State Employees' Insurance Board

Optional Insurance Plan

Dental — Cancer — Hospital Indemnity — Vision

Administered by

Southland Benefit Solutions

Effective January 1, 2024

Discrimination is Against the Law

The State Employees' Insurance Board (SEIB) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The SEIB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The SEIB:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact 1-866-698-7428 or TTY: 711. If you believe that the SEIB has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Section 1557 Coordinator, 201 South Union Street, Montgomery, Alabama, 36104; Direct: (334) 263-8300; Fax (334) 263-8711; Email: 1557Grievance@alseib.org. You can file a grievance by mail, fax, email or in person. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-698-7428 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-698-7428 (TTY: 711). 번으로 전화해 주십시오

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-698-7428 (TTY: 711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-698-7428 (TTY: 711).

Arabic: 7428-698-866-1 اتصل برقم .إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان :هاتف الصم والبكم (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-698-7428 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-698-7428 (ATS : 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો ન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-698-7428 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-698-7428 (TTY: 711).

Hindi: ध्यान द : यदि आप हिंदी बोलते, भाषा सहायता सेवाएँ, निःशु , आप केलिए उपल ह । कॉल । 1-866-698-7428 कॉल (TTY: 711)।

Laotian: ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-698-7428 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-698-7428 (TTY: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-698-7428 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-866-698-7428 (TTY: 711) irtibat numaralarını arayın..

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます 1-866-698-7428 (TTY: 711) まで、お電話にてご連絡ください

STATE OF ALABAMA

STATE EMPLOYEES' INSURANCE BOARD
PO Box 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8300 | 1-866-836-9737
STATE EMPLOYEES' INSURANCE BOARD OPTIONAL INSURANCE PLAN
NOTICE OF PRIVACY PRACTICES

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

The State Employees' Insurance Board Optional Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

THE PLAN'S RESPONSIBILITIES

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

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

Effective Date of Notice: This notice is effective as of January 1, 2024.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION

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

Uses and disclosures related to payment, health care operations, and treatment. The Plan and its business associates may use your health information without your

permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, the State of Alabama for purposes related to payment or health care operations.

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

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

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

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

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

- To persons and entities that provide services to the Plan and assure the Plan they will protect the information;
- If it constitutes summary health information, and it is used only for modifying, amending, or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan;
- If it constitutes de-identified information;
- If it relates to workers' compensation programs;
- If it is for judicial and administrative proceedings;
- If it is about decedents;
- If it is for law enforcement purposes;

- If it is for public health activities;
- If it is for health oversight activities;
- If it is about victims of abuse, neglect, or domestic violence;
- If it is for cadaveric organ, eye, or tissue donation purposes;
- If it is for certain limited research purposes;
- If it is to avert a serious threat to health or safety;
- If it is for specialized government functions;
- If it is for limited marketing activities.

Additional disclosures to others without your written authorization. The Plan may disclose your health information to a relative, a friend, or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Officer at (334) 263-8300.

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 written authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Officer at (334) 263-8300.

YOUR PRIVACY RIGHTS

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

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

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

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

Inspect or Copy Health Information. You have a right to inspect or obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

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

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

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

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

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

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

Complaints. You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Plan, contact the Plan's Privacy Officer at (334) 263-8300. You will not be penalized for filing a complaint.

How to exercise your rights in this notice. To exercise your rights listed in this notice, you should contact the Plan's Privacy Officer at (334) 263-8300.

THIS NOTICE IS SUBJECT TO CHANGE

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

YOUR QUESTIONS AND COMMENTS

If you have questions regarding this notice, please contact the Plan's Privacy Officer at (334) 263-8300.

Revision 10-2023

Table of Contents

Introduction

This summary of health care benefits available to you through the State Employees' Insurance Board (SEIB) Optional Insurance Plan (Optional Plan) is designed to help you understand your coverage. All terms, conditions, and limitations are not covered here. All benefits are subject to the terms, conditions, and limitations of the contract or contracts between the SEIB and Southland Benefit Solutions (Southland). The SEIB shall have absolute discretion and authority to interpret the terms and conditions of the Optional Plan and reserves the right to change the terms and conditions and/or end the Optional Plan at any time and for any reason.

Participation in this plan is completely voluntary, based on elections you make for yourself and your dependents in the time and manner described herein.

The Optional Plan offers a package of four plans of insurance, including dental, cancer, hospital indemnity, and vision. They are administered by Southland at no cost to eligible employees.

The plan year begins on January 1 and runs through December 31.

THE INFORMATION IN THIS BOOKLET IS NOT A SUBSTITUTE FOR THE LAW. IF A DIFFERENCE OF INTERPRETATION OCCURS, THE LAW GOVERNS. THE LAW MAY CHANGE AT ANY TIME ALTERING INFORMATION IN THIS HANDBOOK. THE STATE EMPLOYEES' INSURANCE BOARD RESERVES THE RIGHT TO CHANGE BENEFITS DURING THE PLAN YEAR.

Eligibility and Enrollment Requirements

Eligible Employees

Full-time state employees and employees of county health departments who are paid by the State Comptroller, the State Department of Mental Health, Historic Blakeley, Ft. Payne Improvement Authority, Historic Ironworks Commission, Bear Creek Development Authority, International Motorsports Hall of Fame, Space and Rocket Center, the Alabama Sports Hall of Fame, the State Docks, St. Stephens Historical Commission, USS ALABAMA Battleship Commission, Red Mountain Greenway Commission, County Soil & Water Conservation Districts, and the Alabama Community College System.

Exclusion: You are not eligible for coverage if you are employed on a part-time, seasonal, temporary, intermittent, emergency, or contract basis unless you receive a W-2 and work an average of 30 hours per week, or 130 hours per month during a designated measurement period as stipulated under the Affordable Care Act.

Eligible employees must have primary coverage with eligible Other Group Health Insurance (OGHI) through a spouse, other employer, or previous employer. Primary OGHI coverage cannot be with the State Employees' Health Insurance Plan (SEHIP) or Medicaid. If you are an active employee and your primary OGHI coverage is TRICARE, you are not eligible for the Optional Plan.

Eligible Retired State Employee

A retired employee of the State of Alabama who has at least 10 years of creditable coverage in the SEHIP and receives a monthly benefit from the Employees' Retirement System or Teachers' Retirement System of Alabama or Judicial Retirement Fund.

Eligible Dependent

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

- Your spouse (excludes divorced or common-law spouse);
- A child under age 26, only if the child is:
  - your son or daughter,
  - legally adopted by you or your spouse,
  - your stepchild, or
  - a dependent for whom you, or your spouse, has legal and physical custody granted by a court of competent jurisdiction;

- Your incapacitated child* over age 25 will be considered for coverage provided the incapacitation occurred prior to the child's 26th birthday and the child is:
  - unmarried,
  - permanently mentally or physically incapacitated,
  - so incapacitated as to be incapable of self-sustaining employment,
  - dependent on you for 50% or more support,
  - otherwise eligible for coverage as a dependent except for age,
  - covered as a dependent on your Plan immediately prior to the child's 26th birthday, and
  - not eligible for any other group health insurance benefits.

  *The above requirements must be met to be eligible for coverage as an incapacitated child. The SEIB shall decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by Medical Review. Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is working, the extent of his or her earning capacity will be evaluated.

  See the "Enrolling an Incapacitated Child" section for critical enrollment deadlines. If deadlines are not met and/or continuous coverage is not maintained on the child, an Incapacitated Child over the age of 25 is not eligible for coverage.

Ineligible Dependents

- Your spouse or other dependents if they are independently covered as a state employee unless they are employed as a professional civil engineer trainee with ALDOT and their employment is part of their educational training
- An ex-spouse, regardless of what the divorce decree may state
- Ex-stepchildren, regardless of what the divorce decree may state
- Your biological child if the child has been adopted by someone other than your spouse and you have been relieved of your parental rights and responsibilities
- Children age 26 and older
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements listed above under Eligible Dependent
- A child of a dependent child
- A daughter-in-law or son-in-law
- Grandchildren or other children related to the member by blood or marriage for which the member does not have legal and physical custody

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

Changes in Dependent Eligibility

It is the responsibility of the subscriber to notify the SEIB immediately when the eligibility of a covered dependent changes. If it is determined that an act (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) of the subscriber results in or contributes to the payment of claims for persons ineligible for coverage, the subscriber will be personally responsible for all such overpayments and shall be subject to disciplinary action, including termination of coverage.

Enrollment of Employee or Retiree

An eligible employee or retiree may enroll at any time by submitting an enrollment form directly to the SEIB (not through your payroll clerk) declining coverage in the State Employees' Health Insurance Plan (SEHIP) and electing coverage in the Optional Plan. Once the form has been approved by the SEIB, coverage in the SEHIP will terminate as of the last day of the month during which the enrollment form was received and coverage in the Optional Plan will begin as of the first day of the following month.

Employees or retirees may enroll for either individual or family coverage. Members enrolled for family coverage cannot change to single coverage outside of the open enrollment period unless all dependent(s) become ineligible due to age, death, or divorce.

Participants must remain in the Optional Plan for at least 12 months. If enrollment is effective on any day other than January 1, coverage will remain in effect through the end of the next full plan year.

Enrollment of Dependents

Participating employees must enroll their eligible dependents under this plan by filing a completed enrollment form directly with the SEIB.

If the employee does not have a dependent at the time of coverage, the employee must enroll for the dependents' benefits within 60 days of acquiring a new dependent. If an enrollment form is submitted to the SEIB and approved within 60 days following the date of marriage, birth, adoption, etc., the effective date will be the date of the coverage event.

If the employee has dependent coverage, the employee must enroll a new dependent(s) before any claims can be paid for the new dependent.

Enrolling an Incapacitated Child

If your child meets the other Incapacitated Child eligibility requirements listed above under Eligible Dependent, you must contact the SEIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the SEIB no more than 60 days after the child's 26th birthday. If you fail to submit the form and proof of incapacity within the required time period, or, if you do not maintain continuous coverage on the incapacitated child thereafter, your child is not eligible for future enrollment except in the following two situations:

1. When a new employee requests coverage for an incapacitated child within 60 days of employment; or

2. When an employee's incapacitated child is covered under a spouse's employer group health insurance for at least 18 consecutive months and:

    a. the employee's spouse loses the other coverage because:
        - the employer ceases operations, or
        - of termination of employment or reduction of hours of employment, or
        - spouse's employer stopped contributing to coverage,

    b. a change form is submitted to the SEIB within 60 days of the incapacitated child's loss of other coverage, and

    c. Medical Review approved incapacitation status.

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

Open Enrollment Back into the SEHIP

After a participant has been in the Optional Plan for the time period required under the SEIB rules and procedures, he or she may terminate coverage in the Optional Plan and re-enroll in the SEHIP during the SEHIP's open enrollment period.

Special Enrollment in the Optional Plan or Back into the SEHIP

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that a special enrollment period be provided in addition to the regular enrollment period for eligible employees and retirees and their eligible dependents if:

- The employee or retiree declined to enroll in the SEHIP because of other coverage; and

- The employee or retiree gains a new dependent through marriage, birth, or adoption; or

- The employee or retiree loses the other coverage because:
  - COBRA coverage (if elected) is exhausted, or
  - loss of eligibility (including separation, divorce, death, termination of employment, or reduction of hours of employment), or
  - employer stopped contributing to coverage.

  A letter requesting special enrollment must be submitted to the SEIB within 60 days of the loss of other coverage or within 60 days of gaining a new dependent, along with a completed enrollment form or status change form if only adding dependents. In addition, the following documentation must be submitted within 60 days of the qualifying event:
  - proof of gaining a new dependent (e.g., marriage certificate, birth certificate, adoption papers); or
  - proof of coverage loss listing the reason and the date of the coverage loss for all individuals affected (e.g., employment termination on company letterhead).

Change of Benefits

The benefits in effect at the date of admission into the hospital or other covered health care facility of the employee or the employee's dependent will be the benefits payable until the date of discharge from the hospital or covered health care facility even if benefits under this program are changed during such confinement.

Insurance Commences

Insurance commences no later than the first day of the second month following receipt and approval of the enrollment application by the SEIB.

General Provisions

Privacy of Your Protected Health Information

The confidentiality of your personal health information is important to the SEIB. Under HIPAA, plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the Optional Plan Notice of Privacy Practices at the front of this booklet. You may also request a copy of this notice by contacting the SEIB.

Use and Disclosure of Your Personal Health Information

Southland has an agreement with the SEIB that allows them to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required under HIPAA. By applying for coverage and participating in the Optional Plan, you agree that the Optional Plan, and its business associates, may obtain, use, and release all records about you and your minor dependents needed to administer the Optional Plan or to perform any function authorized or permitted by law. You further direct all persons to release all records about you and your minor dependents needed to administer the plan. If you or any provider refuses to provide records, information, or evidence we request within reason, we may deny your benefit payments. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law.

The privacy provisions of HIPAA require that you be notified at least once every three years about the availability of the SEIB's privacy practices [45 CFR 164.520(c)(1)(ii)]. Accordingly, you may obtain a copy for our privacy practices by visiting www.alseib.org, or you can request a copy by writing to us at:

State Employees' Insurance Board
Attn: Privacy Officer
PO Box 304900
Montgomery, AL 36130-4900

Disclosures of Protected Health Information to the Plan Sponsor

For your benefits to be properly administered, the Optional Plan needs to share your protected health information with the plan sponsor (the State of Alabama). The Optional Plan may disclose your protected health information to the plan sponsor under the following circumstances:

- The Optional Plan may disclose your PHI to the plan sponsor for plan administrative purposes, as required by law, or as permitted under HIPAA

regulations. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the Optional Plan.

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

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under HIPAA regulations. See the Optional Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.

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

- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.

- The plan sponsor will promptly report to the Optional Plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.

- The plan sponsor will allow you or the Optional Plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. HIPAA regulations set forth the rules that you and the Optional Plan must follow in this regard. There are some exceptions.

- The plan sponsor will amend, or allow the Optional Plan to amend, any portion of your protected health information to the extent permitted or required under HIPAA regulations.
- Concerning some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years. You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan-related purposes, such as payment of benefits or healthcare operations.

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

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

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

- Benefits Administration and Operations
- Legal
- Finance

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

Security of Your Personal Health Information

The following restrictions apply to the plan sponsor's storage and transmission of your electronic protected health information:

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

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

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

Responsibility for Actions of Providers of Services

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

Misrepresentation

Any misrepresentation by you in the application for or in connection with coverage under this plan will make your coverage invalid as of your effective date, and in that case, Southland and the SEIB will not be obligated to return any portion of any fees paid by or for you.

Obtaining, Use and Release of Information

By submitting your application for coverage or any claims for benefits you authorize Southland to obtain from all providers, hospitals, facilities, other providers of service, and all other persons or institutions having information concerning you, all records which in its judgment are necessary or desirable for processing your claim, performing our contractual duties or complying with any law. You also authorize providers of health services, and any other person or organization, to furnish to Southland any such records or information it requests. Further, you authorize Southland to use and release to other persons or organizations any such records and information as considered necessary or desirable in its judgment. Neither Southland nor any provider or other person or organization will be liable for obtaining, furnishing, using, or releasing any such records or information.

Responsibility of Members and Providers to Furnish Information

By applying for coverage or a claim for benefits, you agree that to be eligible for benefits:

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

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

Applicable State Law

This Plan is administered in the state of Alabama and will be governed by the law of Alabama to the extent that state law is applicable.

I.D. Card

An identification card will be provided by Southland.

Claim Forms

Claim forms may be obtained from Southland (www.SouthlandSEIB.com) and may also be downloaded from the SEIB website at www.alseib.org.

Claims Administrator

The claims administrator for the Optional Plan is:

Southland Benefit Solutions
PO Box 1250
Tuscaloosa, Alabama 35403
1-866-327-6674

Payment and Claim Filing Limitation

All claims must be submitted in writing and such writing must be received by Southland **no later than 365 days** following the date covered expenses are incurred. If a claim is not submitted and received by Southland within this period, the claim for that benefit will not be paid.

Claim forms must be completed, with proper documentation and certification from the health care provider, upon submission. Failure to provide a completed claim form may cause delays in claims processing and may be cause for the denial of the claim.

Claim forms resubmitted to obtain coverage not normally provided will not be accepted and will be denied.

By submitting a claim for benefits, you agree that any determination Southland makes will be final.

Termination of Coverages

Coverage under the Optional Plan will terminate:

- On the last day of the month in which your employment terminates. The SEIB may continue your coverage if you are absent from work because of injury or

sickness, or if you are absent from work due to leave of absence or temporary layoff, but only for a limited period.

- Once enrolled in the Optional Plan for 12 consecutive months, you can decline coverage during Open Enrollment for an effective date of January 1.

- When the Optional Plan is discontinued.

Coverage under the Optional Plan will also terminate for a dependent:

- On the last day of the month in which such person ceased to be an eligible dependent.

- If the dependent, other than a spouse, becomes covered as an employee.

Please see the section "Continuation of Group Health Coverage" which outlines your rights under the Public Health Service Act [42 USC Sections 300bb-1 through 300bb-8].

Incorrect Benefit Payments

Every effort is made to promptly and correctly process claims. If payments are made to you in error, or to a provider who furnished services or supplies to you, and Southland later determines that an error has been made, you or the provider will be required to repay any overpayment. If repayment is not made, Southland may deduct the amount of the overpayment from any future payment to you or the provider. If this action is taken, Southland will notify you in writing.

Fraudulent Claims

Any person, who knowingly and with intent to defraud any insurance company or other person, files a statement containing any materially false information or conceals any material information, commits a fraudulent insurance act, which is a crime. In addition to any disciplinary action already in place, any employee or retiree knowingly and willfully submitting false information to the SEIB will be required to repay all claims and other expenses incurred by the Optional Plan related to the false or misleading information.

Coordination of Benefits

There is no coordination of benefits for the hospital indemnity and the cancer plans. There is coordination of benefits for the dental and vision plans. See sections entitled "Dental Coordination of Benefits" and "Vision Coordination of Benefits" for specific information on each plan.

Customer Service

If you have questions about your coverage or need additional information about how to

file claims, you should contact Southland. Southland Customer Service, located in Tuscaloosa, is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is 1-866-327-6674.

Southland Appeal Process

In the event payment of a claim is denied by Southland and you believe such denial was improper, you have the right of appeal. The appeal procedure is as follows:

1. To appeal, you must submit a request for review, in writing, to Southland within 60 days from the date of the notice from Southland denying payment of a claim. This request must contain the specific reasons you contend the claim denial was improper. Within the same time period, you may submit any other evidence in support of your position.

2. Southland will review the request and advise you of its final determination. The Southland decision will be final and will exhaust all administrative remedies.

SEIB Appeal Process

General Information

Issues involving eligibility and enrollment should be addressed directly with the SEIB through the appeal process outlined below. However, all issues regarding benefit determinations should be addressed through the Southland appeal process. The following issues will not be reviewed under the SEIB appeal process:

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

Note: <u>Medical decisions will not be questioned</u>.

All requests must be sent to the following address:

State Employees' Insurance Board
Attention: Legal Department
P.O. Box 304900
Montgomery, Alabama 36130-4900

Informal Review

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

Administrative Review

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

parties involved in the review.

Formal Appeal

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

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

Continuation of Group Health Coverage (COBRA)

Introduction

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

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the Optional Plan when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed under the section entitled "Qualified Beneficiaries" below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Optional Plan is lost because of a qualifying event. Under the Optional Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

Who is a Qualified Beneficiary?

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain circumstances, the covered employee. Under current law, to be a qualified beneficiary, an individual must generally be covered under the Optional Plan on the day before the event that caused a loss of coverage, such as termination of employment, or a divorce from, or death of, the covered employee. In addition, a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

COBRA Rights for Covered Employees

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

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

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

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

COBRA Rights for a Covered Spouse and Dependent Children

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Optional Plan because any of the following qualifying events happens:

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

What Coverage is Available?

If you choose COBRA continuation coverage, the SEIB is required to offer you coverage that is identical to the coverage provided under the plan at the time coverage is being provided to similarly situated employees or family members.

When is COBRA Coverage Available?

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

- When Should Your Agency Notify the SEIB?

  Your agency is responsible for notifying the SEIB within 30 days of the following qualifying events:
  - end of employment;
  - reduction of hours of employment; or
  - the death of an employee.

- When Should You Notify the SEIB?

  The employee or a family member has the responsibility to inform the SEIB within 60 days of the following qualifying events:
  - divorce;
  - legal separation; or
  - a child losing dependent status.

Written notice must be given to the SEIB within the applicable timeframe listed above from the date of the event or the date in which coverage would end under the Optional Plan because of the event, whichever is later. All notices should be sent to the address listed under "SEIB Contact Information" at the end of this section.

How is COBRA Coverage Provided?

When the SEIB is notified that a qualifying event has happened, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. In addition, a covered employee may elect COBRA continuation coverage on behalf of his or her spouse and either covered parent may elect COBRA continuation coverage on behalf of their children.

If you do not choose continuation coverage, your coverage under the Optional Plan will end.

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

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the SEIB Option Plan, or (2) the date on which the SEIB notifies you that you have the option to

buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage.

You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date the election notice is sent back to the SEIB.

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

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

What will be the Length of COBRA Coverage?

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

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

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

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

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

Disability – If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the SEIB, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects

the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours.

For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

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

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

For this disability extension of COBRA coverage to apply, you must give the SEIB timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event; (2) the date on which coverage would be lost because of the initial qualifying event; (3) the date of Social Security's determination; or (4) the date on which you, or the qualified beneficiary, is informed, through the furnishing of the SPD or COBRA general notice, of the responsibility to notify the Plan and the procedures for doing so. You must also notify the SEIB within 30 days of any revocation of Social Security disability benefits.

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

Can New Dependents be added to Your COBRA Coverage?

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

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

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

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

If you are on a leave of absence covered by FMLA, and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage. The period of your COBRA continuation coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

How Much Does my COBRA Coverage Cost?

If you qualify for continuation coverage, you will be required to pay the group's premium plus a 2% administrative fee, directly to the SEIB. Members, who are disabled under Title II or Title XVI of the Social Security Act when a qualifying event occurs, will be required to pay 150% of the group's premium for months 19 through 29 of coverage or the month that begins more than 30 days after the date is determined that you are no longer disabled under Title II or Title XVI of the Social Security Act, whichever comes first. (If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.) Your coverage will be canceled if you fail to pay the entire amount on time.

When is my COBRA Coverage Premium Due?

Your initial premium payment is due within 45 days from your date of election. All subsequent premiums are due on the first day of the month of coverage. There is a 30-day grace period.

When Does my COBRA Coverage End?

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

- The SEIB no longer provides the Optional Plan;
- The premium for your continuation coverage is not paid on time;
- You become covered, after electing continuation coverage, under another group plan;
- You become entitled to Medicare; or
- You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the Optional Plan. For example, if you submit fraudulent claims, your coverage will be terminated.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your COBRA continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Keep the SEIB Informed of Address Changes

To protect your family's rights, you must keep the SEIB informed of any changes in the address of family members. You should also keep a copy for your records of any notices you send to the SEIB.

If You Have Any Questions

Questions concerning your COBRA continuation coverage rights may be addressed by calling the SEIB at 1-866-836-9737 or by mail at the contact listed below. For more

information about your COBRA rights, visit the Centers for Medicare & Medicaid Services (CMS) at //www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/COBRA.html. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

SEIB Contact Information

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

State Employees' Insurance Board
COBRA Section
201 South Union Street, Suite 200
PO Box 304900
Montgomery, AL 36130-4900

Dental Benefits Program

Plan Summary

Dental Benefit Schedule

	Plan I (Employee only)	**Plan II** (Employee & Full Family)
Maximum benefits applicable per person per plan year:	$1,250	$1,000
Diagnostic & Preventive Services: Based on Reasonable & Customary Charges		
Deductible	None	None
Oral Examinations	100%	100%
Cleaning of Teeth	100%	100%
Fluoride Applications for Children	None	100%
Space Maintainers for Children	None	Limited
X-Rays	100%	100%
Emergency Office Visits	100%	100%
Sealants	None	100%
Basic & Major Services: Based on Reasonable & Customary Charges		
Deductible	**None**	**$25.00**
Fillings	80%	60%
General Anesthetics	80%	60%
Oral Surgery	80%	60%
Periodontics	80%	60%
Endodontics	80%	60%
Dentures	80%	60%
Bridgework	80%	60%
Crowns	80%	60%

NO ORTHODONTIC BENEFITS

- Space maintainers are limited to $125.00 per unit.
- Deductibles are applied per person, per plan year with a maximum of three per family.
- Oral surgery excludes any procedures covered under a group medical program.
- Expenses are incurred at the preparation date and not the installation, service, or "seating" date.
- Benefits are not provided for temporary partials.

Covered Dental Expenses

Charges of a dentist or medical doctor which an insured is required to pay for services that are necessary for the diagnosis, prevention, or treatment of a dental condition, but only to the extent that such charges are reasonable and customary, and only if rendered in accordance with broadly accepted standards of dental practice.

Expenses are incurred at the preparation date and not the installation, service, or "seating" date.

The maximum benefits applicable per person, per plan year, are Plan I (employee) $1,250.00, Plan II (employee and full family) $1,000.00.

Reasonable and Customary Charges

The terms reasonable and customary charges refer to the actual fee charged by a dentist in Alabama for a service rendered, but only to the extent the fee is reasonable, taking into consideration the following items:

The usual fee which the individual dentist in Alabama most frequently charges the majority of his patients for service rendered;

The prevailing range of fees charged in the same areas by dentists in Alabama of similar training and experience for service rendered; and

Circumstances or complications requiring additional time, skill, and experience.

Diagnostic and Preventive Expenses

This plan will pay all reasonable and customary charges for:

Oral examinations and office visits, but not more than two examinations or office visits in a plan year. An examination and office visit are synonymous for this benefit. This category includes procedures performed by a dentist that aid in making diagnostic conclusions about the oral health of the individual patient and the dental care required. This limitation would not apply to emergency office visits.

Prophylaxis includes cleaning and scaling of teeth, but not more than two times in a plan year. Charges for this type of treatment performed by a licensed dental hygienist are also included if rendered under the supervision of a licensed dentist.

Topical application of fluoride: Benefits are provided to cover the topical application of fluoride for two treatments per plan year. Benefits are available to insured persons to age 19.

Space maintainers are fixed or removable appliances designed to prevent adjacent and opposing teeth from moving, and/or that replace prematurely lost or extracted teeth. Coverage is for charges incurred to maintain existing space. Benefits are available to insured persons to age 14. Benefits are limited to $125.00 per space maintainer unit. However, no benefits will be provided for the replacement of lost space maintainer units or replacement of outgrown space maintainer units, which have been prescribed during the same plan year.

X-rays: Dental x-rays including full mouth x-rays, but not more than once in any 36 consecutive months. Supplementary bitewing x-rays, but not more than twice in a plan year.

Sealants: Pit and fissure sealants are the prophylactic application of composite resin material to cavity-prone enamel pits and fissures. Benefits are provided for covered individuals to age 19. Limited to a one-time basis, per tooth.

Other Covered Dental Expenses

This plan will pay the percentage of reasonable and customary charges as shown in the Dental Benefit Schedule for the following:

Restorations, which include fillings, inlays, onlays, crowns, and the treatment necessary to restore the structure of a tooth or teeth. Benefits are provided for a replacement of gold or crown restoration if the restoration was installed while covered under this plan and at least five years prior to this replacement.

Multiple restorations on one tooth will be paid on the same basis as a multiple surface restoration rather than as an individual restoration. Bonding will be considered equal to crowning with acceptance and replacement restrictions the same.

Endodontics: Procedures used for the prevention and treatment of diseases of the dental pulp and the surrounding structures.

General Anesthesia: when medically necessary and administered in connection with oral surgery.

Periodontics: Procedures for the treatment of the gum and tissue supporting the teeth.

Oral Surgery: Procedures performed in or about the mouth, which involve, but are not limited to, the incision and excision procedures for the correction of disease, injury, or preparation of the mouth for dentures. Dental surgery includes charges for the removal of teeth.

Prosthodontics: Services performed to replace one or more teeth except for third molars (wisdom teeth). The plan will not cover replacement of existing bridgework or dentures; however, the plan will cover the installation of a permanent full denture that replaces or is installed within 12 months of a temporary denture, repairing or re- cementing inlays, crowns, bridgework, dentures, or relining of dentures. The plan will also cover the replacement of an existing partial by a new partial; replacement of a full denture or bridgework; or the addition of teeth to an existing denture or bridgework, but only if:

- The existing denture or bridgework was provided while coverage under this plan was in effect, the existing denture or bridgework is at least five years old and cannot be made serviceable.

No benefit shall be provided under the plan for dental services concerning congenital malformations or primarily for cosmetic or aesthetic purposes.

Pre-Determination of Benefits

Before beginning a course of treatment for which dentist's' charges are expected to be $150.00 or more, a description of the proposed course of treatment and charges to be made should be filed on the claim form with Southland. Southland will then determine the estimated benefit payable for covered dental expenses expected to be incurred and advise the employee and the dentist before treatment begins. Services must be completed within a reasonable length of time from the date predetermination was processed.

Emergency treatments, oral examinations including prophylaxis and dental x-rays are considered part of a course of treatment, but these services may be rendered before the pre-determination of benefit procedure has begun.

A course of treatment is a planned program of one or more services or supplies whether rendered by one or more dentists for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

After the course of treatment is completed, the Plan benefit shall be paid in accordance with the final claim submitted by the dentist. In the event of any change in the final claim or treatment, Southland shall adjust payment accordingly. In the event the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

In the event there is no claim for a predetermination of benefits, the benefit will be paid based upon the information submitted to Southland at the time of the claim.

Alternate Procedures

When it is determined that several methods of treatment exist to treat a particular problem, then benefits will be paid based on the least costly scheduled amount so long as the result meets generally accepted dental standards. Unless prior written consent is received from Southland, dental benefits are limited to the least costly procedure.

DentaNet Benefits

The dental coverage administered by Southland will offer a dental network to members and dependents enrolled in the dental plan. Under the Southland dental network, known as "DentaNet", members have the opportunity to use the network dentists but still have the freedom to use any dentist. DentaNet dentists cannot balance bill you for the difference between the negotiated fee schedule and what they normally charge. On services requiring you to pay a coinsurance fee, the coinsurance payment will be based on a negotiated fee. The SEIB and its members save money when DentaNet dentists are used.

Extension of Dental Benefits

Even though the coverage for an enrolled member has terminated, the member will be entitled to extended coverage for the completion of any dental service for which a treatment plan has been approved by the administrator, provided that the services are completed within 30 days of such approval.

Dental Exclusions

No benefits are payable for certain charges, including but not limited to charges for:

- Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan.
- Work done for appearance (cosmetic) purposes. Facing on crowns and pontics posterior to the second bicuspid, are always considered to be cosmetic.
- Work performed while not covered under this plan.
- Services or supplies in connection with orthodontia except for extractions.
- Extra sets of dentures or other appliances.
- Broken appointment.

- Replacing lost or stolen prosthetic appliances.
- Completion of claim forms or filing of claims.
- Educational or training programs, dietary instructions, plaque control programs, and oral hygiene information.
- Implantology (implants).
- Periodontal splinting.
- Work covered under the group hospital medical indemnity plan.
- Experimental procedures.
- Drugs or their administration.
- Anesthetic services billed by anyone other than the attending dentist or his assistant.
- Services and supplies not ordered by a dentist or physician and not reasonably necessary for the treatment of injury or dental disease.
- Appliances, restorations, and procedures to alter vertical dimensions including, but not limited to, harmful habit.
- Services, appliances, or supplies that exceed the reasonable and customary charges in Alabama.
- Treatment of an accident related to employment or sickness if either or both are covered under Worker's Compensation or similar laws.
- Work that is otherwise free of charge to patients or charges that would not have been made if there were no insurance.
- Work that is furnished or payable by the Armed Forces of any government.
- Services or supplies furnished by the United States, state, or local government.

- Services received for injuries or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan.

- Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state of Alabama participates in the cost thereof.

- Such other expenses as may be excluded by regulations of the board.

- Gold foil restorations.

- Pulp capping or acid etching as a separate procedure.

- Dental services concerning congenital malformations or primarily for cosmetic or aesthetic purposes.

- Periodontal cleaning aids or devices.

- Specific charges for infection control and/or protection supplies, including but not limited to, gloves, masks, gowns, shoes, or other items.

- Microscopic bacteriological examinations.

- Antimicrobial irrigation.

- Temporomandibular joint (TMJ) disorders.

- Benefits are not provided for temporary partials.

- Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider.

- All claims not submitted in writing, not completed, without the requisite certification of the health care provider, or received by Southland more than 365 days following the claim incurrence.

- Hospital expenses for dental work performed in the hospital.

Dental Coordination of Benefits

Coordination of Benefits (COB) is a provision designed to help manage the cost of dental care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary.

A primary plan is one whose benefits for a person's dental care coverage must be determined first without considering the existence of any other plan.

A secondary plan is one that takes into consideration the benefits of the primary plan before determining benefits available under its plan.

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

Order of Benefit Determination

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

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

Employee/Dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

Dependent Child – Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

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

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

    a) first, the plan of the custodial parent;

    b) second, the plan covering the custodial parent's spouse;

    c) third, the plan covering the non-custodial parent; and

    d) last, the plan covering the non-custodial parent's spouse.

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

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

    a) first, the plan of the spouse of the court-ordered parent;

    b) second, the plan of the non-court-ordered parent; and

    c) last, the plan of the spouse of the non-court-ordered parent. If a court decree states that both parents are responsible for the dependent child's dental care expenses or dental care coverage, the provisions of “Dependent Child – Parents Not Separated or Divorced” (the “birthday rule”) above shall determine the order of benefits.

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

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

Active Employee or Retired or Laid-Off Employee:

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

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

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

COBRA or State Continuation Coverage:

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

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

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

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

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

Determination of Amount of Payment

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

2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is a secondary plan on a claim, should it wish to coordinate benefits (that is, pay benefits as a secondary plan rather than as a primary plan concerning that claim), this plan shall calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. When paying secondary, this plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage. In some instances, when this plan is a secondary plan, it may be more cost-effective for the plan to pay on a claim as if it were the primary plan. If the plan elects to pay a claim as if it were primary, it shall calculate and pay benefits as if no other coverage were involved.

COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term “allowable expense” means any dental care expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term “allowable expense” does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. In addition, the term “allowable expense” does not include (a) the amount of any reduction in benefits under a primary plan because the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b) the covered person had a lower benefit because he or she did not use an in-network dentist.

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

Custodial Parent: The term “custodial parent” means:

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

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

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

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

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

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

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this provision; or

- All plans that cover the person use the order of benefit determination rules required by this provision, and under those rules, the plan determines its benefits first.

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

Right to Receive and Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose

of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We are not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to apply these COB rules and to determine benefits payable as a result of these rules.

Facility of Payment

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

Right of Recovery

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

Special Rules for Coordination with Medicare

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

Cancer Program

A. **Hospital Confinement**: $250.00 per day for the first 90 consecutive days of hospital confinement for inpatient charges; $500.00 per day thereafter. Readmission 30 days after discharge starts $250.00 daily payment again. No limit on confinement days or dollar amount.

In-hospital benefit (per day) under this plan does not cover charges for outpatient or same-day surgery UNLESS you are admitted on an inpatient basis where you are charged for a private or semi-private room or for an observation room for more than 24 continuous hours. Emergency room, outpatient room, observation room for less than 24 continuous hours, or a similar type room is not to be considered as a private or semi-private room and benefits are not provided for such charges under this plan.

B. **Hospice Care**: Actual charges to a maximum of $50.00 per day for care provided by a licensed Hospice agency, organization, or unit that provides to persons terminally ill and to their families, a centrally administered and autonomous continuum of palliative and supportive care. The care must be directed and coordinated by the Hospice organization in the patient or family home. This benefit does not apply to non-terminally ill patients, nor does it apply to home health care or custodial care benefits. Lifetime maximum of $3,000 per insured.

C. **Cancer Surgery**: Actual charges for operation depending on the type of surgery (see schedule of policy), to a maximum of $2,400.00. Hospitalization is not required. No limit on the number of operations.

D. **Anesthesia**: Actual charges to a maximum of $400.00 per operation. No limit on the number of operations.

E. **Radiation & Chemotherapy**: Actual charges to a lifetime maximum of $10,000.00. Hospitalization is not required. Diagnostic tests are not included.

F. **Blood & Plasma**: Actual charges to a lifetime maximum of $2,000.00. Includes transfusions, administration, processing and procurement, and cross-matching (excludes other laboratory expenses). Hospitalization is not required.

G. **Nursing Service**: Actual charges for full-time private care and attendance to $80.00 per day for RN or LPN for each day the insured is eligible for Hospital Confinement Benefit.

Such services to be rendered by a person who does not ordinarily reside in the same household with the covered person, and who is not related by blood, marriage, or legal adoption to the covered person. No lifetime maximum.

H. **Attending Physician**: Actual charges to a maximum of $20.00 per day for physician other than the surgeon for each day the insured is eligible for Hospital Confinement Benefit. No lifetime maximum.

I. **Ambulance**: Actual charges to a maximum of $100.00 per trip to and from the hospital where the insured is confined as an in-patient. Limit two trips per confinement. No lifetime maximum.

J. **Prosthetic Devices**: Actual surgery charges to a maximum of $500.00 for each surgically implanted prosthetic device that is prescribed as a direct result of cancer surgery. Lifetime maximum of $1,000.00 per insured.

Schedule of Operations

(Maximum Amounts Payable)

If two or more surgical procedures are performed by the same surgical approach or in the same operative field, the amount paid by the Plan will be that of the more expensive of the two procedures performed.

Procedure	Amount
ABDOMEN	
Paracentesis	$100.00
Exploratory laparotomy	$600.00
Cholecystectomy	$800.00
BLADDER:	
Cystoscopy	$150.00
Cystectomy	
(Partial)	$1,000.00
(Complete)	$1,800.00
TUR bladder tumors	$600.00
BRAIN:	
Exploratory Craniotomy	$1,200.00
Burr holes not followed by surgery	$300.00
Excision brain tumor	$2,400.00
BREAST:	
Needle Biopsy	$150.00
Cutting Operation Biopsy	$300.00
(Simple)	$800.00
(Radical)	$200.00
Lumpectomy	$400.00
CERVIX:	
Dilation and Curettage (D&C)	$200.00
Colposcopy	$200.00
Abdominal and Vaginal	$800.00
Hysterectomy/uterus only	$1,200.00
Uterus, tubes, & ovaries	$200.00
CHEST:	
Thoracentesis	$100.00
Bronchoscopy	$300.00
Mediastinoscopy	$300.00

Thoracostomy	$800.00
Pneumonectomy	$1,600.00
Wedge Resection	$1,200.00
Lobectomy	$1,400.00
ESOPHAGUS:	
Esophagoscopy	$300.00
Resection of Esophagus	$1,600.00
Esophagogastrectomy	$1,400.00
EYE:	
Enucleation	$400.00
P32 uptake	$200.00
INTESTINES:	
Sigmoidoscopy	$150.00
Proctosigmoidoscopy	$150.00
Colonoscopy	$300.00
Cutting Operation of rectum for biopsy	$300.00
Colostomy/or revision of	$400.00
Heostomy	$400.00
Colectomy	$1,000.00
Abdominal-Perineal approach for removal of cancer of sigmoid colon or rectum	$2,000.00
Resection small intestine	$2,000.00
KIDNEY:	
Nephrectomy	$2,000.00
LIVER:	
Needle Biopsy	$150.00
Wedge Biopsy	$300.00
Resection of liver	$1,000.00
LYMPHATIC:	
Excision of lymph node	$200.00
Splenectomy	$800.00
Axillary node dissection	$800.00
Lymphadenectomy	
(Unilateral)	$800.00
(Bilateral)	$1,000.00

MANDIBLE:	
Mandibulectomy	$1,600.00
MISCELLANEOUS:	
Bone Marrow Biopsy or Aspiration	$150.00
Pathological Fracture Hip	$1,000.00
MOUTH:	
Hemiglossectomy	$400.00
Glossectomy	$800.00
Resection of Palate	$800.00
Tonsil/Mucous membrane	$600.00
PANCREAS	
Jejunostomy	$1,000.00
Pancreatactomy	$2,400.00
Whipple Procedure	$2,400.00
PENIS:	
Amputation	
(Partial)	$300.00
(Complete)	$600.00
(Radical)	$800.00
PROSTATE:	
Cystoscopy	$150.00
TUR Prostate	$600.00
Radical Prostatectomy	$1,400.00
SALIVARY GLANDS:	
Biopsy	$400.00
Parotidectomy	$800.00
Radial Neck Dissection	$1,600.00
SKIN:	
Excision of lesion of skin	$150.00
With flap or graft	$400.00
SPINE:	
Laminectomy	$1000.00
Cordotomy	$600.00

STOMACH:	
Gastroscopy	$300.00
Partial Gastrectomy	$1,000.00
Gastrectomy	$1,400.00
Gastrojejunostomy	$1,000.00
TESTIS:	
Orchiectomy	$400.00
THROAT:	
Laryngoscopy	$300.00
Laryngectomy	
(Without neck dissection)	$800.00
(With neck dissection)	$1,600.00
Tracheostomy	$300.00
THYROID:	
Thyroidectomy	
Partial (one lobe)	$600.00
Total (both lobes)	$800.00
VULVA:	
Partial	$1,200.00
Radical	$600.00

Limitations and Exclusions

- This policy pays only for loss resulting from hospitalization for definitive cancer treatment including direct extension, metastatic spread, or recurrence. Pathologic proof must be submitted to support each claim. This policy does not cover any other disease, sickness, or incapacity, and benefits are not provided for premalignant conditions with malignant potential or human immunodeficiency virus.

- No benefits are payable for certain charges, including but not limited to charges for:

    - Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan;

    - Hearing aids and examinations for the prescription or fitting of hearing aids;

- Cosmetic surgery or treatment, specifically but not limited to, coverage for reconstruction, which is prescribed as a direct result of cancer surgery except as provided in Paragraph J. “Prosthetic Devices” under the Cancer Program.

- Benefits for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay such charge;

- Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan;

- Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;

- Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state of Alabama participates in the cost thereof;

- Such other expenses as may be excluded by regulations of the Board;

- Expenses due to Convalescent Long-Term Care, Nursing Home confinement or rehabilitation (the recovery of health and strength after disease, sickness, or injury);

- All claims not submitted in writing, not completed, without the requisite certification of the health care provider or received by Southland more than 365 days following the claim incurrence.

- Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

Definitions

- **Cancer Defined - Positive Pathology Required**
  Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, or leukemia.

  Such cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology to practice Pathologic Anatomy, or an Osteopathic Pathologist. Diagnosis must be based on a microscopic

examination of fixed tissue or preparations from the hemic system (either during life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis does not meet this standard.

- **Hospital Defined**
  Hospital means a lawfully operating institution engaged mainly in providing treatment for sick or injured persons on an inpatient basis at the patient's expense. The treatment must be under the supervision of a licensed physician. The hospital must maintain diagnostic and therapeutic facilities on-premises for surgical and medical treatment of such persons. These facilities must be supervised by a staff of legally qualified physicians and must include a laboratory, x-ray equipment, and operating room. Permanent, full-time facilities for the care of overnight resident bed patients must be maintained.

  The hospital must have surgical facilities on-premises where major surgery is performed on a routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

  Hospital does not include the institution, or part thereof, used as: a Hospice unit including any beds designated as a Hospice; a swing bed; a convalescent home; a rest home; a rest or nursing facility; pain clinic; psychiatric unit; rehabilitation unit; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or treatment for persons suffering from mental disease or disorders, care for the aged, drug and/or substance-addicted or alcoholics.

Hospital Indemnity Program

Plan Summary Coverage

	Plan I (Employee Only)	**Plan II** (Employee & Full Family)
In-hospital benefit (per day)[1]	$150.00	$75.00
Maternity (per day)[1]	$150.00	$75.00
Intensive care benefit (per day)[1]	$300.00	$150.00
Convalescent or long-term care /Rehabilitation (per day)[2]	$150.00	$75.00
Supplemental accident[3]	$1000.00	$1000.00
Ambulance benefit[4]	$100.00	$100.00

In-hospital, maternity, intensive care, and convalescent or long-term care benefits are exclusive and non-duplicating.

Footnotes:

1. Benefits are limited to 365 days per covered accident or illness; Benefits will be paid for any admission on an in-patient basis where charges are incurred for a private or semi-private room.
2. Limited to 90 days' lifetime maximum.
3. Limited to $1,000.00 per plan participant and/or dependent, per plan year.
4. Ambulance benefits limited to the amount of actual charges to a maximum of $100.00 per trip to or from a hospital where the insured is confined as an inpatient. No lifetime maximum.

Definitions

Convalescent or Long-Term Care Facility is an institution that is used primarily as a rest facility, nursing facility, or facility for the aged or for rehabilitation (the recovery of health and strength after disease, sickness, or injury). Convalescent care may include home confinement. In no event, however, shall a convalescent or long-term care facility include any institution that is a hospital as defined in this policy, or any institution primarily used for the care and treatment of drug addicts, alcoholics, and/or mental or nervous disorders or a hospice facility. Assisted living facilities are not covered by this plan and benefits will not be provided.

Convalescent or Long-Term Care Facility Confinement Coverage or Home Confinement Coverage is provided for a lifetime maximum of 90 days in the aggregate for payment of nursing care services. These benefits are payable only if all the following criteria are met:

- The attending physician certifies that 24-hour nursing care by a Registered Nurse or Licensed Practical Nurse is medically necessary for recuperation.

- The convalescent or long-term care facility confinement is preceded by at least three consecutive days of hospital confinement for which benefits were payable.

- It is due to the same sickness or injury and commences within 14 days after a previous hospital, convalescent, or long-term care facility confinement for which benefits were payable.

- The condition of the plan participant or dependent requires 24-hour a day nursing services by registered nurses or licensed practical nurses, such services to be rendered by a person who does not ordinarily reside in the same household with the covered person, and who is not related by blood, marriage or legal adoption to the covered person.

Hospital means a lawfully operating institution engaged mainly in providing treatment for sick or injured persons on an inpatient basis at the patient's expense. The treatment must be under the supervision of a licensed physician. The hospital must maintain diagnostic and therapeutic facilities on-premises for surgical and medical treatment of such persons. These facilities must be supervised by a staff of legally qualified physicians and must include a laboratory, x-ray equipment, and operating room. Permanent, full-time facilities for the care of overnight resident bed patients must be maintained. The hospital must have surgical facilities on-premises where major surgery is performed on a routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

Hospital does not include the institution, or part thereof, used as: a Hospice unit including any beds designated as a Hospice; a swing bed; a convalescent home; a rest home; a rest or nursing facility; pain clinic; psychiatric unit; rehabilitation unit; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or treatment for (1) persons suffering from mental disease or disorders, (2) the aged, or (3) drug and/or substance addicts or alcoholics.

In-Hospital Benefit: In-hospital benefit (per day) under this plan does not cover charges for outpatient or same-day surgery unless you are admitted on an inpatient basis where

you are charged for a private or semi-private room or for an observation room for more than 24 continuous hours. Emergency room, outpatient room, observation room for less than 24 continuous hours, or a similar type room is not to be considered as a private or semi-private room and benefits are not provided for such charges under this plan.

Injury means an accidental injury of the insured or dependent sustained while this policy is in force.

Mental/Nervous Disorder/Addiction Treatment: Mental or nervous disorder means neurosis, psychoneurosis, psychopathy, psychosis, chemical imbalance, or mental or emotional disease or disorders of any kind, including treatment for alcoholism and/or drug addiction. Benefits for treatment of mental or nervous disorders and alcoholism and/or drug addiction treatment are limited to a maximum of 14 days' confinement in a hospital as an in-patient per plan year; provided, however, the facility is not required to include a laboratory, x-ray equipment or an operating room.

Alcoholism and/or drug addiction treatment is further limited to a maximum of one admission of not more than 14 days' confinement as an inpatient per plan year. This benefit is further limited to a lifetime maximum of two admissions of not more than 14 days per admission for the treatment of substance abuse.

Qualified Practitioners are any duly licensed physicians operating within the scope of their license, including podiatrists and doctors of chiropractic.

Supplemental Accident Benefit: This benefit will pay incurred expenses up to the benefit amount shown when an insured sustains an injury as a result of an accident if such injury does not result in hospital confinement during the period ending one year from the date of such accident, and such injury is incurred while the coverage is in force and within 90 days of the date of such accident. Benefits will be limited to a maximum of $1,000.00 per plan participant and/or dependent, per plan year.

The $1,000.00 maximum benefit per participant and/or dependent, per plan year, are covered charges due to, or for, treatment of accidental injury by adjustment or manipulation of the spine or soft tissues, including but not limited to analysis, related x-ray and laboratory examinations, and related support, immobilization, and physical therapy procedures. Treatment must be provided by a qualified practitioner(s) and is limited to a maximum of:

- $25.00 per visit;
- Two visits in any seven consecutive days (all accidental injuries and qualified practitioners combined);

- Thirty visits per plan year (all accidental injuries and qualified practitioners combined).

Accidental injury means all such injuries of a covered person occurring while this plan is in force and caused by an external, violent force that was not expected, could not have been reasonably foreseen, and was unrelated directly or indirectly to all other causes.

Exclusions

No benefits are payable for certain charges, including but not limited to charges for:

- Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan;

- Hearing aids and examinations for the prescription or fitting thereof;

- Cosmetic surgery or treatment, except to the extent necessary for correction of damage caused by accidental injury while covered by the plan or as a direct result of disease covered by the plan;

- Benefit for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay such charge;

- Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this plan;

- Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;

- Expenses to the extent of benefits provided under any employer group plan other than this plan in which the state participates in the cost thereof;

- Such other expenses as may be excluded by regulations of the Board;

- Outpatient or same-day surgery for illness;

- Expenses or charges for emergency rooms, outpatient rooms, same-day surgery rooms, observation rooms, or similar type rooms;

- Dental treatment as a result of any cause, whether accidental or non-accidental;

- All claims not submitted in writing, not completed, with the requisite certification of the health care provider, or received by Southland more than 365 days following the claim incurrence.

Vision Program

Coverage and maximum annual benefits

Examination (actual charges not to exceed):	$40.00
AND	
Frames (not to exceed)	$60.00
Lenses (not to exceed):	
Single Vision	$50.00
Bifocals	$75.00
Trifocals	$100.00
Lenticular	$125.00
OR	
Contacts (not to exceed)	$100.00

Plan provides either contact or lenses and frames, but not both in any plan year.

It is the responsibility of the member to submit a claim for either lenses or contacts and the payment will be made based on the date the claim is received.

Limitations

Examinations: One in any plan year.

Lenses: One new prescription or replacement in any plan year. Benefits are not available under the plan for both lenses and contacts in the same plan year.

Contacts: One new prescription or replacement in any plan year. Plan provides either contacts or lenses and frames, but not both in any plan year.

Frames: One new or replacement in any plan year.

Vision Examination**:** Consisting of one or more, but not limited to the following component services when performed by a licensed ophthalmologist or optometrist:

- case history
- external examination of the eye and adnexa
- determination of refractive status
- ophthalmoscopy
- application of pharmaceutical agents for diagnostic purposes when indicated and allowed by state law
- tonometry test for glaucoma when indicated
- binocular measure
- summary finding and recommendations

- prescribing corrective lenses, if needed

Definitions

Bifocal Lenses: Lenses containing two foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

Contact Lenses: Lenses that fit directly on the eyeball under the eyelids.

Frames: A standard eyeglass frame into which two lenses are fitted.

Lens or Lenses: Ophthalmic corrective lens or lenses, glass or plastic, ground or molded, as prescribed by an ophthalmologist or optometrist, to be fitted into a frame.

Lenticular Lenses: Special non-contact lenses for persons who have cataracts.

Ophthalmologist: A licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of his or her license, performs vision examinations, prescribes lenses to improve visual acuity, and performs surgical procedures to the eye.

Optician: A person qualified in the state in which the service is rendered to supply eyeglasses according to prescriptions written by an ophthalmologist or optometrist, to grind or mold lenses or have them ground or molded according to prescription, to fit them into a frame and to adjust the frame to fit the face.

Optometrist: Any doctor of optometry legally qualified to practice optometry in the state in which vision care services are rendered, who performs vision examinations and prescribes lenses to improve visual acuity.

Trifocal Lenses: Lenses containing three foci, usually arranged with the focus for distance above, for intermediate distance in the middle, and for near vision below.

Exclusions

Vision care plan benefits will not be provided for certain charges, including but not limited to, charges for:

- Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan;

- Services or supplies for which coverage is provided or available under any other medical benefit program maintained by the State Employees' Insurance Board, or by Workers' Compensation Laws, or by any safety lens program;

- Drugs or any other medication;

- Any medical or surgical treatments;
- Special or unusual treatment such as orthoptics, vision training, subnormal vision aids, aniseikonia lenses, or tonography;
- Services or supplies not prescribed by a licensed physician, optometrist, or ophthalmologist, and lenses which do not require a prescription;
- Service or supplies which are experimental in nature or are not approved by the American Ophthalmology Association;
- The extra charge for oversized, photosensitive, or anti-reflective lenses, whether or not medically necessary;
- Sunglasses, including lenses and frames;
- Follow-up visits, fitting fees, dispensing fees, coating or care kits;
- Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
- All claims not submitted in writing, not completed, with the requisite certification of the health care provider or received by Southland more than 365 days following the claim occurrence;
- Services of a physician who is related to the member by blood or marriage or who regularly resides in the same household.

Vision Coordination of Benefits

If an enrolled member is covered under more than one group vision plan or is entitled to any other source, the total amount that is payable under all plans will not be more than 100% of the covered expenses. SEIB benefits will be secondary to all other coverages available to a claimant.

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