PEEHIP

Optional Insurance Plans

Dental | Cancer | Hospital Indemnity | Vision

October 1, 2024

Administered by

Southland Benefit Solutions, LLC

PO Box 1250 • Tuscaloosa, Alabama 35403 • Telephone 205-343-1250
Fax 205-409-2527 • 1-800-476-0677 • www.southlandpeehip.com

DentaNet

is a Southland network of Participating
Dentists benefiting PEEHIP members

Here Are The Top 3 Reasons To Use One Of Our Participating Dentists:

1 **THEY SAVE YOU MONEY**

2 **THEY SAVE PEEHIP MONEY**

3 **THEY SAVE YOU & PEEHIP MONEY**

DentaNet is one of the largest independent dental networks in the State of Alabama.
The network is designed to save you money.
One important reason you purchase benefits is to save money.

For a listing of Statewide DentaNet providers, visit
www.southlandpeehip.com

FACT

DentaNet is the network of participating dentists designed to benefit PEEHIP members.

FACT

DentaNet is one of the largest dental networks in the state of Alabama.

FACT

By using DentaNet providers, PEEHIP members save money.

QUESTION: ARE YOU SAVING MONEY?

If you participate in the PEEHIP Dental Plan, you probably purchased dental insurance to save money.

DentaNet providers are all over the state.
To find a participating DentaNet provider in your area,
visit www.southlandpeehip.com or call us,
toll-free, at 1-800-476-0677 today.
You'll be glad you did.

TruHearing Choice Discount

Because you are a plan participant, you have access to TruHearing, a comprehensive hearing care solution, which provides significant savings on a wide variety of the latest digital hearing aids from the world's leading manufacturers.

Customers save an average of $2,642 per pair of hearing aids when they purchase from TruHearing.

TruHearing is a free program, so you don't have to pay anything to get access to this program which includes state-of-the-art technology, personalized care, and continued service for the life of your hearing aids.

Benefits of choosing TruHearing

- Risk-free 60-day trial period
- 1 year of follow-up visits
- 80 free batteries per non-rechargeable hearing aid
- Full 3-year manufacturer warranty
- One-time loss and damage replacement (deductible applies)
- No-interest finance available
- Dedicated hearing consultant through life of the hearing aid
- Selection of the newest technology hearing aids from the top manufacturers
- Over 7,000 providers nationwide
- Dedicated phone number and landing page
- RIC, IIC, ITE, ITC, CIC, and BTE hearing aids available at a deep discount

3 steps to better hearing.

Getting the care you need for your hearing loss can be confusing—and expensive. It shouldn't be that way. We make the journey to better hearing simple and affordable.

Step 1: **Give us a call.**

Your dedicated Hearing Consultant will answer any questions you might have, check your insurance coverage, and schedule an appointment with a TruHearing provider near you, or virtually with available teleaudiology options.

Step 2**: Go to your appointment.**

Your local hearing health provider will perform a hearing exam and, if needed, recommend hearing aids that will fit your hearing loss, budget, and lifestyle. With your TruHearing benefit, you'll save an average of $2,642 per pair versus retail price.

Step 3: **Get the support you need.**

We'll be there to help as you reconnect to the world of sound. Follow-up care from your provider ensures your hearing aids fit and perform properly. Ongoing support from TruHearing will help you get comfortable with your new hearing aids.

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The Public Education Employees' Health Insurance Plan was established under provisions of Act 83-455 of the 1983 Alabama Legislature. The Act created the Public Education Employees' Health Insurance Board. The Board established a uniform plan of health insurance for employees. This plan includes four optional plans of insurance that are administered by Southland Benefit Solutions, LLC.

Each eligible employee has the opportunity to elect one or more optional coverage(s) provided by the Public Education Employees' Health Insurance Board.

There are four (4) optional plans from which to choose (Dental - Cancer - Hospital Indemnity - Vision). This summary of optional plans available to you is designed to help you understand the individual plan(s) you choose. This booklet replaces any previously issued information. The plan begins October 1 of each year.

Notice of Appeal: In the event payment of a claim is denied by the Plan Administrator and the insured is of the opinion such denial was improper, the insured has the right of appeal. The appeal procedure is as follows:

(1) To appeal, the insured must submit a request for review, in writing, to the Plan Administrator within sixty (60) days from the date any writing is received by the insured from the Plan Administrator denying payment of a claim. This request must contain the specific reasons the insured contends claim denial was improper. Within the same time period, insured may submit any other evidence which insured contends supports his or her position.

(2) The Plan Administrator will review the claim; any written requests or other evidence received from the insured and advise the insured of its final determination.

(3) If the insured is still of the opinion that claim denial is improper, insured may obtain a judicial review of the Plan Administrator's decision by the Circuit Court of Montgomery, Alabama. This judicial review of contested cases is allowed under the Alabama Administrative Procedures Act, 41-22-20 of the Code of Alabama, 1975.

ALL THE TERMS, CONDITIONS, AND LIMITATIONS OF EACH PLAN ARE NOT COVERED HERE. ALL BENEFITS ARE SUBJECT TO THE TERMS, CONDITIONS, AND LIMITATIONS OF THE MASTER CONTRACT BETWEEN THE PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE BOARD AND YOUR PLAN ADMINISTRATOR. A COPY OF THE CONTRACT IS KEPT ON FILE AT THE PUBLIC EDUCATION HEALTH INSURANCE BOARD OFFICE AND IS AVAILABLE FOR YOU TO REVIEW. THE INFORMATION IN THIS BOOKLET IS NOT A SUBSTITUTE FOR THE LAW OR THE MASTER CONTRACT. IF A DIFFERENCE OF INTERPRETATION OCCURS, THE LAW GOVERNS. THE LAW MAY CHANGE AT ANY TIME ALTERING INFORMATION IN THIS HANDBOOK. THE BOARD RESERVES THE RIGHT TO CHANGE BENEFITS DURING THE PLAN YEAR.

"PLAN YEAR" means a period which begins October 1st through the next September 30th. This applies to all plans.

Who is eligible to enroll in PEEHIP coverages?

Full-Time Employees

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

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

Permanent Part-Time Employees

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

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

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

Eligible Dependents

Spouse

The employee's spouse as defined by Alabama law to whom you are currently and legally married. PEEHIP requires a copy of a marriage certificate to verify eligibility and one additional current document to show proof of current marital status. Excludes a divorced spouse or common law spouse.

Children

PEEHIP offers dependent coverage to children up to age 26. Appropriate documentation will be required by PEEHIP before dependents can be enrolled as explained on page 10. In accordance with the federal health care reform legislation, the following children are eligible for PEEHIP coverage:

1. A married or unmarried child under the age of 26 if the child is your biological child, legally adopted child, stepchild or foster child without conditions of residency, student status, or dependency. A foster child is any child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
2. The eligibility requirements for any other children such as grandchildren, for example, must meet the same requirements as foster children and must be placed with you by decree or other order of any court of competent jurisdiction, for example, legal custody or legal guardianship.
   PEEHIP is not required and will not provide coverage for a child of a child receiving dependent coverage. Also, maternity benefits and delivery charges are not covered for children of any age regardless of marital status.
3. An unmarried incapacitated child 26 years of age or older who:
   - is permanently incapable of self-sustaining employment because of a physical or mental handicap,
   - is chiefly dependent on the member for support, and
   - was disabled prior to the time the child attained age 26, and the child had to be covered as a dependent on the member's PEEHIP policy before reaching the limiting age of 26.

Exception:

- New member requests coverage of an incapacitated child over the age of 26 within 30 days of employment.

The employee must contact PEEHIP and request an INCAPACITATED DEPENDENT form. Proof of the child's condition and dependence must be submitted to PEEHIP within 45 days after the date the child would otherwise cease to be covered because of age. PEEHIP may require proof of the continuation of such condition and dependence.

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

Aged Out:

When the dependent has attained the chronological age of 26, the child's coverage will terminate the first day of the month following their 26th birthday. Once an eligible dependent has "aged out", then such person is ineligible to participate in the plan again as a dependent except subsequently as the spouse of an eligible member.

Enrollment of Dependents:

Participating employees must enroll their eligible dependents under this plan by enrolling in the PEEHIP Member Online Services (MOS) system or completing a paper enrollment form and submitting the form to the PEEHIP office within the specified deadline.

Required Documentation For Dependents:

Every member who has a dependent enrolled on their PEEHIP coverage(s) will be required to certify to PEEHIP their dependent's eligibility. Certification may require appropriate documents to support your dependent's eligibility. Such documents required will be a marriage certificate and one additional document to show proof of current marital status for a spouse. Other documents required are a birth certificate for a natural child; a certificate of adoption for an adopted child; a marriage certificate and a birth certificate for a step-child; a placement authorization for a foster child; a court order signed by a judge appointing legal guardianship or legal custody for other children who are not biological, adopted or step children.

Enrollments cannot be processed without the appropriate documentation.

PEEHIP is not bound by a court order to insure dependents who do not meet PEEHIP guidelines.

Who is not eligible to enroll?

Ineligible employees

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

Ineligible family members (dependents)

- An ex-spouse regardless of what the divorce decree may state
- Ex-stepchildren regardless of what the divorce decree may state
- Children age 26 and older
- Disabled children over age 26 who were never enrolled or whose coverage was previously canceled

- A child of a dependent child cannot both be covered on the same policy.
- A spouse of a dependent
- Grandchildren or other children related to the member by blood or marriage for which the member does not have legal guardianship or legal custody who are not foster children or adopted children and temporarily disabled dependent children who have aged out.
- Grandparents
- Parents
- A fiancé(e) or non-married significant other

If you are covering an ineligible dependent, you must notify PEEHIP and disenroll the dependent immediately. If you know of someone who is covering an ineligible dependent, please notify PEEHIP by phone 877-517-0020, email peehipinfo@rsa-al.gov or mail PEEHIP, PO Box 302150, Montgomery, AL 36130-2150.

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

Newly Acquired Dependents and Single Coverage

Marriage

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

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

Members will be required to make payment for dental coverage at time of enrollment.

Birth, Adoption, or Legal Custody of a Child

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

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

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

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

Newly Acquired Dependents and Family Coverage

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

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 though benefits under this program are changed during such confinement.

Insurance Commences:

Insurance commences upon the application of final approval by the administrative staff of the Public Education Employees' Health Insurance Plan.

I.D. Card:

Will be provided by the Plan Administrator as quickly after enrollment as possible.

Claim Forms:

Claim forms are available on the Southland and PEEHIP websites or can be mailed to members upon request.

Plan Administrator:

The Plan Administrator for the optional plans is Southland Benefit Solutions, LLC - PO Box 1250 Tuscaloosa, Alabama 35403-1250.(1-800-476-0677)

PAYMENT AND CLAIM FILING LIMITATION:

All claims must be submitted in writing and such writing must be received by the Plan Administrator **no later than 365 days** following the date covered expenses are incurred. If a claim is not submitted and received by the Plan Administrator 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 in an effort to obtain coverage not normally provided will not be accepted and will be denied.

Termination of Coverages:

Coverage remains in effect through the last day of the month in which employment terminates or month of last payment due employee. Coverage will be terminated in accordance with the applicable federal and state laws and regulations. Please see the section "Continuation of Coverage" in this brochure which outlines your rights under Public Law 99-272, Title X.

Enrollment:

Enrollment in any or all of the plans must continue through the end of the plan year.

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 the Plan Administrator later determines that an error has been made, you or the provider will be required to repay any overpayment. If repayment is not made, the Plan Administrator may deduct the amount of the overpayment from any future payment to you or the provider. If this action is taken, the Plan Administrator 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 for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

Southland Benefit Solutions administers the optional plans offered through PEEHIP. Enrollment in optional plans must be retained for the entire plan year (October 1-September 30). New members employed during the Open Enrollment period cannot enroll in optional plans on their date of employment and cancel the plans October 1 of that same year. Members enrolled in family optional plans cannot change to individual optional plans outside of the Open Enrollment period unless all dependent(s) become ineligible due to age, death or divorce.

NOTWITHSTANDING ANYTHING IN THE PLAN SUMMARY OR THE MASTER PLAN TO THE CONTRARY, THE BENEFIT BOARD RESERVES THE RIGHT TO DENY COVERAGE OR PAYMENT FOR ANY CHARGE INCURRED BY A COVERED PERSON THAT WAS NOT MEDICALLY NECESSARY.

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; SPECIFICALLY, PEEHIP DENTAL AND VISION PLAN BENEFITS WILL BE SECONDARY TO ALL OTHER COVERAGES AVAILABLE TO ANY CLAIMANT. THE TOTAL AMOUNT THAT IS PAYABLE UNDER ALL PLANS WILL NOT BE MORE THAN 100% OF THE MAXIMUM ALLOWABLE EXPENSES.

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[1]	None	Limited
X-Rays	100%	100%
Emergency Office Visits	100%	100%
Sealants	None	100%

Basic & Major Services: Based on Reasonable & Customary Charges

Deductible[2]	None	$25
Fillings	80%	60%
General Anesthetics	80%	60%
Oral Surgery[3]	80%	60%
Periodontics	80%	60%
Endodontics	80%	60%
Dentures[4]	80%	60%
Bridgework[4]	80%	60%
Crowns	80%	60%

NO ORTHODONTIA BENEFITS

1 Space maintainers limited to $125 per unit
2 Deductibles are applied per person, per plan year with a maximum of three (3) per Family
3 Oral surgery excludes any procedures covered under a Group Medical Program
4 No benefits are provided for replacement of teeth removed before coverage is effective.
* 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 employee is required to pay for services which 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, Plan II (employee and full family) $1,000.

REASONABLE AND CUSTOMARY CHARGES

The term "reasonable and customary charges" means 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: Maximum of two (2) examinations or office visits in a plan year. An examination and office visit are synonymous for the purposes of 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 (2) 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 topical application of fluoride for two (2) treatments per plan year. Benefits are available to insured persons to age nineteen (19).

Space Maintainers: 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 fourteen (14). Benefits are limited to One Hundred Twenty-Five ($125) Dollars per space maintainer unit. However, no benefits will be provided for 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 nineteen (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: Treatment necessary to restore the structure of a tooth or teeth (includes fillings, inlays, onlays, and crowns).

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 (5) 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: Provided 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 removal of teeth.

Prosthodontics: Services performed to replace one or more teeth except third molars (wisdom teeth), extracted while the patient is covered under the plan. 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 recementing 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:

A. The existing denture or bridgework was provided while coverage under this plan was in effect, the existing denture or bridgework is at least five (5) years old and cannot be made serviceable; or
B. The replacement or addition of teeth is required to replace one or more natural teeth extracted or accidentally lost while insured.

No benefits shall be provided under the plan for dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.

No benefits are provided for replacement of teeth removed before coverage is effective.

PRE-DETERMINATION OF BENEFITS

Before beginning a course of treatment for which dentists' charges are expected to be $150 or more, a description of the proposed course of treatment and charges to be made should be filed on the claim form with the Plan Administrator. The Plan Administrator will then determine the estimated benefits 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 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 Benefits procedure is 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, the Plan Administrator 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 the Administrator of the Plan 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 acceptable dental standards. Unless prior written consent is received from the Plan Administrator, dental benefits are limited to the least costly procedure.

COORDINATION OF DENTAL BENEFITS

If an enrolled member is covered under more than one group dental 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 maximum allowable expenses. **PEEHIP dental benefits will be secondary to all other dental coverages available to a claimant.**

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. PEEHIP and its members save money when DentaNet dentists are used. You may obtain a list of DentaNet dentists from the Southland website, www.southlandpeehip.com.

EXTENSION OF DENTAL BENEFITS

Even though the coverage for an enrolled member has terminated, he will be entitled to extended coverage for the purpose of 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:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan.
2. Replacement of teeth removed before coverage is effective.
3. Work done for appearance (cosmetic) purposes. Facing on crowns and pontics posterior to the second bicuspid, are always considered to be cosmetic.
4. Work done while not covered under this plan.
5. Services or supplies in connection with orthodontia except for extractions.
6. Extra sets of dentures or other appliances.
7. Broken appointment.
8. Replacing lost or stolen prosthetic appliances.
9. Completion of claim forms or filing of claims.
10. Educational or training programs, dietary instructions, plaque control programs, and oral hygiene information.
11. Implantology (implants).
12. Periodontal splinting.
13. Work covered under the group hospital medical indemnity plan.
14. Experimental procedures.
15. Drugs or their administration.
16. Anesthetic services billed by anyone other than the attending dentist or his assistant.
17. Services and supplies not ordered by a dentist or physician and not reasonably necessary for treatment of injury or dental disease.
18. Appliances, restorations, and procedures to alter vertical dimension including, but not limited to, harmful habit appliances.
19. Services or supplies that exceed the reasonable and customary charges in Alabama.
20. Treatment of an accident related to employment or sickness if either or both are covered under Workmen's Compensation or similar laws.
21. Work that is otherwise free of charge to patients or charges that would not have been made if there were no insurance.

22. Work that is furnished or payable by the Armed Forces of any government.
23. Services or supplies furnished by the United States, state or local government.
24. 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.
25. 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.
26. Such other expenses as may be excluded by regulations of the board.
27. Gold foil restorations.
28. Pulp capping or acid etching as a separate procedure.
29. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
30. Periodontal cleaning aids or devices.
31. Specific charges for infection control and/or protection supplies, including but not limited to, gloves, masks, gowns, shoes or other items.
32. Microscopic bacteriological examinations.
33. Antimicrobial irrigation.
34. Temporomandibular joint (TMJ) disorders.
35. Benefits are not provided for temporary partials.
36. 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.
37. All claims must be submitted in writing, completed, with the requisite certification of the health care provider, and received by the Plan Administrator no later than 365 days following the claim incurrence.
38. Hospital expenses for dental work performed in the hospital.

CANCER PROGRAM
Coverage Outline

A. **Hospital Confinement:** $250 per day for first 90 consecutive days of hospital confinement for in-patient charges; $500 per day thereafter. Readmission 30 days after discharge starts $250 daily payment again. No limit on number of confinements or dollar amount.

In-hospital benefits (per day) under this plan do not cover charges for out-patient or same day surgery UNLESS you are admitted on an in-patient basis where you are charged for a private orsemi-private room, or for an observation room for a period of more than 24 continuous hours. Emergency room, out-patient room, 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 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 type of surgery (see schedule of policy), to a maximum of $2,400. Hospitalization not required. No limit on number of operations. 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.

D. **Anesthesia:** Actual charges to a maximum of $400 per covered operation. No limit on number of operations.

E. **Radiation & Chemotherapy:** Actual charges to a lifetime maximum of $10,000 for Cobalt Therapy, X-Ray Therapy or Chemotherapy Injections. Hospitalization not required. Diagnostic tests not included.

F. **Blood & Plasma:** Actual charges to a lifetime maximum of $2,000. Includes transfusions, administration, processing and

procurement, and cross-matching (excludes other laboratory expenses). Hospitalization not required. Leukemia to pay a maximum of $5,000 per plan year for blood and plasma.

G. **Nursing Service:** Actual charges for full-time private care and attendance to $80 per day for R.N., L.P.N., or L.V.N. 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 per day for physician other than the surgeon for each day the insured is eligible for Hospital Confinement Benefit. No lifetime maximum.

I. **Prosthetic Devices:** Actual surgery charges to a maximum of $500 for each surgically implanted prosthetic device for which is prescribed as a direct result of cancer surgery. Lifetime maximum of $1,000 per insured.

J. **Ambulance:** Actual charges to a maximum of $100 per trip to and from hospital where insured is confined as an in-patient. Limit two trips per confinement. No lifetime maximum.

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.

ABDOMEN:

Paracentesis	100.00
Exploratory laporatomy	600.00
Cholecystectomy	800.00
Bile Duct Stent	400.00

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
Mastectomy	
(Simple)	800.00
(Radical)	1,200.00
Lumpectomy	400.00

CERVIX:

D&C	200.00
Colposcopy	200.00
Abdominal and Vaginal Hysterectomy/uterus only	800.00
Uterus, tubes, & ovaries	1,200.00

CHEST:

Thoracentesis	100.00
Bronchoscopy	300.00
Mediastinoscopy	300.00
Thoracostomy	800.00
Pleurodesis	100.00
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
Amputation of Digit	300.00
Amputation of Hand	500.00
Amputation of Foot	500.00
Amputation of Leg	
Below or Above Knee	600.00
At Hip Joint	1,000.00
Amputation of Arm	
Below or Above Elbow	600.00
At Shoulder Joint	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
Radial Prostatectomy	1,400.00

SALIVARY GLANDS:

Biopsy	400.00
Partidectomy	800.00
Radial Neck Dissection	1,600.00

SKIN:

Excision of lesion of skin	150.00
With flap or graft	400.00

SPINE:

Laminectomy	1,000.00
Cordotomy	600.00

STOMACH:

Gastroscopy	300.00
Partial Gastrectomy	1,000.00
Gastrectomy	1,400.00
Gastrojejunostomy	1,000.00

TESTES:

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)	600.00
(Radical)	1,200.00

LIMITATIONS AND EXCLUSIONS

A. 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.

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

1. Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the plan;
2. Hearing aids and examinations for the prescription or fitting of hearing aids;
3. Cosmetic surgery or treatment, specifically but not limited to, coverage for reconstruction surgery. However, there are limited benefits available for a surgically implanted prosthetic device which is prescribed as a direct result of cancer surgery. Please see Provision I under Coverage;
4. Benefits are not paid 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;
5. 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;
6. 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;
7. 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;
8. Such other expenses as may be excluded by regulations of the Board;
9. Expenses due to Convalescent Long-Term Care, Nursing

Home confinement or rehabilitation (the recovery of health and strength after disease, sickness or injury);

10. All claims must be submitted in writing, completed, with the requisite certification of the health care provider, and received by the Plan Administrator no later than 365 days following the claim incurrence;
11. Expenses for blood or plasma for leukemia greater than $5,000 per year.

DEFINITIONS

A. **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.

B. **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 premise 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 patient's written history and medical records must

be kept on the premises. The hospital must have surgical facilities on premises where major surgery is performed on a regular routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, 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/Family)
*In-hospital benefit (per day)[1]	150.00	75.00
*Maternity (per day)	150.00	75.00
*Intensive care Benefit (per day)	300.00	150.00
*Convalescent or Long-Term care/Rehabilitation (per day)[2]	150.00	75.00
Supplemental accident[3]	1,000.00	1,000.00
Ambulance Benefit[4]	100.00	100.00

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

1. In-hospital 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 per plan participant and/or dependent, per plan year
4. Ambulance benefits: limited to the amount of actual charges to a maximum of $100 per trip to or from a hospital where the insured is confined as an in-patient. No lifetime maximum.

DEFINITIONS

Convalescent or Long-Term Care Facility: An institution which 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 which 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: Provided for a lifetime maximum of ninety (90) days in the aggregate for payment of nursing care services. These benefits are payable only if all the following criteria are met:

A. The attending physician certifies that 24-hour nursing care by a Registered Graduate Nurse or Licensed Practical Nurse is medically necessary for recuperation.
B. The convalescent or long-term care facility confinement is preceded by at least three consecutive days of hospital confinement for which benefits were payable.
C. 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.
D. The condition of the Plan Participant or dependent requires 24-hour a day nursing services by Registered Graduate 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: 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 patient's written history and medical records must be kept on the premises. The hospital must have surgical facilities on premises where major surgery is performed on a regular routine basis. The hospital must be approved by the Joint Commission on the Accreditation of Hospitals, 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.

In-Hospital Benefit: In-hospital benefits (per day) under this plan do not cover charges for out-patient or same day surgery UNLESS you are admitted on an in-patient basis where you are charged for a private or semi-private room, or for an observation room for a period of more than 24 continuous hours. Emergency room, out-patient room, 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: 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 in-patient per plan year. This benefit is further limited to a lifetime maximum of two (2) admissions of not more than 14 days per admission for the treatment of substance abuse.**

Supplemental Accident Benefit: This benefit will pay incurred expenses up to the benefit amount shown, when an insured sustains 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 per plan participant and/or dependent, per plan year.

Inclusive in the $1,000 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, include only those made by or on behalf of qualified practitioners and are limited to a maximum of:

1. $25 per visit;
2. Two visits in any seven consecutive days (all accidental injuries and qualified practitioners combined);
3. 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.

Qualified Practitioners: Any duly licensed physicians operating within the scope of their license, including podiatrist, and doctors of chiropractic.

EXCLUSIONS

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

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan;
2. Hearing aids and examinations for the prescription or fitting thereof;
3. 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;

4. Benefits are not paid for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay suchcharge;
5. Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of warshall have occurred after the effective date of this plan;
6. 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;
7. Expenses to the extent of benefits provided under any employer group plan other than this plan in which the stateparticipates in the cost thereof;
8. Such other expenses as may be excluded by regulations of the Board;
9. Outpatient or same-day surgery for illness is not a covered charge;
10. Expenses or charges for emergency rooms, outpatient rooms, same-day surgery rooms, or similar type rooms;
11. Dental treatment as a result of any cause, whether accidental or non-accidental.
12. All claims must be submitted in writing, completed, with the requisite certification of the health care provider, and received by the Plan Administrator no later than 365 days following the claim incurrence.

Vision Program
Coverage and maximum benefits

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

* 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 findings and recommendations
* prescribing corrective lenses, if needed

DEFINITIONS

Bifocal Lenses: Lenses containing 2 foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

Trifocal Lenses: Lenses containing 3 foci, usually arranged with the focus for distance above, for intermediate distance in the middle,and for near vision below.

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

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

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

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.

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.

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.

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.

EXCLUSIONS

Vision Care Plan benefits will not be provided for certain charges, including but not limited to charges for:

1. Expenses incurred by or on account of an individual prior to such persons effective date of coverage under the plan;
2. Services or supplies for which coverage is provided or available under any other medical benefit program maintained by the Public Education Employees' Health Insurance Board, or by Workers' Compensation Laws, or by any Safety Lens program;
3. Drugs or any other medication;
4. Any medical or surgical treatments;
5. Special or unusual treatment such as orthoptics, vision training, sub-normal vision aids, aniseikonia lenses or tonography;
6. Services or supplies not prescribed by a licensed physician, optometrist, or ophthalmologist, and lenses which do not require a prescription;
7. Service or supplies which are experimental in nature or are not approved by the American Ophthalmology Association;
8. The extra charge for oversized, photo sensitive, or anti-reflective lenses, whether or not medically necessary;
9. Sunglasses, including lenses and frames;
10. Follow-up visits, fitting fees, dispensing fees, coating or care kits;
11. 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;
12. All claims must be submitted in writing, completed, with the requisite certification of the health care provider, and received by the Plan Administrator no later than 365 days following the claim occurrence.

COORDINATION OF VISION 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. PEEHIP benefits will be secondary to all other coverages available to a claimant.

CONTINUATION COVERAGE FOR ALL PLANS

--- VERY IMPORTANT NOTICE ---

Federal Law requires that most employers sponsoring group health plans offer 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. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. (Both you and your spouse should take time to read this notice carefully).

If you are an employee of Public Education in Alabama (the "Employer") covered by the Public Education Employees' Health Insurance Plan (the "Plan"), you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;

3. Divorce or legal separation from your spouse; or
4. Your spouse becomes eligible for Medicare.

In the case of a dependent child or an employee covered by the Plan, he or she has the right to continuation coverage if group health coverage under the plan is lost for any of the following five reasons:

1. The death of a parent;
2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Employer;
3. Parents' divorce or legal separation;
4. A parent becomes eligible for Medicare; or
5. The dependent ceases to be a "dependent child" under the Plan.

Under COBRA, the employee, ex-spouse or dependent family member has the responsibility to inform PEEHIP within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan and must obtain a *Continuation of Coverage Application* Form. PEEHIP may be notified by phone or in writing. It is the employer's responsibility to notify PEEHIP within a maximum of 30 days of an employee's termination, death or reduction in hours.

When PEEHIP is notified that one of these events has happened and that the employee or dependent desires continuation of coverage, PEEHIP will in turn notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you would lose coverage because of one of the events described above to inform PEEHIP that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance coverage will end on the last day of the month in which you become ineligible.

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

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

However, the law also provides that your continuation coverage may be cut short for any of the following five reasons:

1. PEEHIP no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid by the member when payment is due, or the premium payment is insufficient;
3. The member becomes covered under another group health plan, which does not contain any exclusions or limitations with respect to any preexisting condition;
4. The member or dependent becomes entitled to Medicare after COBRA benefits begin; or
5. The member becomes divorced from a covered employee and subsequently remarries and is covered under the new spouse's group health plan, which does not contain any exclusions or limitations with respect to preexisting conditions.

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

Public Education Employees' Health Insurance Plan
201 South Union Street
Montgomery, AL 36104

PEEHIP
Southland Benefit Solutions, LLC
PO Box 1250
Tuscaloosa, Alabama 35403-1250