- PEEHIP members cannot be enrolled in the PEEHIP Hospital Medical Plan and the PEEHIP Supplemental Plan.
- Active members who have TriCare or Champus as their primary insurance coverage cannot enroll in the PEEHIP Supplemental Plan.

PEEHIP Wellness Program

PEEHIP has ***Teamed Up For Health*** with the Alabama Department of Public Health (ADPH) and will soon team up with another strategic partner to launch a new and improved wellness program for PEEHIP members. 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,
- Change behavior that lowers 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, which means being able to keep the same healthcare benefits coverage in place for a longer period of time.

Who is required to participate in the PEEHIP Wellness Program?

The following members enrolled in the PEEHIP Hospital Medical Plan are required to participate:

- **Active members,**
- **Non-Medicare retirees, and**
- **Non-Medicare Covered spouses.**

All of the above must complete the applicable wellness components by the specified deadlines in order to receive the wellness premium discount. The program does not require meeting any conditions related to a health factor to obtain a discount. The wellness premium discount will be determined by the PEEHIP Board before January 1, 2015.

Participation for Medicare-eligible retirees and covered Medicare-eligible spouses is optional and not required. Under no circumstances will they have a wellness premium increase.

Wellness Components

The Wellness Program consists of some new programs and greater access to existing ones to help our members manage their health and become more educated in the lifestyle choices they have.

Required to complete in order to qualify for the wellness premium discount:

- Wellness Screening
- Health Risk Assessment Questionnaire (HRA)

Required **only** if you are identified as a candidate for these programs:

- Disease Management
- Wellness and Lifestyle Education Coaching

Wellness Screenings Begin August 1

The Wellness Screenings consist of the following measurements:

- blood pressure
- total cholesterol including HDL and LDL
- triglycerides
- blood glucose
- height, weight, waist
- body mass index

Beginning August 1, 2014, the ADPH provides the screenings at the worksite locations for active employees only. Alternatively, active employees as well as non-Medicare retirees and covered non-Medicare spouses can obtain the screenings at any of the statewide ADPH county locations or through your personal healthcare provider. Screenings obtained as of June 1, 2014, at these alternative locations will be accepted.

All screenings regardless of location must be completed by May 31, 2015, to receive the wellness premium discount effective October 1, 2015.

ADPH has a PEEHIP Wellness Calendar and Wellness County Contacts on their website (www.adph.org/worksitewellness) that will inform you when the screenings will take place in your area.

If you decide to use your personal healthcare provider to do your screening, the Healthcare Provider Screening Form is located on the PEEHIP website at www.rsa-al.gov/index.php/members/peehip/pubs-forms/. The form must be completed and faxed or mailed to ADPH **by your healthcare provider**. 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.

Also, no copay is required if an ADPH wellness coach gives you an Office Visit Referral Form to take with you to a physician's office to follow up with the abnormal results or risk factors identified during the screening process. The referral is only good for 60 days from the screening date.

Starting January 1, 2015

The **Health Risk Assessment (HRA)** which will be available January 1, 2015, is a health questionnaire used to provide you with an evaluation of your health risks and quality of life and gives individualized feedback to motivate behavior change to reduce health risks. If the HRA identifies an opportunity for improving your health, **Wellness and Lifestyle Education Coaching** will be available to you. The coaching process will offer numerous resources and services to help you maintain or improve upon a healthy lifestyle.

PEEHIP's **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). The program is a system of coordinated healthcare interventions and communications in which patient self-care efforts are significant. Applicable members will be required to participate beginning January 1, 2015, if identified as a candidate.

PEEHIP will continue to provide information about the ***Team Up for Health*** Wellness Program in future PEEHIP Advisors as well as on the PEEHIP Wellness web page at www.rsa-al.gov/index.php/members/peehip/health-wellness/.

Baby Yourself Program

Blue Cross and Blue Shield of Alabama and PEEHIP offer Baby Yourself, a prenatal wellness program 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 deductible for the delivery of your baby for those members **enrolling in the first trimester** and completing the program. The $25 copay for days 2 through 5 will still apply.

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.

Non-Tobacco User Premium Discount

All PEEHIP members enrolled in the PEEHIP Hospital Medical or VIVA Health Plan are charged a $28 per month PEEHIP premium increase. However, non-tobacco users can have the $28 premium removed from their monthly premium by certifying that they (and their spouse, if the spouse is covered as a dependent) have not used tobacco products within the last 12 months. Members must certify their tobacco status to PEEHIP to qualify for the $28 to be removed from their monthly premium. The tobacco premium only applies to the PEEHIP Hospital Medical Plan or Viva Health Plan and not the PEEHIP Optional Plans or the PEEHIP Supplemental Plan.

Members can certify their and their covered spouse's tobacco usage status online by answering the tobacco questions through Member Online Services (MOS) or by answering the tobacco questions on the New Enrollment and Status Change form and submitting the completed form to PEEHIP.

If you have previously certified your tobacco status and your covered spouse's tobacco status and nothing has changed, you do not need to re-certify every year. You are only required to update your tobacco status with PEEHIP if your or your spouse's tobacco status changes during the year or unless you make changes to your coverages. The update can be made anytime during the plan year either online through Member Online Services (MOS) or by submitting a completed New Enrollment and Status Change form, and the premium change will be applied prospectively.

Tobacco premium 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 has been a non-tobacco user for the previous consecutive twelve months.

If you or your covered spouse are tobacco users and do not qualify for the non-tobacco user discount, PEEHIP can provide information and guidance to help you or your spouse stop smoking through a tobacco cessation program PEEHIP utilizes. If you complete the program, you can qualify to receive the non-tobacco user discount from the time you begin the program until the end of the plan year. Additionally, your physician may recommend an alternative method for you to qualify for the discount, if you or your covered spouse are medically unable to participate in the tobacco cessation program. Members 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 they continue to use tobacco products. For members who utilize the tobacco cessation program and then become non-tobacco users for 12 months, the premium discount will be applied and no further cessation program participation will be required 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 Program Coordinator toll free at 877.517.0020.

New employees who enroll in the 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 the Member Online system at the time of enrollment.

Flexible Spending Accounts

(Administered by Blue Cross and Blue Shield of Alabama)

We are all looking for ways to increase our spendable income and participating in PEEHIP's Flexible Spending Account program is one way that really works! You save money by not paying taxes on the contribution amount you elect. The PEEHIP Flexible Spending Accounts program is available to all active members of PEEHIP and is also a great way to offset the costs of your out-of-pocket copayments and deductibles. Retired members are not eligible to participate in any of the Flexible Spending Accounts.

PEEHIP offers a Flex Debit Card that can be used as a reimbursement option with the Health Care Spending Account, and there is no additional charge for members to use this debit card. Retain copies of any invoices, receipts or other documentation you receive in connection with a transaction made with the card because you may have to file these with the Preferred Blue Customer Service Center to substantiate your charge.

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 no longer has to pay federal and state of Alabama income taxes on their health insurance premium.

2. **Dependent Care Flexible Spending Account** allows eligible active members the opportunity to pay dependent care expenses using pre-tax dollars.

3. **Health Care Flexible Spending Account** allows eligible employees to set aside tax-free money in an account to pay themselves back for eligible health care expenses incurred by them and their dependents.

The Open Enrollment deadline for the Flexible Spending Accounts is September 30, for an effective date of October 1. Members who are currently enrolled in a Flexible Spending Account through their employer are allowed to enroll in the PEEHIP spending accounts at the end of their employer's plan year. To continue the Flex Plan, members currently enrolled in the PEEHIP Flexible Spending Accounts must re-enroll every year. These programs do not automatically renew each year.

To enroll in the Flexible Spending Accounts, members can easily enroll in the Flexible Spending Accounts by using the Member Online Services system at **www.rsa-al.gov**. Members can also complete the Flexible Spending Account Enrollment Application located in the back of this packet and return the form to the PEEHIP office prior to October 1. More information is available at **www.bcbsal.org/peehip1/preferredBlue/index.cfm** and at **www.rsa-al.gov/peehip/flex.html**.

Listed below are some of the eligible expenses that can be paid from your Flexible Benefits Account:

Health Care Flexible Spending Account:

- Prescription drug co-pays
- Physician co-pays
- Vision care including Lasik and Prelex surgery
- Hearing care
- Deductibles
- Orthodontia
- Coinsurance
- OTC medications are eligible expenses only with a prescription.

Dependent Care Flexible Spending Account:

- Licensed nursery school and day care facilities for children
- Child care in or outside your home
- Day care for an elderly or disabled dependent

To determine how much per year you want to contribute to your Flexible Spending Account(s), you should assess what your expenses were the year before and determine if these expenses will occur again and then add in any new expenses including the increase in copayments and deductibles. Your annual contributions must be whole dollars. The maximum annual amount for the Dependent Care Account is $5,000 if single or married filing a joint return or $2,500 if married filing a separate return; and $2,500 for the Health Care Account. The funds are deducted from your pay before taxes are withheld and deposited into your account.

If your medical and/or dental insurance is with any PEEHIP medical or optional plan, your out-of-pocket expenses for medical and/or dental services will automatically apply to your Flexible Spending Account. This saves you time and you get reimbursed quicker because you don't have to submit a claim form for reimbursement! If you have medical, dental or secondary coverage with another insurance plan, you will need to file a Request for Reimbursement form with appropriate documentation and provide documentation of what the other carrier paid. You can also use the "Alabama Blue" mobile app on your smart phone to submit your reimbursement.

The out-of-pocket money is reimbursed to you from your account. You may even elect to have it deposited directly into your checking or savings account. Expenses for both the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account can be submitted to Blue Cross by January 15 following the end of the plan year.

$500 Carryover Provision (Applicable to Health FSA Only)

The Department of Treasury and Internal Revenue Service issued Notice 2013-7 on October 31, 2013, announcing a modification to the long standing "use-it-or-lose-it" rule applicable to health Flexible Spending Accounts (FSAs). The Public Education Flex Employees' Benefits Board on December 2, 2013, adopted the modification for inclusion in the PEEHIP Health FSA Plan, effective with the October 1, 2013, flex plan year.

The modification allows up to $500 of unused funds remaining in a health FSA at the end of the plan year to be carried over and used in the following plan year for covered health FSA eligible expenses. The carryover limit will apply to all plan participants. Under IRS rules, the carryover provision is an alternative to the grace period provision and the IRS does not permit a plan to have both. Consequently, PEEHIP will cancel the grace-period provision at the same time the new carryover provision is effective. Even though the grace period provision will be canceled, the "use-it-or-lose-it" rule still applies to the carryover provision. Therefore, any unused amounts in excess of $500 remaining in your health FSA at the end of the plan year will be lost.

The new carryover provision does not affect the maximum contribution amount you can make to your health FSA. For plan year 2014, the maximum contribution amount is $2,500. The $500 carryover provision is not cumulative. For example, an employee who carries over $500 from year one to year two does not have up to $1,000 to carry over from year two to year three, and $1,500 from year three to year four, etc. The new carryover provision allows a maximum carryover amount of only $500 per year, regardless of carryovers from prior years or account balance in the current year. The new carryover option does not affect the ability of a health FSA to use a timely filing period. The timely filing period for the PEEHIP flex plan year is still permitted, allowing plan participants 105 days at the end of the plan year (from October 1 – January 15) to file claims for reimbursement.

If you terminate employment or retire before the end of the plan year, your Flexible Spending Accounts will terminate the first day of the following month. When a member retires or terminates employment before the end of the plan year, the member must use or incur the money in his or her Flex account by the Flex termination date. For example, if a member retires June 1, and the Flex account terminates September 1, the member must incur the covered expenses by September 1. Claims must be filed within 105 days from the end of the plan year.

ALL Kids Children's Health Insurance Program (CHIP)

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). Therefore, PEEHIP does not offer a CHIP program.

Eligibility for ALL Kids must be determined annually. 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,
- Within the income ranges established for participation (see income guidelines), and
- Not covered by other group health insurance.

If you want to apply for ALL Kids for your child, submit your application to ADPH now! For more information about ALL Kids, go to **www.adph.org** or call 888.373.KIDS (5437).

How to apply:

- Complete an application online at **www.adph.org** or download a paper application from the ADPH website. You can also call 888.373.5437 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.

Monthly Gross Income Guidelines for Medicaid and ALL Kids

Children Under 19 Years

Family Size	Medicaid	ALL Kids
1	0-$1,420	$1,421-$3,083
2	0-$1,914	$1,915-$4,156
3	0-$2,408	$2,409-$5,228
4	0-$2,902	$2,903-$6,301
5	0-$3,396	$3,397-$7,373

Federal Poverty Level Assistance Program (FPL)

PEEHIP provides premium assistance to PEEHIP members with a combined family income of less than or equal to 300% of the Federal Poverty Level (FPL) as defined by federal law. To qualify for FPL assistance, 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. 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 Viva 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 dependent contract. The FPL premium discount 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.

The FPL enrollment form is included at the back of this handbook. FPL enrollment is not available online through MOS.

Federal Poverty Level Premium Discount:

Over 300% of the FPL	member pays 100% of the member contribution	
equal to or less than 300% but more than 250% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 250% but more than 200% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 200% but more than 150% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 150% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2014 Federal Poverty Levels (FPL)

Family Size	100% of FPL	150% of FPL	200% of FPL	250% of FPL	300% of FPL
1 member	$11,670	$17,505	$23,340	$29,175	$35,010
2 members	$15,730	$23,595	$31,460	$39,325	$47,190
3 members	$19,790	$29,685	$39,580	$49,475	$59,370
4 members	$23,850	$35,775	$47,700	$59,625	$71,550
5 members	$27,910	$41,865	$55,820	$69,775	$83,730
6 members	$31,970	$47,955	$63,940	$79,925	$95,910
7 members	$36,030	$54,045	$72,060	$90,075	$108,090
8 members	$40,090	$60,135	$80,180	$100,225	$120,270

Comparison of Benefits

Effective October 1, 2014 – September 30, 2015
(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.

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only.) (Available for Active and Non-Medicare Members Only.)
Preventive Medical	$0 copayment then covered in full	$0 copayment then covered in full
Well Baby Care	$0 copayment per visit, 9 visits first two years of life, one visit per year age 2-6 years (based on birth year); age 7 and older, one visit per calendar year.	$0 copayment then covered in full
Routine Immunizations	$0 copayment then covered in full	$0 copayment then covered in full
Office Care		
Physician's Care	$30 per visit	**$20 per visit for primary care. $40 for specialty care and eye exam.**
Lab Procedure	$5 per test	**$5 per test**
Telemedicine Consultation	Not covered	**$40 copay**
Inpatient Facility (including Maternity)**		
Physician's Care	Covered in full	Covered in full
Inpatient/ Hospital Services	$200 hospital copayment and a $25 copayment for days 2-5	Covered in full after $200 copayment and a $25 copayment for days 2-5
Outpatient Surgery	$150 copayment	**$150 copayment, then covered in full**
In-Hospital Care		
Surgeon	Covered in full	Covered in full
Physician Visits	Covered in full	Covered in full
Anesthesiologist	Covered in full	Covered in full
Emergency		

** 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.**

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only.) (Available for Active and Non-Medicare Members Only.)
In Area/Out of Area Emergency Room Facility Charge	$150 per visit, accident within 72 hours covered 100% of the allowance; 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 allowance subject to calendar year deductible.	**$175 emergency room visit for facility**, waived if admitted within 24 hours; Physician's charges covered at 100%.
Calendar Year Deductible for Major Medical Services		
	Calendar year deductible $300 per individual; $900 maximum per family.	Calendar year deductible $300 per individual; $900 maximum per family.
Major Medical Services and Coinsurance		
	After you pay the $300 deductible, the plan pays 80% of the Usual Customary Rates (UCR) of covered expenses for the first $2,000 and 100% UCR 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 Usual Customary Rates (UCR) of covered expenses for the first $2,000 and 100% UCR 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.
Mental Health and Substance Abuse		
Inpatient	Copayments: Days 1-9 $0, days 10-14 $15, days 15-19 $20, days 20-24 $25, days 25-30 $30. Maximum of 30 days per member per fiscal year at approved facilities. Limit of one substance abuse admission per year and two admissions per lifetime.	Covered in full after $200 copayment and a $25 copayment for days 2-5.
Outpatient	$10 copayment for up to 20 outpatient visits at approved facilities.	**Covered in full after $40 copayment**

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only.) (Available for Active and Non-Medicare Members Only.)
Prescription Drugs	(Administered by MedImpact.) Generic - $6 copayment (30-day supply) Formulary (preferred brand name) drugs $40 copayment (30-day supply). Non-formulary (non-preferred brand name) drugs $60 copayment (30-day supply). Pharmacists must dispense generic drug unless 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 for generic, $80 for preferred, and $120 for 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. Zero copay for generic contraceptives; applicable copay for brand-name contraceptives.	Generic - $5 preferred, $20 non-preferred Brand Name - *$40 preferred brand (formulary) Brand Name - *$65 non-preferred (non-formulary) *When an appropriate grade generic is available and 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. 90-day supply available with mail order - 2.5x copay 90-day supply at retail pharmacy for 3x copay. **80% coverage for self-administered injectibles, bio-technical and biological drugs and maximum out-of-pocket is $6,350 per member or $12,700 per family per calendar year for these drugs.** Participating pharmacies only. Contraceptives are covered. Zero copay for generic contraceptives; applicable copay for brand-name contraceptives.

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only.) (Available for Active and Non-Medicare Members Only.)
Prescription Drugs (cont'd)	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.	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% UCR after $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

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only.) (Available for Active and Non-Medicare Members Only.)
Vision Examinations	Not Covered	Covered in full once each 12 months after a **$40** copayment with participating provider
Dental	Not Covered	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. The VIVA dental benefit is administered by Delta Dental. Type I – Preventive & 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
Spinal Service & Chiropractic Services	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. Non-participating Chiropractor- Covered under major medical at 80% of allowed amount. Member will owe 20% co-insurance, major medical deductible of $300 and charges over allowed amount. Limited to 12 visits in a calendar year per member.	Limited to 25 visits per calendar year **$40 copayment per visit**

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan* (In approved areas only.) (Available for Active and Non-Medicare Members Only.)
Infertility Services	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 medications after the $2,500 lifetime maximum is reached. Benefits are not provided for IVF, ART, or GIFT.	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.
Annual Out-Of-Pocket Maximums for In-Network Services	**PEEHIP covered members will pay no more than:** **$6,350 for single coverage** **$12,700 for family coverage** **Out-of-pocket maximums apply to in-network medical expenses (excludes drug copayments) during PEEHIP's fiscal plan year ending 9-30-15.**	**Covered members will pay no more than:** **$6,350 for single coverage** **$12,700 for family coverage** **Out-of-pocket maximums apply to in-network medical expenses (excludes prescription drugs covered by Caremark) during the calendar year.**

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

Remember, this is only a summary of benefits. Members should refer to the Summary Plan Description for detailed information and limitations.

Updating Information

Name and Social Security Number Changes

Currently, 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. Also, PEEHIP updates names from information received from the Social Security office. Therefore, the name on all insurance 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 change can be made. Also, active employees must provide a correct Social Security card to their employer to correct their TRS and PEEHIP accounts. 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). Your Social Security number will be used by PEEHIP for the purpose of Coordination of Benefits.

Address Changes

To change an address, you must notify PEEHIP in writing. The preferred method to update your address is to use the secure online process. To change your address online, go to the RSA website at **www.rsa-al.gov**. Select the **Member Online Services (MOS) Login** option at the top of the main page and follow the instructions. This address change will automatically transmit to the insurance carriers and also update your address with the Teachers' Retirement System and RSA-1 if you are a participant in those accounts. However, the address change you make through the RSA online system will not change your address with your employer. You must contact your employer to have your address changed in their system.

Alternatively, you can change your address in writing by completing an Address Change Notification form which can be downloaded from the RSA website. PEEHIP will also accept a letter with the old address, new address, insured's name and Social Security number.

The PEEHIP department cannot accept an address change by phone or email. All address changes should be made online or on the address change cards provided by the U.S. Postal Service or the Address Change Notification form provided by the RSA. The card must then be mailed to PEEHIP for the actual change to occur.

Premium Rates

Insurance premiums and enrollments are handled by PEEHIP, not by the employer. PEEHIP determines and manages the premium deductions; therefore, active and retired members are required to send all insurance changes to PEEHIP.

Prior to the payroll cutoff date, PEEHIP sends an electronic file to each employer authorizing the payroll deductions for each employer. The payroll deduction amount is based on the insurance plan(s) each member selects. If the payroll deduction is incorrect, members need to contact PEEHIP instead of their employer. It is imperative for PEEHIP to have your correct home mailing address so all members can receive important PEEHIP information.

Payment of Premiums

- PEEHIP premiums for health insurance and optional plans are deducted in the month prior to the month of coverage for active and retired members (i.e. the premium for October's insurance coverage is deducted in September).
- Flexible spending account contributions are deducted in the current month and are based upon twelve month deduction cycles (i.e. the contribution for October is deducted in October).
- Those who do not receive a check large enough to cover the amount of their total premium shall submit their monthly premium payment directly to PEEHIP (i.e. new employees who have not begun receiving a paycheck; those covered under COBRA; members on Leave of Absence; etc.).
- Failure to pay premiums timely will result in cancellation of coverage.
- New employees and members changing to family coverage outside of Open Enrollment will be required to pay their initial premiums at the time of enrollment.

Premium Rates 2014 - 2015 Plan Year

The health insurance premiums are set by the PEEHIP Board. The following monthly premiums are effective October 1, 2014 - September 30, 2015. **These rates do not include the $28 monthly tobacco premium.**

Full-Time Active Members

PEEHIP Hospital Medical or VIVA Health Plan

Coverage Type	Active Employee Monthly Out-of-Pocket Premium	Cost to State on Behalf of Active Employee
Single	$ 15	$386
Family	$177	$844

PEEHIP Supplemental Medical Plan

Single or Family	$0

PEEHIP participates in the Premium Reduction Program. Under this program, premiums for PEEHIP medical, dental, vision, cancer, and indemnity will be paid with pre-tax dollars and are excludable from income under Sections 105(b) or 106 of the Internal Revenue Code for active employees. This program is strictly a function of the payroll system in which an employee (active member) does not pay federal and state of Alabama income taxes on their health insurance premiums.

Tobacco Premium

Tobacco Premium applies to the Hospital Medical and VIVA Health plans only for members or spouses.

Active, Retired, LOA, COBRA, Surviving Dependent Members or Spouse	$28

Optional Coverage Plans

Cancer	$38/month	Individual or Family Coverage
Dental	$38/month	Individual Coverage
	$45/month	Family Coverage
Indemnity	$38/month	Individual or Family Coverage
Vision	$38/month	Individual or Family Coverage

COBRA and Leave of Absence (LOA)

PEEHIP Hospital Medical or VIVA Health Plan

Single	$ 409
Family	$1,041

Supplemental Medical Plan

Single or Family	$156

Tobacco Premium and Optional Coverage Plans are the same premiums as for Full-Time Active Members.

Allocations

An active member receives the state insurance allocation for each month the member is in pay status at least one-half of the working days of that month.

Allocations are earned in the actual month worked.

Example:

An employee who works October 1 through November 8 earns the October allocation but not the November allocation.

An employee may get paid for a portion of a month but may not earn the allocation for that month if he or she is not in pay status at least one-half of the workdays of that month.

To be eligible for a full allocation, a teacher, counselor, librarian, administrative employee or other professional employee must be employed full-time. A support worker, such as janitorial staff employee, custodian, maintenance worker, lunch room 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 a full allocation. Permanent part-time employees who meet the qualifications will be entitled to a pro rata allocation.

	Allocation Entitlement if Enrolled in Hosp/Med or HMO Plan	Allocation Entitlement if Enrolled in Optional Plans
Professional/Administrative Employee Works		
Less than ¼ time	0	0
At least ¼ time but < ½ time	¼ insurance allocation	1 Plan
At least ½ time but < ¾ time	½ insurance allocation	2 Plans
At least ¾ time but < Full-time	¾ insurance allocation	3 Plans
Full-time	Full allocation	4 Plans
	(Each additional optional plan can be purchased for $38/month or $45/month for the family dental plan.)	
Support Worker Works		
0 to 4.9 hours/week	0	0
5.0 to 9.9 hours/week	¼ insurance allocation	1 Plan
10.0 to 14.9 hours/week	½ insurance allocation	2 Plans
15.0 to 19.9 hours/week	¾ insurance allocation	3 Plans
20 or more hours/week	Full allocation	4 Plans
	(Each additional optional plan can be purchased for $38/month or $45/month for the family dental plan.)	

Leave

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

3-1 Rule

A member earns **one** month of an additional insurance allocation for every **three** months the employee is in pay status at least one-half of the workdays 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 work days in 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 allocations 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 allocation.
- 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 an insurance allocation.
- An employee can only use the earned allocation credit for the current fiscal year, i.e., the allocation credit 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 allocations, 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, the first day of the month after 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 the insurance allocation:

Actual Service (months)	Earned Allocation(s)
1	1
2	2
3	4
4	5
5	6
6	8
7	9
8	10
9	12
10	12
11	12
12	12

Terminated Employee

The school system is not required to pay the September allocation for an employee terminating the end of May when the employee has worked September through May. These employees have earned the insurance allocation through August and should not be given credit for the September insurance allocation.

Additional Information about Insurance Allocations

An allocation for the month will be due if a member is hired on the first day of the month. An allocation 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 have an allocation to burn for July, August, and September.

A full August allocation 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 entitled to a full August allocation.

Insurance is 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.

Family Medical Leave Act (FMLA)

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

Military Leave

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

Death

Extra insurance allocations 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.

Retiring Members

Retiring members are eligible to receive the extra allocations earned under the 3-1 Rule.

Example:

- A June 1 retiree who works 9 months during the school year earns extra allocations through August 31.
- A July 1 retiree who works the entire school year earns extra allocations through September 30.

The school system is required to provide the appropriate insurance allocation earned under the 3-1 Rule. PEEHIP assumes that the system will not pay the September allocation for June 1 retirees in most cases. June 1 retirees should continue to receive the active allocation 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 any extra allocations earned. Medicare-eligible members and/or dependents must have Medicare Part B on their retirement date to have adequate coverage with PEEHIP.

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 allocation the **first full month** of the employee's contract and the earned summer allocations for the following year.

Active Employees Not Enrolled in Coverage

Section 16-25A-5, *Code of Alabama, 1975*, requires the insurance allocation 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 allocation for August if the employee does not elect coverage on his date of employment; **however, PEEHIP would require the insurance allocation 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 allocation for a new employee if the employee does not enroll in insurance coverage on his date of employment. However, Section 1625A-9, Code of Alabama 1975 requires the insurance allocation to be paid for a full month of coverage even if the employee does not enroll in any coverage.

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 active allocation according to 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 and enroll in their own PEEHIP medical plan during the Open Enrollment period 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.

Provision for Medicare-Eligible Active Members

PEEHIP is required by the Age Discrimination in Employment Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, to offer its active employees over age 65 coverage under its group health plan under the same condition as any employees under age 65. As a result of an accompanying amendment to the Social Security Act, Medicare is secondary to benefits payable under an employer-sponsored health insurance plan for employees over age 65 and their spouses over age 65. If the service is also covered by Medicare, the claim can be submitted to Medicare which may pay all or a portion of the unpaid balance of the claim subject to Medicare limitations.

As a result of these changes, PEEHIP does not provide an active member or his or her spouse with benefits which supplement Medicare. The member has the right to elect coverage under PEEHIP on the same basis as any other employee.

If an active employee chooses to be covered under PEEHIP, the plan will be the primary payer for those items and services covered by Medicare. (Note that Medicare covers hospitalization, post-hospital nursing home care, home health services.) This means that the plan will pay the covered claims and those of the active employee's Medicare-eligible spouse first, up to the limits contained in the plan, and Medicare may pay all or a portion of the unpaid balance of the claims, if any, subject to Medicare limitations. If the active employee's spouse is not eligible for Medicare and has no other coverage, the plan will be the sole source of payment for the spouse's claims. Since PEEHIP also covers items and services not covered by Medicare, PEEHIP will be the sole source of payment of medical claims for these services.

Because of the cost of Medicare Part B, an active employee age 65 or older may decide to defer enrolling for Part B until he or she actually reaches retirement, at which point Medicare will become the primary payer and the retired member must enroll in Medicare Part B effective the date of retirement to have adequate coverage with PEEHIP. However, a member and his or her Medicare-eligible spouse can enroll in Medicare Part B only during certain times allowed by Medicare. **Medicare-eligible members must contact their local Social Security office at least two months prior to retiring to enroll in Part A and Part B so that the Medicare Part A and Part B coverage is effective no later than the date of retirement of the policyholder.**

The Social Security Administration handles Medicare enrollments. Therefore, if you have questions about when to enroll in Medicare Part B, you should contact the Social Security Administration at 800.772.1213. A Medicare-eligible retiree and/or spouse must have both Medicare Part A and Part B to have adequate coverage with PEEHIP. If you do not have Part B, PEEHIP will only pay 20% of the Medicare allowable fee (subject to a $30 copay on office visits, emergency room visits and outpatient consultations) as if you had Part B.

If I work after age 65 or become eligible for Medicare, am I still covered?

If you continue to be actively employed when you are age 65 or older and are insured on a PEEHIP active contract, you and your spouse will continue to be covered for the same benefits available to employees under age 65. In this case, your PEEHIP plan will pay all eligible expenses first. If you are enrolled in Medicare, Medicare will pay for Medicare-eligible expenses, if any, not paid by the group benefits plan.

If both you and your spouse are over age 65, you may elect to withdraw completely from the PEEHIP plan and purchase a Medicare Supplement contract. This means that you will have no benefits under the PEEHIP plan. In addition, the employer is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract.

Other Medicare Rules

Disabled Individuals: If you or your spouse are eligible for Medicare due to disability and also covered under the plan by virtue of your current employment status with the employer, the plan will be primary and Medicare will be secondary. However, if you are retired, Medicare is primary and PEEHIP will be secondary.

End-Stage Renal Disease: If you are eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), the plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility. Thereafter, Medicare will be primary and the plan will be secondary.

If you have any questions about coordination of your coverage with Medicare, please contact PEEHIP for further information. PEEHIP members who retired on disability after September 30, 2005, but are also eligible for service retirement are subject to the Sliding Scale for PEEHIP premiums.

Medicare rules require a Medicare-eligible, active PEEHIP member who is covered on their spouse's PEEHIP **retired** contract to have Medicare as the primary payer on the active PEEHIP member. 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 and enroll in their own PEEHIP medical policy during the Open Enrollment period or their spouse's date of retirement. When the active Medicare-eligible member retires, he or she must enroll in Medicare Part B. The effective date of Medicare Part B must be the date of retirement to avoid a lapse in coverage.

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 state allocation, 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.

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.

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 allocation. However, employees enrolled in one or more Optional Plans while on COBRA cannot enroll in a Hospital Medical Plan until Open Enrollment.

Can COBRA Coverage be Extended for Covered Members who Become Disabled?

Yes. 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.

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.

Leave of Absence & Family and Medical Leave Act

Leave of Absence

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 Enrolment 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 Plans while on leave of absence can add the remaining Optional Plans when he or she becomes eligible for a full allocation. However, employees enrolled in one or more Optional Plans 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

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.
- If an employee earns an extra summer allocation under the 3-1 Rule, that month should be applied to the end of the 12 weeks that were granted under FMLA.
- An employee cannot earn the insurance allocation 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.
- Employees on FMLA do accrue extra insurance allocation while on leave under FMLA. Therefore, the 3-1 Rule does apply while an employee is on FMLA.
- Employers must enter the new status and ending date in the Employer Portal when the FMLA benefit ends.

Retirees

PEEHIP Medicare Plus

(Coverage for 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)*

Benefit		
Inpatient Hospital Charges		
Medicare Pays	PEEHIP Pays	YOU Pay
All but the Part A deductible per admission. All but applicable coinsurance after 60 days.	All but $200 per admission and daily $25 copayment for days 2-5. Applicable coinsurance after 60 days.	A $200 deductible, copay of $25 per day for days 2-5, and any personal charges (such as private room, telephone, TV, etc.).

PEEHIP Non-Hospital Benefits

Benefit		
Outpatient Hospital Charges		
Medicare Pays	PEEHIP Pays	YOU Pay
80% of Medicare's approved amount after the Medicare Part B deductible.	20% of Medicare's approved amount after the member meets Medicare Part B deductible and the $30 copay for physician visit.	The Part B deductible, a copay up to $30 for physician visits, any charges not covered by Medicare or PEEHIP, and charges above the Medicare allowable amount when using unassigned providers.

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.

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 GenerationRcx website at **https://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 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.

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.

Remember, 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 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.

IMPORTANT: Retired members who retired on or after October 1, 2005, and are ineligible for the PEEHIP coverage cannot be covered as a dependent on their spouse's PEEHIP coverage.

PEEHIP will soon begin requiring an annual audit of the retiree employment information for members who retired on or after October 1, 2005.

Premium Rates for Retirees

Optional Coverage: Active and Retired Members

Cancer	$38/month	Individual or Family Coverage
Dental	$38/month	Individual Coverage
	$45/month	Family Coverage
Indemnity	$38/month	Individual or Family Coverage
Vision	$38/month	Individual or Family Coverage

Retired Members

The monthly premiums listed in the chart below show a retiree's out-of-pocket cost after subtracting the retiree allocation. These rates apply only to 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. All members who retired on or after October 1, 2005, are subject to the Retiree Sliding Scale premium based on years of service. 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. These retirees will experience a rate adjustment effective October 1, 2014. The sliding scale premium rates can be found on the PEEHIP website at www.rsa-al.gov. Click on Premiums and then Retiree Sliding Scale Premium Rates.

Type of Contract	*Retiree Monthly Out-of-Pocket Premium	Cost to State on Behalf of the Retiree
Individual Coverage/ Non-Medicare-eligible Retired Member	$151	$549
Family Coverage/Non-Medicare-eligible Retired Member and Non-Medicare-eligible Dependent(s)	$391	$924
Family Coverage/Non-Medicare-eligible Retired Member and Only Dependent Medicare-eligible	$250	$836
Individual Coverage/ Medicare-eligible Retired Member	$ 10	$344
Family Coverage/Medicare-eligible Retired Member and Non-Medicare-eligible Dependent(s)	$250	$719
Family Coverage/Medicare-eligible Retired Member and Only Dependent Medicare-eligible	$109	$631

**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

Members who retired after September 30, 2005, are subject to a sliding scale premium, based on years of service. 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.

For members retiring after September 30, 2005, with 25 years of service, PEEHIP pays 100% of the employer share of the premium. The member will only be responsible for the employee share of the premium. For members who retire prior to January 1, 2012, and have less than 25 years of services, 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. For all members retiring after September 30, 2005, for each year of service above 25, the employer (PEEHIP) share increases by 2% and the retiree share is reduced accordingly. PEEHIP members who retire on disability but are also eligible for service retirement are subject to the sliding scale for PEEHIP premiums.

All members who retired before October 1, 2005, are not affected by the Retiree Sliding Scale Premium. A chart illustrating the sliding scale premiums can be found on the RSA website at www.rsa-al.gov. Click on PEEHIP, then Premiums, and then Retiree Sliding Scale Premium Rates.

The retiree sliding scale premium will not apply to disability retirements 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. Therefore, it is important to send in your proof of application for Social Security disability and your subsequent approval for Social Security disability as soon as you receive it in order to receive a premium reduction.

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 and only applies to employees who retired on or after January 1, 2012.

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 our 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**) and 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 - the amount the state contributes to the cost of retiree health care (employer contribution) is decreased by 4% for each year of service less than 25 and increased by 2% for each year of service more than 25 (**Service Premium Component**).

Employees who retired on or after January 1, 2012, (regardless of age) and have less than 25 years of service will have 4% (instead of 2%) deducted from the employer contribution of the sliding scale premium calculation for each year under 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.

Employees who have 25 or more years of service will see no change in the service component of the sliding scale premium. Employees will continue to receive a 2% bonus for every year of service over 25 years.

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.

Example:
If you retire at age 60 (regardless of years of service), you are 5 years away from Medicare entitlement and will have 5% deducted from the employer contribution. The employee contribution (or premium) will increase by an amount equal to 5% of the employer contribution. This deduction will cease upon notification to PEEHIP of Medicare entitlement.

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 2015, the subsidy component is $143.87. 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 new sliding scale premium will 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.

Act 2011-704 Increases Assistance to Low Income Families

Act 2011-704 also increased the income range of employees and retirees eligible for a premium discount from 200% to 300% of the Federal Poverty Level (FPL). This will keep the premiums more affordable for employees and retirees whose family income falls within 300% of FPL. Information regarding this program is available on our website.

Provision for Medicare-Eligible Retired Employees

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 our office becomes aware of your Medicare eligibility regardless of whether our office has received your Medicare card. Medicare-eligible members and dependents must have Medicare Part A and Part B to have adequate coverage with PEEHIP.

Health Insurance Policies for Retired Members

Form 10 - Application for Retirement

In order to file for retirement benefits, a member must complete Part I, Retirement Application Packet. 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 nor 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 the 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 Plans, he or she cannot drop the Optional Plan(s) until the Open Enrollment period.

The state allocation 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 coverages. The member must indicate which optional coverages 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 add the PEEHIP Hospital Medical Plan on the date of retirement.

If the member did not have a Hospital Medical Plan with his or her school system, the member can enroll in single PEEHIP or the PEEHIP Supplemental Plan.

If the retiring member only had single coverage, he or she cannot add family coverage on the date of retirement. In this situation, the retiring member must wait until the Open Enrollment period to add family coverage.

The retiring employee 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 if the employee retires outside of the Open Enrollment period. The employee cannot add any Optional Plans until the Open Enrollment period.

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 October 1 effective date.

A Member Retiring from a Participating System

If a member retires from a participating system and was enrolled in the four Optional Plans at 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 any of the Optional Plans on the date of retirement. The state allocation 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 at the date of retirement cannot add the Hospital Medical Plan until the Open Enrollment period.

Retiree Examples

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 date of the member's 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. I**n 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 date of the member's 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. 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 PEHIP 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 date of the member's 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. Beginning January 1, 2013, 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.

Medicare Part D Prescription Drug Coverage

Medicare-eligible retirees and Medicare-eligible dependents covered under the Public Education Employees' Health Insurance Plan (PEEHIP) are automatically enrolled into the Medicare GenerationRx Part D Prescription Drug Program 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 (Employer PDP) is a Medicare approved Part D sponsor and is sponsored by Stonebridge Life Insurance Company. Participation in this Employee Group Waiver Plan (EGWP) is a win-win for Medicare-eligible retirees, covered Medicare-eligible dependents, and PEEHIP.

Dependents Who Are Not Yet Medicare -eligible

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 program, refer to the Retirees with Medicare handbook.

Medicare Part D Prescription Drug Benefit Resources

Telephone Number	Description
Medicare 800-MEDICAR 800.633.4227	Medicare Help Line
Social Security Administration 800.772.1213	Recorded information and services are available 24 hours a day, including weekends and holidays.

Web Site	Description
Medicare www.medicare.gov	Provides access to information about Medicare and Medicare health plans.
Centers for Medicare and Medicaid Services www.cms.gov	CMS administers Medicare and Medicaid programs. A database of frequently asked questions is available.
Social Security Administration www.ssa.gov	Link to the Social Security Administration's site for information on low-income subsidies and other resources.
AARP www.aarp.com/bulletin	Access the Medicare Benefit Drug Calculator, which illustrates what the Medicare drug benefit means to you.
Access to Benefits Coalition www.accesstobenefits.com	Prescription drug savings for those who need them most.
Aging Parents and Elder Care www.todaysseniors.com	Senior Solutions is an independent organization providing information on issues to help seniors get the most out of retirement.
Benefits Check Up https://benefitscheckup.org	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.

Web Site	Description
Destination Rx www.destinationrx.com	Provides a pharmacy discount buying service.
Medicare Rights Center www.medicarerights.org	Medicare Rights Center (MRC) is the largest independent U.S. source of health information and assistance for people with Medicare.
Needymeds.com www.needymeds.com	Find information on patient assistance programs that provide no cost prescription medications to eligible participants.
Rxaminer.com www.rxaminer.com	Use this prescription drug comparison tool to find lower-cost prescription drugs.
Together Rx www.togetherrx.com	Offers a prescription drug savings program.

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. The monthly premiums effective October 1, 2014, are as follows:

Surviving Dependent Monthly Premiums for the 2014-2015 Plan Year

Type of Contract	Monthly Premium for PEEHIP Hospital Medical or the VIVA Health Plan
Individual Coverage/Non-Medicare-eligible (NME) Survivor	$700
Family Coverage/NME Survivor & NME Dependents	$934
Family Coverage/NME Survivor & Only Dependent Medicare-eligible (ME)	$907
Individual Coverage/ME Survivor	$354
Family Coverage/ME Survivor & NME Dependent(s)	$595
Family Coverage/Medicare-eligible Survivor & Only Dependent ME	$568
Tobacco Premium for Survivor enrolling in Hospital Medical	$28
Optional (Each) - Cancer, Indemnity, Vision, and Single Dental	$ 38
Family Dental Premium	$ 45

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 our office becomes aware of your Medicare eligibility regardless of whether our office has received your Medicare card. Medicare eligible members and dependents must have Medicare Part A **and** Part B to have adequate coverage with PEEHIP.

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.

Effective January 1, 2013, the PEEHIP prescription drug benefit for Medicare retirees and Medicare covered dependents changed to the PEEHIP 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 you 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. 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.

When Can You Join A Medicare Drug Plan?

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.

What Happens To Your Current PEEHIP Coverage If You Decide to Join A Standard Medicare Drug Plan?

If you do 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.

When Will You Pay A Higher Premium (Penalty) To Join A Standard Medicare Drug Plan?

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. For 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 Your Options under Medicare Prescription Drug Coverage...

More detailed information about 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 Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- 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, or call them at 800.772.1213 (TTY 800.325.0778).

For More Information About This Notice Or Your 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 Creditable Coverage notice. If you decide to join one of the standard Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage.

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, health care operations and treatment

The Plan and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, 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.

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.

HIPAA also requires PEEHIP to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

For more information regarding this notice, please contact PEEHIP.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or 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.

State	Program	Contact Information (website; Phone)
Alabama	Medicaid	www.medicaid.alabama.gov; 800.362.1504
Alaska	Medicaid	www.health.hss.state.ak.us/dpa/programs/medicaid/; (Outside of Anchorage) 888.318.8890; (Anchorage) 907.269.6529
Arizona	CHIP	www.azahcccs.gov/applicants/default.aspx; 877.764.5437
Arkansas	CHIP	www.arkidsfirst.com/; 888.474.8275
California	Medicaid	www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx; 866.298.8443
Colorado	Medicaid and CHIP	Medicaid: www.colorado.gov/; 800.866.3513 CHIP: www.CHPplus.org; 303.866.3243
Florida	Medicaid	www.fdhc.state.fl.us/Medicaid/index.shtml; 866.762.2237
Georgia	Medicaid	www.dch.georgia.gov/ (Click on Programs, then Medicaid); 800.869.1150
Idaho	Medicaid and CHIP	Medicaid: www.accesstohealthinsurance.idaho.gov; 800.926.2588 CHIP: www.medicaid.idaho.gov; 800.926.2588
Indiana	Medicaid	www.in.gov/fssa/2408.htm; 877.438.4479
Iowa	Medicaid	www.dhs.state.ia.us/hipp/; 888.346.9562
Kansas	Medicaid	www.khpa.ks.gov; 800.766.9012
Kentucky	Medicaid	www.chfs.ky.gov/dms/default.htm; 800.635.2570
Louisiana	Medicaid	www.la.hipp.dhh.louisiana.gov; 888.342.6207
Maine	Medicaid	www.maine.gov/dhhs/oms/; 800.321.5557

State	Program	Contact Information (website; Phone)
Massachusetts	Medicaid and CHIP	www.mass.gov/MassHealth; 800.462.1120
Minnesota	Medicaid	www.dhs.state.mn.us/ (Click on Health Care, then Medical Assistance); 800.657.3739
Missouri	Medicaid	www.dss.mo.gov/mhd/index.htm; 573.751.6944
Montana	Medicaid	www.medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml; 800.694.3084
Nebraska	Medicaid	www.dhhs.ne.gov/med/medindex.htm; 877.255.3092
Nevada	Medicaid and CHIP	Medicaid: www.dwss.nv.gov/; 800.992.0900 CHIP: www.nevadacheckup.nv.org/; 877.543.7669
New Hampshire	Medicaid	www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm; 800.852.3345 x5254
New Jersey	Medicaid and CHIP	Medicaid: www.state.nj.us/humanservices/dmahs/clients/medicaid/; 800-356-1561 CHIP: www.njfamilycare.org/index.html; 800.701.0710
New Mexico	Medicaid and CHIP	Medicaid: www.hsd.state.nm.us/mad/index.html; 888.997.2583 CHIP: www.hsd.state.nm.us/mad/index.html (Click on Insure New Mexico); 888.997.2583
New York	Medicaid	www.nyhealth.gov/health_care/medicaid/; 800.541.2831
North Carolina	Medicaid	www.nc.gov; 919.855.4100
North Dakota	Medicaid	www.nd.gov/dhs/services/medicalserv/medicaid/; 800.755.2604
Oklahoma	Medicaid	www.insureoklahoma.org; 888.365.3742
Oregon	Medicaid and CHIP	www.oregonhealthykids.gov; 877.314.5678
Pennsylvania	Medicaid	www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm; 800.644.7730
Rhode Island	Medicaid	www.dhs.ri.gov; 401.462.5300
South Carolina	Medicaid	www.scdhhs.gov; 888.549.0820
Texas	Medicaid	www.gethipptexas.com/; 800.440.0493
Utah	Medicaid	www.health.utah.gov/medicaid/; 866.435.7414
Vermont	Medicaid	www.ovha.vermont.gov/; 800.250.8427
Virginia	Medicaid and CHIP	Medicaid: www.dmas.virginia.gov/rcp-HIPP.htm; 800.432.5924 CHIP: www.famis.org/; 866.873.2647
Washington	Medicaid	www.hrsa.dshs.wa.gov/premiumpymt/Apply.shtm; 877.543.7669
West Virginia	Medicaid	www.wvrecovery.com/hipp.htm; 304.342.1604
Wisconsin	Medicaid	www.dhs.wisconsin.gov/medicaid/publications/p-10095.htm; 800.362.3002
Wyoming	Medicaid	www.health.wyo.gov/healthcarefin/index.html; 307.777.7531

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

A self-addressed envelope is included in this packet to return forms to PEEHIP. 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 Member Online System is the required method of enrollment for new employees.

PEEHIP New Enroll/Status Chg
(07/14)
6U

Check One:
☐ Active Member
☐ Retired Member

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
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.

Social Security # or PID	First Name	Middle Initial	Last Name	Date of Birth	Sex
				____/____/____	☐ M ☐ F

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?	Home Phone	Cell Phone	Work Phone
☐ Yes ☐ No	____-____-____	____-____-____	____-____-____

Employer/School System	Date of Employment	Email Address
	____/____/____	

Have you or your spouse used tobacco products within the last 12 months?*
This information is required for enrollment.

Member	Spouse
☐ Yes ☐ No	☐ 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

Basic Hospital/Medical
(PEEHIP plans are administered by Blue Cross and Blue Shield of AL)

Coverage Type: (*Select only one of the three plans*)
☐ PEEHIP Hospital/Medical
☐ VIVA Health Plan (HMO) (Primary Care Physician _____)
☐ PEEHIP Hospital/Medical Supplemental**(*Secondary Medical*)
***Complete Primary Insurance Information in Section D if choosing this plan. This plan is not a Medicare supplement & differs from Optional Plans.*
☐ Single or ☐ Family *(complete Section C)*

Requested Effective Date ____/____/____ ***(required)***

Optional Coverage Plans
(*administered by Southland National)*

Note: *Optional plans must be all Single or all Family*
Coverage Type(s):
☐ Cancer ☐ Dental ☐ Indemnity ☐ Vision
☐ Single or ☐ Family *(complete Section C)*

These plans must be retained for one year until the following October 1. PEEHIP will not automatically cancel any coverage(s).

Requested Effective Date ____/____/____ ***(required)***

Section B. PEEHIP Coverage Information

Coverage Type: (Only check boxes requiring a change)	**PEEHIP Hosp/Med**	****PEEHIP Supplemental**	**VIVA HMO**	**Cancer**	**Dental**	**Indemnity**	**Vision**
Change from Single to **Family** Coverage	☐	☐	☐	☐	☐	☐	☐
Add dependent(s) listed in Section C to Family Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel Coverage	☐	☐	☐	☐	☐	☐	☐
Change from Family to **Single** Coverage	☐	☐	☐	☐	☐	☐	☐
Cancel dependent(s) listed in Section C from Family Coverage	☐	☐	☐	☐	☐	☐	☐

Requested Effective Date ____/____/____ ***(required)***

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)*
☐ Dependent 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
☐ 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.)*

Name of Dependent *(First, Middle, Last)*	**Social Security #**	**Date of Birth**	**Relation to Subscriber**	**Sex**	**Handicapped**
			☐ Husband ☐ Wife	☐ M ☐ F	N/A
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No
			☐ Biological ☐ Adopted ☐ Step ☐ Other	☐ M ☐ F	☐ Yes ☐ No

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

Name of Insurance Company	Phone Number	Contract/Policy #	Effective Date of Coverage
	_____-_____-_____		_____/_____/_____

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.

Name	Medicare Card Number

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

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

Name	Medicare Card Number

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.

PEEHIP FSA
Enroll (7/14)
2H

FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION

ACTIVE MEMBERS ONLY

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
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

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

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	Sex
_____/_____/_____	_____-_____-_____	_____-_____-_____	☐ Male ☐ Female

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

Employer/School System	Email Address	Date of Employment
		_____/_____/_____

Healthcare Flexible Spending Account Information

I wish to enroll in the Health Care Flexible Spending Account. ☐Yes ☐No

I choose: ☐ The Flex Debit Card ☐ Traditional Reimbursement (bump) ☐ Manual Reimbursement

Monthly Contribution Amount $ _____ × 12 months = $ _____ Annual Contribution Amount.

I understand that:

- PEEHIP will divide this amount by 12 (pay periods) and will reduce my pay by this amount during those pay periods during the plan year.
- Do not include health insurance premiums in your annual election amount.
- The maximum annual amount cannot exceed $2,500 and the minimum annual amount is $120.
- Non-prescription over-the-counter medications are not eligible for reimbursement.

Dependent Day Care Flexible Spending Account Information

I wish to enroll in the Dependent Day Care Flexible Spending Account. ☐Yes ☐No

Monthly Contribution Amount $ _____ × 12 months = $ _____ Annual Contribution Amount.

I understand that:

- PEEHIP will divide this amount by 12 (pay periods) and will reduce my pay by this amount during those pay periods during the plan year.
- **Do not enroll in the Dependent Care Flexible Spending Account for reimbursement of out-of-pocket medical costs for dependents. You must use the Healthcare Flexible Spending Account instead.**
- This plan is for:
  - licensed nursery school and daycare facilities
  - childcare in or outside your home
  - daycare for an elderly or disabled dependent
- The maximum annual amount cannot exceed:
  - $5,000 if single or married filing a joint return, or
  - $2,500 if married filing a separate return.
- The minimum annual amount is $120.
- Remember to factor in summer childcare costs.

PEEHIP Subscriber Certification

I understand that:

- I cannot change or revoke any of my elections on this compensation redirection agreement at any time during the plan year (Oct. 1 – Sep. 30) unless I have a qualifying change in status.
- During the Annual Open Enrollment Period, I will be given the opportunity to enroll in the plan for the upcoming plan year (Oct. 1 – Sep. 30). I must enroll each year during the Open Enrollment period since participation in the plan for subsequent years is not automatic, even if I want to contribute the same amount as the previous year.
- Amounts unused and unspent in excess of $500 in the Healthcare Flexible Spending Account as of September 30 will be lost. The grace period has been eliminated and replaced with the $500 carryover provision.
- Expenses for both the Healthcare Flexible Spending Account and Dependent Care Flexible Spending Account can be submitted to Blue Cross by January 15 following the end of the plan year.

I hereby 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 _____/_____/_____

PEEHIP FSA Change
(5/13)
2l

FLEXIBLE SPENDING ACCOUNT STATUS CHANGE

ACTIVE MEMBERS ONLY

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

In lieu of completing and mailing this form, you can make your changes online using the Web site above.

PEEHIP Subscriber Information

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

Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name

Mailing Address	City	State	ZIP Code

Date of Birth	Home Phone	Work Phone	Email Address
_____/_____/_____	_____-_____-_____	_____-_____-_____	

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:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual Amount

Maximum amount cannot exceed $2,500 and the minimum annual amount is $120.

☐ 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:

Note: *Cannot be less than the amount already payroll deducted or paid in reimbursements.*

☐ New Annual Election Amount $ _____ × 12 months = $ _____ Annual 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.

☐ 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 _____/_____/_____

PEEHIP FPL
(5/14)
2G

FEDERAL POVERTY LEVEL ASSISTANCE APPLICATION (FPL)

ACTIVE OR RETIRED MEMBERS

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

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.				
Social Security Number or PID Number	First Name	Middle Name/Initial	Last Name	
Mailing Address	City	State	ZIP Code	
Home Phone ____-____-____	Work Phone ____-____-____	Date Received *(For internal use only)* ____/____/____		

Marital 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.

Employee Signature _____ Date Signed ____/____/____

Spouse Signature _____ Date Signed ____/____/____

Please mail the completed form to the address located on the top of this form.
See reverse for FPL levels.

PEEHIP provides premium assistance to PEEHIP members with a 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:

Over 300% of the FPL	member pays 100% of the member contribution	
equal to or less than 300% but more than 250% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 250% but more than 200% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 200% but more than 150% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 150% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2014 Federal Poverty Levels (FPL)

Family Size	100% of FPL	150% of FPL	200% of FPL	250% of FPL	300% of FPL
1	$11,670	$17,505	$23,340	$29,175	$35,010
2	$15,730	$23,595	$31,460	$39,325	$47,190
3	$19,790	$29,685	$39,580	$49,475	$59,370
4	$23,850	$35,775	$47,700	$59,625	$71,550
5	$27,910	$41,865	$55,820	$69,775	$83,730
6	$31,970	$47,955	$63,940	$79,925	$95,910
7	$36,030	$54,045	$72,060	$90,075	$108,090
8	$40,090	$60,135	$80,180	$100,225	$120,270

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
Fax: 877-517-0021 (toll-free) (Please fax front and back of form)
Mail: PEEHIP, P.O. BOX 302150, Montgomery, AL 36130

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 go online at 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. SUBSCRIBER INFORMATION About You (Subscriber) and Your Spouse

SSN or PID:	Cell Phone Number:	Telephone Number:	First and Last Name:	Email Address:
	( )	( )		

SECTION B. OTHER INSURANCE COVERAGE INFORMATION, EXCLUDING MEDICARE AND PEEHIP, About You, Your Spouse, and/or Dependent Children (Check all that apply)

☐ Yes ☐ No - I have other insurance coverage
☐ Yes ☐ No - My spouse has other insurance coverage and/or provides other insurance coverage for my dependent children
☐ Yes ☐ No - My dependent children are covered through other insurance not provided by my current spouse

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)

Name of Policy Holder:	Date of Birth:	Contract/Policy Number:	Effective Date of Coverage:	Insurance Company Phone Number:
				( )

Name of Insurance Company (check one):	Coverage Provided Through:	Type(s) of Coverage (check all that apply):
☐ Aetna ☐ Blue Cross Blue Shield ☐ Cigna ☐ Tricare ☐ United Health Care ☐ VA ☐ Other → Name: ____________	☐ Current Employer ☐ Former Employer ☐ Other	☐ 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 Coverage*

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

Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policy Holder	Are both parents married or living together?	Based on court decree, who is responsible for health care expenses? (check first that applies) **
		☐ Spouse ☐ Child → ☐ Stepchild →	☐ Yes ☐ No →	☐ You (PEEHIP Subscriber) or your Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree
		☐ Spouse ☐ Child → ☐ Stepchild →	☐ Yes ☐ No →	☐ You (PEEHIP Subscriber) or your Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree
		☐ Spouse ☐ Child → ☐ Stepchild →	☐ Yes ☐ No →	☐ You (PEEHIP Subscriber) or your Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree

SEE REVERSE SIDE – THIS FORM CONTAINS MORE INFORMATION.

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEET(S) IF NEEDED)				
Name of Policy Holder:	Date of Birth:	Contract/Policy Number:	Effective Date of Coverage:	Insurance Company Phone Number: ( )
Name of Insurance Company (check one): ☐ Aetna ☐ Blue Cross Blue Shield ☐ Cigna ☐ Tricare ☐ United Health Care ☐ VA ☐ Other → Name: ______		Provided Through: ☐ Current Employer ☐ Former Employer ☐ Other	Type(s) of Coverage (check all that apply): ☐ Hospital/Medical with Prescription Drug ☐ Hospital/Medical without Prescription Drug ☐ Prescription Drug Only ☐ Dental ☐ Vision ***Note:*** *HSA, HDHP, and HRA Plans are considered Hospital/Medical with Prescription Coverage*	

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

Dependent(s) Name(s)	Effective Date(s) of Coverage	Relationship to Policy Holder	Are both parents married or living together?	Based on court decree, who is responsible for health care expenses? (check first that applies) **
		☐ Spouse ☐ Child → ☐ Stepchild →	☐ Yes ☐ No →	☐ You (PEEHIP Subscriber) or your Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree
		☐ Spouse ☐ Child → ☐ Stepchild →	☐ Yes ☐ No →	☐ You (PEEHIP Subscriber) or your Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree
		☐ Spouse ☐ Child → ☐ Stepchild →	☐ Yes ☐ No →	☐ You (PEEHIP Subscriber) or your Spouse is responsible ☐ Policy Holder or their Spouse is responsible ☐ You (PEEHIP Subscriber) or your Spouse has custody ☐ Policy Holder or their Spouse has custody ☐ Joint custody or no court decree

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 C. SUBSCRIBER 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.

X ______________________________

Subscriber's 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' plan. When a PEEHIP subscriber 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:

The primary plan pays the full extent of its benefits. PEEHIP uses the first of the following rules that applies:

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 species 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. The benefits of a 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 contracts, the plan that has covered you longer is primary.

PEEHIP REV
06/13
2U

Retiree Employment Verification

This form is to be completed by the PEEHIP Retiree and his/her current employer (if applicable) to verify employer health insurance benefits offered to its employees.

The PEEHIP Retiree must return this completed, signed, and dated form to PEEHIP using one of the following methods:
Online: https://mso.rsa-al.gov **Fax:** 1-877-517-0021 (toll-free)
Mail: PEEHIP, P O BOX 302150, Montgomery, AL 36130

SECTION A. PEEHIP RETIREE INFORMATION

Retiree's Name:	Social Security Number or PID:

Are you currently employed? ☐ Yes ☐ No ***(If "No", skip to Section B)***

Name of Retiree's Employer:	Employer's Telephone #: ( )	Date of Hire (MM/DD/YYYY):

Employer's Address 1:	Employer's Address 2:	City:	State:	Zip Code:

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*
   a. 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 submittin 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.

X _____ _____

Retiree's Signature **Date**

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

Employee Hire Date: (MM/DD/YYYY):	Employee Status: ☐ Full-time ☐ Part-time

Is the person, named above as the Employee, eligible for your company's Health Insurance Coverage? ☐ Yes ☐ No

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.*

Total Monthly Single Premium:	Employee Share of Monthly Single Premium:	Company Share of Monthly Single Premium:

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, or a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including public plan such as the Public Education Employee's 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

2U

Public Education Employees' Health Insurance Plan
P. O. Box 302150
Montgomery, Alabama 36130-2150
(334) 517-7000 or (877) 517-0020
www.rsa-al.gov

Under Alabama law, Code of Alabama 1975, Section 16-25A-5.2(1), 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 1-877-517-0021 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 (Code of Alabama 1975, Section 16-25A-20).

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.

SEE REVERSE SIDE AND COMPLETE THE RETIREE EMPLOYMENT VERIFICATION FORM.

2014

PEEHIP

PUBLIC EDUCATION EMPLOYEES'
HEALTH INSURANCE PLAN
P. O. Box 302150
Montgomery, Alabama 36130-2150

www.rsa-al.gov