City of Mobile –

Employee Health Plan

Retiree-Only Health Plan –

Medicare Advantage Plan

Dental Plan

Effective January 1, 2018

City of Mobile Employee Health Plan
City of Mobile Retiree-Only Health Plan
City of Mobile Dental Plan

These plans are commonly referred to as the City of Mobile Health & Dental Plan but remain separate and distinct employer sponsored plans.

CITY OF MOBILE EMPLOYEE HEALTH PLAN

CITY OF MOBILE RETIREE-ONLY HEALTH PLAN

CITY OF MOBILE DENTAL PLAN

FLEXIBLE SPENDING ACCOUNT – SECTION 125 PREMIUM CONVERSION PLAN – LIFE INSURANCE

BENEFITS BOOKLET

Please read this Benefits Booklet and share it with your family members covered by the City of Mobile Health & Dental Plan (the Plan), and retain for future reference. It is most important that you understand the benefits offered by the Plans so you will be able to obtain the maximum benefits available.

THE PLANS & THIS BOOKLET

This Benefits Booklet has been prepared in an easy-to-read format to assist you with understanding each Plan. This booklet supersedes all previously published material. Certain words and terms have specific meaning and are explained in the "Definitions" section or in the context of the booklet. This booklet describes the Health and Dental Plan eligibility rules, benefits, limitations, exclusions and provisions for covered employees and non-Medicare retirees and dependents. The Employee Health & Dental Plan is not a "Grandfathered Plan" under the Affordable Care Act and complies with all requirements of the Act. The Retiree-Only Health Plan is exempt from the Affordable Care Act and does not comply with all requirements of the Act. The Plans are not covered by the Employee Retirement Income Security Act of 1974 referred to as ERISA.

Medicare eligible retired members have coverage terminate at Medicare eligibility and may transfer to the City's Medicare Advantage Plan if qualified. The City's Medicare Advantage Plan is fully-insured and governed by the policy of insurance. A copy of the summary plan description for the Medicare Advantage Plan is available from the Human Resources Department.

This booklet also describes the Flexible Spending Account, Section 125 Premium Conversion Plan and the Group Term Life Insurance Plan. Additional information is available from the Human Resources Department.

SELF-FUNDING BENEFITS

The health and dental benefits provided by the Plans are self-funded. The City of Mobile and its eligible employees pay the cost of all benefits. This funding method is designed to reduce cost for you and for the City of Mobile.

The City of Mobile Human Resources Department manages eligibility and enrollment. The City contracts with Blue Cross Blue Shield of Alabama, the Claims Administrator, to process claims and pay benefits.

Self-funding places responsibility upon all of us to spend money for benefits with the same care we would use in spending our own money. There is a limit to the benefit dollars available. Prudent use of health care services will preserve those benefit dollars. We must be aware of the cost of health care and act as wise health care consumers when spending our money.

LIMITATION OF LIABILITY

The City of Mobile Health & Dental Plan benefits are paid as a general obligation of the City of Mobile. The Medicare Advantage Plan is an insured contract and the premium is paid by the City of Mobile. The life benefit is a group term life insurance contract and the premium is paid by the City of Mobile. The City of Mobile establishes the plan of benefits and eligibility and has the authority to make additional rules and regulations concerning eligibility and benefits and reserves the right to interpret the Plans and make final determinations with regard to all matters. The City of Mobile reserves the right to change, modify, reduce and terminate any and all benefits, self-funded or insured for any class of employees, dependents, or retired employees at its sole discretion. Eligibility and benefits are not guaranteed and continue on a month to month basis.

ADDITIONAL INFORMATION & ASSISTANCE

Questions concerning eligibility and enrollment should be directed to:

CITY OF MOBILE
HUMAN RESOURCES DEPARTMENT

205 Government Street
4th Floor, South Tower
Mobile, AL 36602

(251) 208-7059

www.cityofmobile.org

Questions concerning claims payment, benefits, or to determine if a medical provider is a Network Provider should be directed to:

BlueCross BlueShield of Alabama
We cover what matters.

BLUE CROSS BLUE SHIELD OF ALABAMA

450 Riverchase Parkway East
Birmingham, AL 35244-2858

Customer Service	1-800-253-9305
Preadmission Certification	1-800-248-2342
BlueCard PPO	1-800-810-2583
Tobacco Cessation (Quit for Life®)	1-888-768-7848
Baby Yourself	1-800-222-4379
Disease Management	1-888-841-5741
Individual Case Management	1-800-821-7231
Blue Cross Blue Shield Website	www.AlabamaBlue.com
BlueCard PPO Website	www.provider.bcbs.com

myBlueCross

You have 24-hour access to personalized healthcare information and many valuable services with an easy-to-use online tool called **myBlueCross** and you may register at **www.AlabamaBlue.com/register**.

Use it to easily manage your healthcare coverage. Use **myBlueCross** to –

- Download and print your benefit booklet;
- Request replacement or additional identification cards;
- View all your claim reports in one convenient place;
- Find a doctor;
- Track your health progress;
- Take a health assessment quiz;
- Get fitness, nutrition, and wellness tips;
- Get prescription drug information.

BlueCare Health Advocate

All members have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your Health Advisor can explain benefits and help you locate a doctor, specialist or pharmacy. The Advocate can also assist with making a doctor appointment, find a support group and community services available to assist with your health concerns. Contact your Advisor at the number on the back of your ID card or 1-800-253-9305.

Group 71447 Employee
Group 71448 Retiree Non-Medicare
Group 71449 Retiree Split-Contracts

SUMMARY OF BENEFITS

The City of Mobile sponsored Plans include several different programs designed for the health and welfare of City of Mobile Employees, Retirees, and their Eligible Dependents. The following pages provide a description of these programs. Additional information may be found in the appropriate sections of this benefits booklet.

DESCRIPTION OF PLANS OFFERED	
EMPLOYEE HEALTH PLAN	The Employee Health Plan, administered by Blue Cross Blue Shield, offers comprehensive medical benefits when you receive care from a Blue Cross Blue Shield Network Provider. Services received Out-of-Network are subject to reduced benefits and some services will not be covered. Coverage as an employee terminates at retirement, but Retirees may qualify for coverage under the Retiree-Only Health Plan.
DENTAL PLAN	The Dental Plan is administered by Blue Cross Blue Shield. You must receive dental care from a Blue Cross Blue Shield Network Provider to receive the maximum benefit. Services received Out-of-Network are subject to reduced benefits and the Member is responsible for filing a claim for reimbursement. Coverage for an employee terminates at retirement, but Retirees may qualify for coverage under the Retiree-Only Health Plan. The Dental Plan is **not** available for retirees and dependents of retirees who are Medicare eligible and covered under the Medicare Advantage Plan.
RETIREE-ONLY HEALTH PLAN	The Retiree-Only Health Plan is administered by Blue Cross Blue Shield for retirees and eligible dependents who are **not** Medicare eligible. Coverage includes medical and dental benefits. Medicare eligible retirees, based on age or disability, and dependents must transfer to the Medicare Advantage Plan or have coverage terminate. The Medicare Advantage Plan is not described in this booklet and the coverage does not include the dental benefit. Contact the Human Resources Department for additional information.
FLEXIBLE SPENDING ACCOUNT	Employees may enroll in the Health Flexible Spending Account which allows you to pay for eligible non-covered health care expenses with pre-tax dollars.
SECTION 125 PREMIUM CONVERSION PLAN	Eligible employees are automatically enrolled in the Section 125 Plan when they elect to participate in the Health & Dental Plan. This Plan allows employees to pay the Contribution with pre-tax dollars. Employees are allowed to elect not to participate in this plan during open enrollment or for a change-in-status event.
LIFE INSURANCE	The City of Mobile provides a Group Term Life Insurance Plan for Eligible Employees and their Eligible Dependents through a policy of insurance.

Coverage & Limitations

The Health Plan provides benefits for non-work-related Illness or Injury only, and only when the Illness or Injury occurs at the time the Member is covered under the Plan. In addition to physical Illness, benefits are provided for Mental Health and Substance Abuse Treatment and for Pregnancy and childbirth. The Plan also provides certain preventive health services at no cost to the Member. Benefits are provided only for Covered Services determined by Blue Cross Blue Shield, the Claims Administrator, to be Medically Necessary, subject to all Plan provisions, limitations, and exclusions. Payment of benefits is subject to any benefit limitation and the Allowed Amount. Some situations, conditions, services and expenses are not covered under any part of the Plan. Any expense not specifically included as a Covered Service is not covered under the Plan. The Health Plan is designed to protect you from a significant financial loss due to illness or injury. It is not designed to cover all expenses. The Member and physician have the final determination of what medical treatment is best regardless of the Plan's coverage.

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MEMBER RESPONSIBILITIES

Employees, Retirees, and their Eligible Dependents have obligations to the Plan. These responsibilities are designed to ensure benefits and eligibility rules are applied equally and fairly to all Members. It is important that you fulfill your responsibility by reading this Benefits Booklet which explains eligibility, benefits, limitations and your rights and obligations to the Plan.

EMPLOYEE & RETIREE RESPONSIBILITIES

1. Submit the Application for coverage provided by the Human Resources Department. An Application also must be submitted to add or remove a dependent. **Addition or removal of dependents is not automatic** and requires completion of the Application and approval by the Human Resources Department.
2. File the Application with the Human Resources Department within 60 days of your date of employment or within 60 days of a Change-In-Status Event. An Employee who fails to make timely Application for coverage may request Late Enrollment, in which case, coverage will start on the first of the month following 60 days from the date the Application is approved by the Human Resources Department.
3. Notify the Human Resources Department within 60 days of a Change-In-Status Event. **Failure to report an event causing a dependent to cease as an Eligible Dependent will result in the Employee being liable for benefits paid by the Plan on behalf of that individual.** Example, coverage under the Plan for a divorced spouse is terminated the last day of the month in which the divorce is finalized. An Employee who fails to notify the Human Resources Department of a divorce will be responsible to reimburse the City of Mobile for benefits paid for charges the divorced spouse incurred after the date of divorce and termination of coverage.
4. Provide information within 30 days upon written request by the Human Resources Department. Requested information will be deemed to be filed on the date actually received by the Human Resources Department. Failure to provide information may result in a termination of eligibility or denial of a claim.
5. Notify the Human Resources Department when the Employee or Dependent becomes eligible for Medicare.
6. Provide to the City of Mobile Human Resources Department and the Claims Administrator the information necessary for administering the Plan. Payment of benefits is conditioned upon the Plan promptly receiving the information necessary to provide benefits.

MEMBER RESPONSIBILITIES

1. Carefully read this Benefits Booklet to ensure an understanding of the eligibility rules, benefits, provisions and limitations.
2. Notify the Human Resources Department within 60 days when a Member ceases to be an Eligible Dependent.
3. Check with the medical provider prior to receiving services to verify that the provider is a Network Provider.
4. Obtain or verify that Precertification has been provided when required.
5. File a claim, when required, within 12 months of the date of service.
6. Assist the Claims Administrator when information is requested. Payment of benefits is conditioned on the Plan promptly receiving the complete information necessary to provide benefits.
7. Follow the requirements for claim review when a claim has been denied.
8. Notify the Human Resources Department when the member becomes eligible for Medicare.

Failure to fulfill your obligations to the Plan may result in the denial of benefits in whole or in part or your financial liability to reimburse the Plan for any benefits paid due to your failure to provide required information to the Plan in a timely manner.

HUMAN RESOURCES DEPARTMENT: (251) 208-7059 www.cityofmobile.org

ELIGIBILITY & ENROLLMENT

FOR

EMPLOYEES & DEPENDENTS

CITY OF MOBILE EMPLOYEE HEALTH & DENTAL PLAN

THE ELIGIBIITY RULES DESCRIBED IN THIS SECTION DO NOT INCLUDE THE ELIGIBILTY RULES FOR THE RETIREE-ONLY HEALTH PLAN WHICH ARE EXPLAINED IN THE NEXT SECTION

ELIGIBILITY & ENROLLMENT FOR EMPLOYEES

PARTICIPATION

You may participate in the City of Mobile Health & Dental Plan, Section 125 Premium Conversion Plan, Health Flexible Spending Account and Life Insurance if you are a benefits eligible Employee of the City of Mobile.

The City of Mobile also allows the Mobile Public Library, Emergency Management Agency and Mobile Museum Board to participate in the City of Mobile Health & Dental Plan for eligible employees.

EMPLOYEE ELIGIBILITY

Employees who are in a benefits eligible position based on the City of Mobile Eligibility Policy are offered this coverage and may elect to cover Eligible Dependents. The employee must elect single or family coverage authorizing payment of the required monthly cost sharing amount.

The City of Mobile Health & Dental Plan is intended to comply with the Affordable Care Act which requires an offer of coverage to all full-time employees.

Full-time employees and their eligible dependents as defined below are eligible to enroll in the Plan.

Hour of Service: An hour of service means each hour for which an employee is paid, or entitled to payment, for the performance of duties, and each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or approved leave of absence.

Full-Time Status: The City of Mobile utilizes the following classifications to determine eligibility for the Plan:

Full-Time Employee: An employee who is expected to be or is credited with at least 30 hours of service per week or 130 hours of service per month on average.

Part-Time Employee: An employee who at the time of hire is not expected to be credited with at least 30 hours of service per week or 130 hours of service per month on average, such as:

Seasonal Employee: An employee in a position for which the customary annual employment is six months or less.

Variable Hour Employee: An employee in a position that does not require or does not indicate the employee is reasonably expected to work on average at least 30 hours per week.

The City of Mobile uses the look back measurement method to determine the full-time status of employees. Most employees will be known to be Full-Time upon employment with the City. The City will utilize the look back measurement method in cases where the City is unable to determine whether an employee will be Full-Time based on the facts and circumstances at the employee's start date.

New Employees: The initial measurement period for a newly employed variable hour employee is 12 months in length and begins the first of the month following the employee's start date. If during the initial measurement period the employee is determined to be a Full-Time Employee, then coverage under the Plan is offered during the corresponding 12 month stability period. Coverage must start no later than the last day of the month following the initial measurement period (not to exceed 13 months), so long as the employee has submitted the required application and authorization for the employee contribution toward the cost of coverage and any required documentation of dependent eligibility. Coverage will continue for the 12 month stability period regardless of the number of hours worked or until the employee fails to pay the employee contribution or terminates employment.

Ongoing Employees: An ongoing employee is one who has been employed by the City of Mobile for 12 consecutive months. An ongoing employee will have Full-Time status determined during the standard measurement period, each October 1st through September 30th. If during the standard measurement period the employee is determined to be a Full-Time Employee, coverage under the Plan is offered during the corresponding 12 month stability period. Coverage will continue for the 12 month stability period regardless of the number of hours worked or until the employee fails to pay the employee contribution or terminates employment.

Application Required: An Employee becomes an Eligible Employee by making timely Application to the Human Resources Department. Application includes the required authorization for payroll deduction of the Employee Contribution. Coverage is contingent upon approval by the Human Resources Department and is evidenced by issuance of an identification card or some other written notification of coverage. You must complete an Application and file it with the Human Resources Department within 60 days of your first day of employment. You may elect to cover your Eligible Dependents at this time. Eligible Dependents include only those persons listed on the Application and approved by the Human Resources Department.

Upon enrollment in the Plan, you authorize the Payroll Department to deduct the Employee Contribution from your pay check. Participation in the Section 125 Premium Conversion Plan is automatic for active Employees, unless you elect not to participate.

DEPENDENT ELIGIBILITY

A dependent becomes an Eligible Dependent when the Employee has made timely Application to the Human Resources Department and authorized payroll deduction of the required Contribution for Dependent Coverage.

Eligible Dependents include:

1. Your legal spouse.
2. Your child under the age of 26 (married or unmarried).
3. Your Disabled child of any age, provided the Disability commenced prior to age 19, the child was enrolled under the Plan prior to age 19, and has maintained continuous coverage under the Plan. Coverage under the Plan continues without interruption for the duration of the Disability so long as the Employee maintains Dependent Coverage. Coverage for a Disabled child who has reached age 26 will not continue beyond the Employee's date of retirement (Retiree dependent coverage terminates at age 19).

Child may include the following when Required Documentation is filed with the Human Resources Department:

4. Your natural-born or legally adopted child under age 26, including a legally adopted child living with you as the adopting parent during a period of probation (under age 19 for the Retiree-Only Health Plan).
5. Your stepchild under age 26.
6. A child under age 26 who permanently resides in your home over whom you have permanent legal custody by court appointment (physical custody alone is not sufficient).
7. A child under age 26 who permanently resides in your home and over whom you have legal guardian status by court appointment.
8. A child under age 26 for whom you are legally required to provide health insurance coverage during the period specified in a Qualified Medical Child Support Order (QMCSO).
9. A grandchild may only be covered if legally adopted and living in the employee's home and coverage terminates at age 26 or 19 for the dependent of a Retiree.

IMPORTANT: The extension of dependent child coverage to age 26 does NOT apply to the Retiree-Only Health Plan and dependent child coverage terminates at age 19 years.

REQUIRED DOCUMENTATION

Evidence of dependent eligibility must be submitted within 60 days of enrollment and when requested by the Human Resources Department. The Plan may conduct an audit of dependent eligibility, and the Human Resources Department may request Required Documentation to verify dependent status eligibility. Failure to provide the Required Documentation within 30 days from the request will be deemed fraud or intentional misrepresentation of a material fact and may result in retroactive termination of coverage and liability for benefits paid by the Plan. See the table of Required Documentation for acceptable evidence of dependent eligibility.

LISTING OF REQUIRED DOCUMENTATION FOR ELIGIBLE DEPENDENTS

Evidence of dependent eligibility must be submitted with your Application for coverage and when requested by the Human Resources Department. The Plan may conduct an audit to verify dependent eligibility. Failure to timely provide Required Documentation will prevent the start of coverage or result in a retroactive termination of coverage in which case the Member will be held liable for benefits paid by the Plan.

Legal spouse: Marriage Certificate AND one of the following to show current marriage:

- Most recent federal income tax return as filed with the IRS listing the spouse.
- Current mortgage statement, loan or lease agreement listing both member and spouse.
- Current property tax documents listing both member and spouse.
- Vehicle registration currently in effect listing both member and spouse.
- Current credit card or bank account statement listing both member and spouse.
- Current utility bill listing member and spouse.

Common law spouse status prior to 1/1/2017; on and after 1/1/2017 the City does <u>not</u> provide eligibility for a common law spouse: <u>Each</u> of the following:

- Questionnaire and affidavits provided by Human Resources Department.
- Most recent federal income tax return as filed with the IRS listing the spouse.
- One of the documents listed in the spouse category above as proof of current marriage.

Maximum Dependent Child Age: **Employee Plan – Age <u>26</u> years**
Retiree-Only Plan – Age <u>19</u> years

Employee dependent child coverage terminates on the last day of the month of the child's 26th birthday.
Retiree-Only dependent child coverage terminates on the last day of the month of the child's 19th birthday.

Biological child: Birth certificate issued by a state, county or vital records office or QMCSO.

Stepchild: <u>Each</u> of the following:

- Legal spouse documentation.
- Birth certificate of stepchild issued by state, county or vital records office showing spouse as parent.

Adopted child: <u>One</u> of the following documents:

- Certificate of adoption or Court Order granting legal custody during a probationary period prior to adoption.
- International adoption papers from country of adoption.
- Birth certificate issued by state, county or vital records office naming the adoptive parents.

Child over whom you have legal guardian or legal custody status: <u>One</u> of the following documents:

- Final court order signed by a judge.
- Placement authorization signed by a judge.

Disabled child over age 26 who is not married and became disabled prior to age 19 while covered by the Plan (disability extension does not apply to Retiree-Only Plan)**:** <u>Each</u> of the following:

- Acceptable proof of dependent child status.
- Social Security Disability Entitlement Certificate.
- Proof of continuous coverage for disabled child as the dependent of member since the disability commenced.

Grandchild: A grandchild may only be covered if legally adopted and living in the employee's home.

Dependents must have a Social Security number to be eligible for coverage. **The Retiree-Only Plan limits dependent child coverage to age 19.** Assistance with documentation may be obtained from: <u>www.edc.gov/nchs/w2w.htm</u> (click on your state for details). Alabama birth and death certificate: contact the Health Department: (251) 690-8150.

OPEN ENROLLMENT PERIOD

There is an annual one-month Open Enrollment Period, usually the month of November, during which an Employee may add and/or remove Eligible Dependents on the City of Mobile Health & Dental Plan. During this period, you may file an Application with the Human Resources Department and, if approved, coverage will change on the first day of the following calendar year.

SPECIAL ENROLLMENT PERIOD DUE TO CHANGE-IN-STATUS EVENTS

You may also enroll in the Plan, enroll your Eligible Dependents or terminate coverage for yourself or a dependent when certain events cause a Change-In-Status. An enrollment change due to a Change-In-Status requires Application to the Human Resources Department within 60 days of the event. A Change-In-Status Event, which would allow you to make changes to your enrollment in the Plan within 60 days of the event, is deemed to have occurred upon:

1. A change in your marital status (marriage, divorce, or death of a spouse).
2. A change in the number of your dependents (birth or adoption, death of a child, or obtaining permanent legal custody or legal guardianship status by court order).
3. A change in you or your spouse's employment status (starting/ending employment, changing from part-time to full-time or vice versa, a strike or lock-out, or taking or returning from an unpaid leave of absence or leave under the FMLA or USERRA, during which you or your spouse's coverage terminated).
4. Exhaustion of your coverage period under a previous employer's COBRA continuation.
5. A significant change in the cost of or coverage provided by you or your spouse's employer health plan.
6. A change in the eligibility status of a dependent child, such as the child reaching age 26, the maximum age for coverage under the Plan.
7. An end to the Disability of a Disabled child enrolled as your dependent under the Plan.
8. A change in your residence or work site, or that of a spouse or dependent, which affects ability to access benefits under this or another employer health plan.
9. A required change pursuant to a court order.
10. You or your dependent becoming entitled to Medicare or Medicaid.
11. You or your dependent's loss of coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility. Enrollment request must be made within 60 days of the termination of coverage.
12. You or your dependent becomes eligible for the premium assistance under Medicaid or SCHIP. Enrollment request must be made within 60 days of becoming eligible for the premium assistance.

The change in coverage must be consistent with the Change-In-Status Event, and you must provide written documentation, upon request, to verify the Change-In-Status Event.

LATE ENROLLMENT

An Employee who fails to make timely Application for coverage upon initial enrollment or a Change-In-Status Event may request Late Enrollment. Late Enrollment requires that the Employee file an Application with the City's Human Resources Department. Coverage will start on the first of the month **following 60 days** from the date the Application is approved by the City's Human Resources Department. Eligibility and benefits are NOT retroactive.

DUPLICATE COVERAGE EXCLUDED

If both you and your spouse are eligible for the City of Mobile Health & Dental Plan as Employees:

1. Both Employees may elect single coverage, or
2. One Employee may elect Dependent Coverage and the spouse may be covered as an Eligible Dependent.

Under no circumstances may both Employees elect Dependent Coverage or an Employee be covered as both an Eligible Employee and as an Eligible Dependent.

WHEN COVERAGE BEGINS

Coverage will begin on the first day of the month following your first day of employment, in a benefits eligible position if qualified as eligible by the City's Human Resources Department, provided you have made Application to the Human Resources Department within 60 days of your date of employment if approved by the Human Resources Department. Eligible Dependents will be covered on the date you become covered, provided you have made Application for Dependent Coverage that has been approved by the Human Resources Department. If you fail to make Application to the Human Resources Department within 60 days of your date of employment, or the date you have a new dependent you may apply for coverage:

1. During the Open Enrollment Period for coverage to start the first day of the following Calendar Year.
2. Within 60 days of a Change-In-Status Event for coverage to start the first day of the month following approval by the Human Resources Department.
3. Anytime with a Late Enrollment and coverage starts the first day of the month following 60 days from approval by the Human Resources Department.

WHEN COVERAGE TERMINATES

Coverage under the Plan will end at 12:01 a.m.:

1. The first day of the month following the month in which you cease to be an Employee or your employment status changes so that you are no longer considered to be a full-time Employee (including retirement).
2. The first day of the month for which you fail to make payment of the required Contribution or the Member fails to pay the required COBRA premium within the grace period.
3. The day you enter full-time military service, except as provided by USERRA, as explained in this booklet.
4. Upon discovery of fraud or intentional misrepresentation of a material fact.
5. The day the Plan is terminated or coverage for a class of Members is terminated.

Dependent Coverage will end at 12:01 a.m.:

1. The date the Employee's coverage terminates.
2. The first day of the month following the date the individual no longer meets the definition of an Eligible Dependent, which includes the:
   a) Date of divorce (last day of the month in which the divorce is finalized);
   b) Date your child reaches age 26 (last day of the month of the child's 26th birthday);
   d) Date the Retirees' child reaches age 19 (last day of the month of the child's 19th birthday).
3. The first day of the month for which the Contribution is not paid within the 30-day grace period.
4. When you fail to provide information to verify dependent status; in such case, coverage terminates retroactive to the earliest date it is determined the individual ceased to be an Eligible Dependent.

IMPORTANT: The extension of dependent child coverage to age 26 does NOT apply to the Retiree-Only Health Plan and dependent child coverage terminates at age 19 years.

A dependent that loses coverage under the Plan is eligible for COBRA continuation of coverage only if the Human Resources Department is notified in writing within 60 days of the event that caused the individual to no longer meet the definition of an Eligible Dependent.

In the case of divorce, when an employee is required by the terms of the divorce to provide health insurance coverage for the divorced spouse, coverage may be provided under this Plan **only** under COBRA continuation of coverage. Coverage under the Plan for a divorced spouse is terminated on the last day of the month in which the divorce is finalized. **If notice to the Human Resources Department is not made within 60 days of the date of divorce, COBRA continuation of coverage will not be available to the divorced spouse. Failure to provide timely notice of a divorce may result in the Employee being financially liable for any benefits paid in behalf of the former spouse.**

CONTINUATION WHILE ON APPROVED LEAVE

An Eligible Employee who is no longer in "pay" status on payroll may qualify for a continuation of coverage while on Approved Leave. The Employee must make Application for the extension within 30 days of leaving pay status. The Eligible Employee will be required to pay the Contribution for the first 6 months of the Approved Leave; if the Approved Leave is extended beyond 6 months, the Eligible Employee is required to pay the COBRA rate to continue coverage with no subsidy from the City of Mobile.

Failure to pay the required Contribution in a timely manner will result in termination of coverage and coverage may be reinstated only when the Employee returns to pay status and pays all Contributions due.

If the Employee does not return to pay status, the continuation of coverage while on Approved Leave will run concurrent with COBRA. The Employee may be eligible to elect COBRA continuation of coverage for any months remaining under COBRA.

SURVIVING DEPENDENT BENEFIT

The Eligible Dependents of an employee covered under the Plan at the time of the employee's death may continue coverage under the Plan. The Eligible Dependents must request COBRA continuation coverage within 60 days of the date of termination of coverage to be eligible for this Surviving Dependent Benefit. Application must be made to the Human Resources Department.

The Surviving Dependent Benefit provides an extension beyond the normal COBRA maximum continuation period and a subsidized premium.

The Surviving Dependent Benefit is available only if the Surviving Dependents are not eligible for enrollment in any other group health plan, including that provided by a Surviving Dependent's employer, or Medicare.

Coverage may be continued as follows:

1. If an Employee dies in the performance of his or her occupation, the Surviving Dependents may continue coverage under the Plan for a maximum of 5 years (60 months) following the date of the Employee's death. The Employee's death must be directly related to and a result of the performance of the Employee's occupation, excluding related disease as provided for by law. The Surviving Dependents may continue coverage by paying the applicable Contribution rate for the first 12 months and the applicable COBRA rate for the remaining 48 months.
2. If the Employee's death was not related to occupation, and the Employee had a minimum of 10 years of full-time service with an Employer, the Surviving Dependents may continue coverage under the Plan by paying the applicable Contribution rate for the first year (12 months) beginning the first of the month following the date of the Employee's death, and the applicable COBRA rate for the remaining COBRA continuation period.

The COBRA continuation period is governed by the COBRA rules. The Surviving Dependent Benefit extension is subject to the following termination provisions.

1. The maximum Surviving Dependent Benefit extended period.
2. The first day of the month for which the Contribution is not paid within the 30-day grace period.

3. The first day of the month following the date on which the Surviving Dependent no longer meets the definition of an Eligible Dependent.
4. For all dependents, the first day of the month following the date the surviving spouse remarries.
5. For all dependents, the first day of the month following the date the surviving spouse becomes eligible for other group health coverage.
6. For all dependents, the first day of the month following the date the surviving spouse becomes eligible for Medicare.
7. The date the Plan is amended to terminate the Surviving Dependent Benefit, or the date the Plan is terminated.

If the Eligible Dependents of a deceased Employee are not eligible for the Surviving Dependent Benefit it will not affect COBRA rights for continuation of coverage.

LEGAL PROTECTION FOR CONTINUATION OF COVERAGE

There are conditions under which a Member's health and dental benefits may be continued beyond the date coverage would otherwise terminate. Refer to the sections in this booklet concerning COBRA Continuation Coverage, Family and Medical Leave (FMLA) and Uniformed Services Leave (USERRA) for circumstances that allow for a limited continuation of a Member's coverage.

RESCISSION OF COVERAGE

As permitted by the Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact. A cancellation – discontinuance of coverage is not a rescission if: it has only a prospective effect or it is attributable to non-payment of premiums or contributions.

ACTIVE EMPLOYEES ELIGIBLE FOR MEDICARE

If you continue to be an Employee of the Employer when you are age 65 or older, or otherwise eligible for Medicare, you and your Eligible Dependent(s) will continue to be covered under the same benefits available to Employees under age 65. This Plan will be primary over Medicare and will provide benefits first. Medicare will then pay for Medicare eligible expenses, if any, not paid by this Plan. This rule applies to active Employees eligible for Medicare and Eligible Dependents of an active Employee who are eligible for Medicare.

There is one exception to this policy: If an Eligible Employee or Eligible Dependent becomes eligible for Medicare benefits based solely on End Stage Renal Disease (ESRD), this Plan will be primary for the first 30 months of eligibility for Medicare. After the first 30 months of eligibility for Medicare, if the Employee or Dependent is still eligible for Medicare due to ESRD or for any other reason, Medicare will be primary.

Employees and/or their Eligible Dependents may enroll in Medicare Parts A (hospitalization) and B (physician services) at the time they become eligible for Medicare. If you are eligible, you should enroll in Medicare Part A, which is premium-free.

The Plan's prescription drug coverage has been determined to be at least equal to standard Medicare prescription drug coverage. This means that you can enroll in Medicare Part D within 60 days of ceasing to be an active Employee and you will not pay a penalty for late enrollment.

If you do not enroll in Medicare Part B or Medicare Part D when you are initially eligible, you can enroll in Parts B or D during Medicare's Special Enrollment Period, which begins the month after employment ends or the group health plan insurance based on current employment ends, whichever happens first. You should contact Medicare upon termination of employment for enrollment in order to avoid any late enrollment penalties.

Under the City's Plan, you may elect to enroll in Medicare Parts A, B and D and terminate coverage from the Plan. If you do so, you will not be required to pay the Contribution for coverage and you will have no health or dental benefits under the City of Mobile Health & Dental Plan.

ELIGIBILITY & ENROLLMENT

FOR

RETIREES & DEPENDENTS

CITY OF MOBILE RETIREE-ONLY HEALTH PLAN

EMPLOYEES HIRED ON AND AFTER JANUARY 1, 2015 DO NOT QUALIFY FOR THE RETIREE-ONLY HEALTH PLAN

RETIREE ELIGIBILITY

Employees covered by the Plan at retirement may be eligible to continue coverage under the Retiree-Only Health Plan (including dependent coverage). **No active Employee may participate in the Retiree-Only Health Plan.** A retiring Employee must sign an Application for coverage and file it with the Human Resources Department at the time of retirement. **Employees hired on and after January 1, 2015 are not eligible for the Retiree-Only Health Plan. Museum of Mobile employees are not eligible for the Retiree-Only Health Plan.**

Eligibility: Employees who have some vesting service earned prior to January 1, 2013 (RSA Tier 1):

1. Have reached age 60 with at least 10 years of service of the last 12 year period preceding retirement in active full-time service with a Participating Employer;
2. Have reached age 50 with at least 25 years of creditable service with the Retirement Systems of Alabama of which 20 years of creditable service must have been full-time service within the Mobile County Merit System and the last 10 years of service with a Participating Employer;
3. Any age with at least 25 years of creditable service within the Mobile County Merit System, with the last 15 years of service with a Participating Employer;
4. Have at least 10 years of the last 12-year period in active full-time service with a Participating Employer and be approved for a Disability retirement with the Retirement Systems of Alabama;
5. Elected officials must meet the number of years of service required for eligibility under a statute that provides retirement benefits to municipal elected officials;
6. In all cases the retiree must be receiving a pension benefit (other than Social Security) which results from contributions made by the Employer except employees who elected not to participate in the City's plan.

Eligibility: Employees who start to earn vesting service on and after January 1, 2013 (RSA Tier 2):

Have reached age 62 with at least 10 years of service of the last 12 year period preceding retirement in full-time service with a Participating Employer.

Years of service within the Mobile County Merit System do not include purchased military time, purchased CETA time, employment with the Mobile County School System, State employment, or any other service that is not permanent, active full-time years of service within the Mobile County Merit System.

POLICE & FIRE RETIREES

Employees of the City of Mobile Police or Fire-Rescue Departments who are covered under the Plan and retiring under the Police and Fire Pension Plan may continue coverage for themselves and Eligible Dependents based on the eligibility requirements:

1. Have reached age 55 or older with at least 20 years of active full-time service with the City of Mobile Police or Fire-Rescue Department;
2. Have reached age 50 with at least 20 years of active full-time service with the City of Mobile Police or Fire-Rescue Department and have an employment date prior to March 28, 1990;
3. Have been awarded a service-connected disability retirement by the City of Mobile;
4. Receiving a pension benefit which results from contributions made by the City of Mobile.

The employee must make an application to the Human Resources Department prior to the date of retirement for participation in the Retiree-Only Health Plan and authorize a deduction for the monthly premium from the retirement benefit. No other method of payment is allowed.

DEFERRED RETIREMENT – POLICE & FIRE PENSION ONLY

Eligibility for Retiree continuation coverage does not apply to an Employee who elects a deferred retirement under the Police and Fire Pension Plan, except for an Employee of the City of Mobile Police or Fire-Rescue Departments with 20 years of service who applies for continued coverage within 60 days of the date employment terminates. Continuation of coverage is optional and the Employee (who is not Disabled) will be required to pay the COBRA rate for continuing health and dental coverage.

Coverage can be maintained until the Employee is eligible to receive a pension benefit from the City of Mobile, at which time the former Employee would be eligible for this Plan and eligible to pay the same Contribution as other Retirees for health and dental coverage.

In cases of Disability, the COBRA rate will be waived and the Employee will be required to pay only the monthly Contribution, provided the federal Social Security Disability award letter is submitted to the Human Resources Department. Employment after that date will void the waiver and the full COBRA rate will be required during the deferred retirement period.

If the individual on deferred retirement discontinues coverage or fails to pay the required COBRA rate or other required Contribution for continuing coverage prior to becoming eligible for benefits through the City of Mobile Retired Life, Health & Dental Plan; coverage will terminate and **cannot** be reinstated.

CONTINUATION OF COVERAGE FOR DEPENDENTS

The Retiree may continue coverage for Eligible Dependent(s) covered under the Plan at the time of retirement. **No new dependent may be added, including a spouse, except for a natural newborn child of the Retiree.**

Dependent Coverage terminates when the dependent ceases to meet the eligibility rules for coverage except that dependent child coverage terminates at age **19** and does **not** continue to age 26. Also, the extension of the dependent maximum age for Disability will not apply. Coverage for an Eligible Dependent child may not extend beyond age **19** under any circumstance.

Retirees who do not meet these eligibility rules may qualify for continuation of coverage under COBRA.

MAPD COVERAGE AT AGE 65 OR MEDICARE ELIGIBILITY

Members maintaining coverage under the Retiree-Only Health Plan must transfer to the Medicare Advantage Plan with drug coverage (MAPD) upon reaching age 65 or becoming entitled to Medicare due to total disability or have coverage terminate.

Medicare eligible members may qualify to participate in the City's Medicare Advantage Plan if they are covered by both Medicare Part A (hospitalization) and Medicare Part B (physician services). To qualify for the Medicare Advantage Plan the member must notify the Human Resources Department prior to reaching age 65 or becoming eligible for Medicare due to disability and complete an Application for the Medicare Advantage Plan. The member must approve and authorize payment of the required Contribution to continue coverage.

The Medicare Advantage Plan is a fully-insured plan governed by the policy of insurance and does not provide the same benefits as the Non-Medicare plan and specifically does not provide dental benefits.

Medicare Advantage Plan: Contact the Human Resources Department for a benefits booklet explaining the Medicare Advantage Plan.

RETIREE CONTRIBUTION

Contribution payments for continuation of coverage under the Retiree-Only Health Plan are required to be paid on a monthly basis. The amount is established by the City of Mobile. Eligibility for all Members will terminate upon failure to make timely payment of the required Contribution for maintaining coverage (**within the 30-day grace period**). Coverage may not be reinstated after termination. It is the Retiree's responsibility to make sure that the monthly payment is being made in a timely manner.

EMPLOYEES HIRED AFTER JANUARY 1, 2015 DO NOT QUALIFY FOR THE RETIREE-ONLY HEALTH PLAN

RETIREE SURVIVING DEPENDENT BENEFIT

The Eligible Dependents of a Retiree covered under the Plan at the time of the Retiree's death may continue coverage through COBRA and this Surviving Dependent Benefit. The Eligible Dependents must request COBRA to be eligible for this Surviving Dependent Benefit within 60 days of the date of termination of coverage by making Application to the Human Resources Department.

In the event of the Retiree's death, the Surviving Dependents may continue coverage for a maximum of 5 years (60 months) beginning the first of the month following the date of the Retiree's death. Coverage may continue to the end of the COBRA period or Medicare eligibility, whichever comes first. The Surviving Dependents may continue coverage by paying the same Retiree Contribution, for the first year (12 months), as if the Retiree had lived. The COBRA rate for coverage will apply after the first 12 months for the remaining coverage period.

This benefit is available only if the Surviving Dependents are <u>not</u> eligible for enrollment in any other group health plan, including that provided by a Surviving Dependent's employer or Medicare.

Coverage may be continued until:

1. The later of the maximum COBRA continuation period or the Employer's extended period, if eligible.
2. The first day of the month for which the Contribution is not paid within the **30-day grace period**.
3. The first day of the month following the date on which the Surviving Dependent no longer meets the definition of an Eligible Dependent.
4. The first day of the month following the date the surviving spouse remarries; for all dependents.
5. The first day of the month following the date the surviving spouse becomes eligible for other group health coverage; for all dependents.
6. The first day of the month following the date the surviving spouse becomes eligible for Medicare; for all dependents.
7. The date the Plan is amended to terminate the Surviving Dependent health benefit, or the date the Plan is terminated.

Termination provisions are specific to the Surviving Dependent Benefit and do not affect COBRA rights for continuation of coverage. COBRA continuation of coverage applies first and then the Retiree Surviving Dependent Benefit will provide an extension as stated herein.

RETIREE BENEFITS ARE NOT GUARANTEED

The City of Mobile has the authority to make additional rules and regulations concerning eligibility and benefits and reserves the right to interpret the Plan and make final determinations with regard to all matters. The City of Mobile Management Committee reserves the right to change, modify, reduce and terminate any and all benefits, self-funded or insured, for any class of employees, dependents, or retired employees at its sole discretion. Eligibility and benefits are not guaranteed and continue on a month to month basis. Retirees and their Eligible Dependents have the same responsibilities to the Plan and to the Employer as active Employees.

HEALTH PLAN INFORMATION

FOR

EMPLOYEE HEALTH PLAN
RETIREE-ONLY HEALTH PLLAN
DENTAL PLAN

The City of Mobile Employee Health & Dental Plan and the City of Mobile Retiree-Only Health Plan are separate and distinct benefit plans.

The benefits offered by both plans are similar with only a few differences. To assist in understanding the benefits, this section includes benefits under both Plans with a special notation for any benefits or provisions which should vary between plans.

This Benefits Booklet does not describe benefits available through the Medicare Advantage Plan which is governed by a policy of insurance. Information concerning the Medicare Advantage Plan can be obtained from the City's Human Resources Department.

HEALTH PLAN INFORMATION

This benefits booklet combines information for the **Employee Health Plan**, the **Retiree-Only Health Plan** and the **Dental Plan**. This section describes the Health Benefits. The Plan's provisions concerning eligibility, benefits, limitations and exclusions are for the most part shared by both the Employee and Retiree-Only Plans but there are some differences.

EMPLOYEE HEALTH & DENTAL PLAN

This Plan complies with all provisions of the Affordable Care Act.

RETIREE-ONLY HEALTH PLAN

This plan is exempt from the Affordable Care Act and does not provide the following:

a) Dependent child coverage terminates at age 19 years and the extension of coverage to age 26 does not apply.
b) Deductibles and copay amounts do not accumulate towards the annual out-of-pocket maximum.
c) Third party independent review of appeals is not provided.

IMPORTANT: These and other benefit differences specific to the Retiree-Only Health Plan will be so noted as they appear in this Benefits Booklet.

MEDICARE ADVANTAGE PLAN

The Retiree-Only Health Plan offers coverage to Medicare eligible retirees and their Medicare eligible dependents under a fully insured Medicare Advantage Plan underwritten by the insurance company selected by the City of Mobile. The Medicare Advantage Plan is not described in this benefits booklet and the Member should contact the City of Mobile Human Resources Department for information and the benefits booklet specific to this plan.

NOTICE OF THE PLAN'S OPT-OUT OF SOME FEDERAL REGULATIONS

The City of Mobile Health & Dental Plan has elected to opt-out of certain federal regulations where permitted including: the Health Insurance Portability & Accountability Act of 1996 as amended by the Patient Protection and Affordable Care Act, the Newborns' and Mothers' Health Protection Act of 1996, the Mental Health Parity Act of 1996, the Mental Health Parity and Addition Equity Act of 2008, and Michelle's Law (2008). The Plan voluntarily complies with most of these regulations but not all provisions. Please read the Benefits Booklet carefully regarding limitations.

LIMITATION OF LIABILITY

The City of Mobile Health & Dental Plan benefits are paid as a general obligation of the City of Mobile. The City of Mobile Health & Dental Plan is governed by the Management Committee. The Management Committee is responsible for designing and managing the Plan. The Management Committee has the power and authority to make rules and regulations concerning eligibility, benefits and Plan provisions and reserves the right to interpret the Plan and make final determinations with regard to all matters. All questions, controversies, appeals or other matters concerning the Plan are under the authority of and will be decided by the Management Committee. Any decision by the Management Committee is final and binding. No action at law or in equity shall be brought after the expiration of **12** months from the date of a decision issued by the Claims Administrator or Management Committee. The City of Mobile reserves the right to change, modify, reduce and terminate any and all benefits, self-funded or insured for any class of employees, dependents, or retired employees at its sole discretion. Eligibility and benefits are not guaranteed and continue on a month to month basis subject to change.

The Health Plan is designed to protect you from a significant financial loss due to illness or injury. It is not designed to cover all expenses. The Member and physician have the final determination of what medical treatment is best regardless of the Plan's coverage.

The City of Mobile Health & Dental Plan is designed to allow the Plan to use its purchasing power to negotiate with health care providers. Negotiated savings are passed on to you through increased benefits when you use Network Providers. You must be familiar with the following terms and the benefits available:

FREEDOM OF CHOICE

You are not required to use an In-Network Provider. However, benefits are reduced or may not be available if you use an Out-of-Network Provider.

IN-NETWORK

Services received from a Blue Cross Blue Shield of Alabama Network (PPO) Provider, including but not limited to, Hospitals, Physicians, outpatient clinics, and pharmacies.

OUT-OF-NETWORK

Services **not** rendered by an In-Network Provider are paid under Out-of-Network benefits. Out-of-Network benefits are usually paid at a lower benefit level and some services may not be covered.

NETWORK PROVIDER DIRECTORY

A listing of the network of hospitals, physicians, pharmacies, outpatient clinics, and other providers participating in the Plan is available at **www.AlabamaBlue.com**.

From time to time providers are added and deleted from the network. It is your responsibility to check with your provider or Blue Cross Blue Shield of Alabama prior to treatment to verify if a provider is a Network Provider.

It is important to let your physician know that you desire to use an In-Network hospital if hospitalization is required. If your physician refers you to another health care provider, it is your responsibility to ensure that provider is an In-Network Provider.

BLUECARD PPO

The national network of providers contracted with the Blue Cross Blue Shield organization allows you to receive Network Provider benefits when you are outside Alabama. You should verify that a provider is a Network Provider using the PPO symbol (the outline of a suitcase) on your insurance ID card. You may also locate a Network Provider by calling the toll-free number on the back of your ID card (1-800-810-2583) or accessing the Blue Cross Blue Shield website: **www.bcbs.com/healthtravel/finder.html**.

The BlueCard PPO provider will verify your enrollment in the Plan and submit the claim to their local Blue Cross Blue Shield plan. The local plan will pay the provider directly and you will be responsible for the applicable Copay or Deductible and any balance above the Allowed Amount. You will receive an Explanation of Benefits.

COVERED SERVICES

The table that follows provides a schedule of benefits for some major health service categories. A more detailed list of services covered by the Plan is provided in the section titled "Health Plan Covered Services." Covered Services may have limitations and must be Medically Necessary. All Covered Services are subject to the Allowed Amount and benefit limitations. Some Covered Services received Out-of-Network are eligible for benefits only in the event of Injury or Medical Emergency.

COVERED SERVICES NOT PROVIDED BY IN-NETWORK PROVIDERS

The Plan has made provisions to provide benefits for some services that are not available from Network Providers, such as ambulance service and Mental Health and Substance Abuse Treatment. Coverage for these services is provided at the Allowed Amount.

COST SHARING

The cost of medical care is shared with the City of Mobile Health & Dental Plan paying most of the expense. The member is subject to payment requirements. Most requirements are stated in this benefit plan booklet. The following will help you understand some of the terms used.

Admission Deductible: Paid upon admission to a hospital. Only one deductible is required when two or more family members have hospital expenses resulting from injuries received in one accident.

Copay or copayment: A fixed dollar amount paid for specific services on receipt of care. The most common example is the office visit copay.

Coinsurance: The amount that you must pay as a percent of the allowed amount under the Major Medical Benefit which is limited by the annual out-of-pocket maximum.

Excess of Allowed Amount or Allowance: The Claims Administrator determines the value of services and expenses based on network provider contracts. The allowed amount may be significantly less than the actual charge. Network providers do not bill for any excess over the Allowed Amount. Out-of-Network providers may bill for the excess. The Member is responsible for the amount billed in excess of the Allowed Amount.

Out-of-Area Services: Typically, when accessing care outside the Blue Cross Blue Shield of Alabama service area, you will obtain care from healthcare providers that have a contractual agreement with Blue Cross Blue Shield in that geographic area. The BlueCard® Program will assist with obtaining services from a Blue Cross Blue Shield In-Network provider.

Out-of-Network: Some services are not covered when rendered by an Out-of-Network provider. Some services may only be covered in the case of emergency care or for accidental injury. Other services may require a higher copay or coinsurance amount for the Out-of-Network provider.

Calendar Year Deductible or Deductible: The amount each member must pay for some medical expenses before the Plan starts to pay the Major Medical percentage. Only one calendar year deductible is required when two or more family members have expenses resulting from injuries received in one accident. The deductible is applied to claims in the order in which claims are processed.

Calendar Year Out-of-Pocket Maximum: Cost sharing amounts (deductible, coinsurance and copays) for essential health services as defined by the Affordable Care Act (ACA) and received by a network provider are limited by the out-of-pocket maximum. There is an annual out-of-pocket maximum for individual and family coverage. The maximums are set by the ACA. Benefits for ACA essential health services provided in-network increase to 100% for the remainder of the calendar year after the out-of-pocket maximum as been reached. The family out-of-pocket maximum is an aggregate amount. This means that all amounts that count towards the individual calendar year maximum will count toward the family calendar year out-of-pocket maximum. Not all expenses apply to the out-of-pocket maximum including but not limited to: amounts paid for out-of-network services or supplies; non-covered services; amounts in excess of any plan limits; any penalty such as for failure to pre-certify a service and any excess over the Allowed Amount.

IMPORTANT: The Retiree-Only Health Plan does not accumulate deductibles and copay amounts towards the annual maximum as it is exempt from ACA requirements.

OUT–OF–COUNTRY COVERAGE

Covered medical treatment rendered outside of the United States when medically necessary will be covered by the Plan. Claims must be filed, in U.S. dollars, with the Claims Administrator. Only medical treatment for which the individual would be charged regardless of health insurance coverage will be considered a covered expense.

SUMMARY OF HEALTH BENEFITS

The summary that follows provides a schedule of benefits for major health services. A more detailed list of services covered by the Plan is provided in the section titled "Health Benefits – Covered Services." Benefits for Covered Services may have limitations and must be determined as Medically Necessary by the Claims Administrator. All Covered Services are subject to the Allowed Amount or Allowance as determined by the Claims Administrator and are subject to any benefit limitations. Some Covered Services received Out-of-Network are eligible for benefits only in the event of Accidental Injury or Medical Emergency.

This booklet describes the Health and Dental Plan eligibility rules, benefits and provisions for active employees and non-Medicare retirees. Medicare eligible members have coverage terminate at Medicare entitlement and may transfer to the City's Medicare Advantage Plan if qualified. The City's Medicare Advantage Plan is fully-insured and governed by the policy of insurance. A copy of the summary plan description for the Medicare Advantage Plan is available from the Human Resources Department.

INPATIENT HOSPITAL BENEFITS		
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Facility *365 days of care per confinement*	Covered at 100% of the allowed amount after a **$125** per admission deductible; no copay.	Covered at 100% of allowed amount after **$750** admission deductible and **$50** per day copay.
Gastric Bypass Surgery	Covered at 100% of the allowed amount after a **$125** per admission deductible; no copay. *Limit 1 per lifetime and must be performed by a Bariatric Network Provider in Alabama*	Not covered.
Excess Over First 365 Days of Care: 80% of the allowed amount after the calendar year deductible (70% Out-of-Network).		
Preadmission Certification is required for all hospital admissions, except maternity. Emergency admissions require certification within 48 hours of admission: call **1-800-248-2342** (toll-free). **If precertification is not obtained, no benefits are available.** **Out-of-Network** hospitals in Alabama are **not** covered unless the treatment is for accidental injury or medical emergency.		

OUTPATIENT HOSPITAL BENEFITS		
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Surgery *Including Ambulatory Surgical Centers*	Covered at 100% of the allowed amount after **$125** hospital copay.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Emergency Room – Medical Emergency & Accident	Covered at 100% of the allowed amount after **$125** hospital copay.	
Diagnostic: X-ray, Lab, and Pathology. IV Therapy, Chemotherapy, Radiation Therapy, Dialysis	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Precertification is required for some outpatient hospital benefits and physician-administered drugs as explained in this Benefits Booklet. **If precertification is not obtained, no benefits are available.**		

PHYSICIAN BENEFITS		
Primary Care Physicians include: General Practice, Family Practice, Internal Medicine, Pediatrics, Geriatrics, OB/GYN, Nurse Practitioner, Physician Assistant and Certified Nurse Midwife.		
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits – PRIMARY CARE	Covered at 100% of the allowed amount; after **$25** primary care physician copay.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Office Visits – SPECIALIST *Any physician or therapist not listed above - not primary care*	Covered at 100% of the allowed amount; after **$50** specialty physician copay.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Emergency Room Physician *(Medical Emergency)*	Covered at 100% of the allowed amount; after applicable physician copay: **$25** primary care or **$50** specialty physician.	Covered at 100% of the allowed amount; after applicable physician copay: $25 primary care or $50 specialty physician. **Retiree-Only Health Plan** pays 70% after the calendar year deductible.
Emergency Room Physician *(Non-Medical Emergency)*	Covered at 70% of the allowed amount subject to the calendar year deductible.	
Maternity Care	Covered at 100% of the allowed amount; no copay or deductible. Office visit copay applies to the initial visit to confirm pregnancy.	Covered at 70% of the allowed amount subject to the calendar year deductible.

PHYSICIAN BENEFITS - CONTINUED		
Surgery, Second Opinion, Anesthesia	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Inpatient Hospital Visits & Consultations	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Diagnostic: X-ray, Lab, and Pathology	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Special Diagnostic Procedures (see definition)	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Chemotherapy and Radiation Therapy	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Allergy testing & treatment	Covered at 100% of the allowed amount; after applicable physician copay: **$25** primary care or **$50** specialty physician.	Not covered.
Bariatric Surgery (surgery, assistant surgeon, anesthesia)	100% of the allowed amount, no deductible or copay. *Bariatric services must be performed by Bariatric Surgery Network providers.*	Not covered.
Certified Surgical Technician, Surgical Assistants, CRNA, Clinical Nurse Specialist, Certified Nurse Midwife, Licensed Clinical Social Worker, and Licensed Professional Counselor are all considered eligible providers under this Plan.		
Precertification is required for some physician benefits and physician administered drugs. **If precertification is not obtained, no benefits are available.**		

The benefits listed apply only to the physician's charges for the services indicated. Claims for outpatient facility charges associated with any of these services will be processed under outpatient hospital benefits and subject to any applicable outpatient facility copayments. Examples may include: 1) laboratory testing performed in the physician's office but sent to an outpatient hospital facility for processing, 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

Physician benefits include provider-administered drugs; prior authorization is required for benefit coverage. You can find more information about provider-administered drugs in the Medical Necessity and Precertification programs, contact BCBS customer service for assistance. A listing of physician-administered drugs can be found at –

www.AlabamaBlue.com/web/pharmacy/drugguide.html

PRESCRIPTION DRUG BENEFITS		
Point-of-Sale Drug Program: You must pay for the drug and then file for reimbursement. A Claim Authorization Number is provided at the time of purchase and required for reimbursement. You must file the claim within 12 months of the date of purchase. **PreferredONE Retail Network** is the pharmacy network for the Plan – locate a pharmacy at – **AlabamaBlue.com/pharmacy** Prescription drugs limited up to a 30-day supply at retail. Benefits are not provided for PCSK-9 drugs.	**Network or Participating Pharmacy:** **Tier I – Generic:** Covered at 100% of the allowed amount; no calendar year deductible. **Tier 2 – Brand Name:** Covered at 80% of the allowed amount after calendar year deductible. **Tier 3 – Non-Preferred Brand Name:** Covered at 80% of the allowed amount after calendar year deductible. **Tier 4 – Specialty Drugs:** Covered at 80% of the allowed amount after calendar year deductible. **Pharmacy Vaccine Network** benefit covers 100% with no copay or deductible for Flu, Shingles, Pneumonia and other vaccines received at a Pharmacy Vaccine Network provider. Certain immunizations may also be obtained through the Pharmacy Vaccine Network. **www.bcbsal.org/web/pharmacy-vaccine-network**	**Non-Participating Pharmacy:** No benefits are available for prescriptions purchased in a non-Participating Pharmacy in the state of Alabama. Drugs purchased from a non-participating pharmacy outside Alabama are paid at the In-Network level, and you are responsible for any difference between the allowed amount and the actual billed charge. --- **Non-Network Pharmacy – Not covered** **Network Pharmacy – PreferredONE** **A listing of Network Pharmacies is available at AlabamaBlue.com/pharmacy.** **The PreferredONE Retail Network uses the Walgreens retail chain as the anchor and includes some independent pharmacies.**
Extended Supply Point-of-Sale The extended supply pharmacy network is the **PreferredONE ESN Network.** Only maintenance drugs can be purchased through this extended supply service – up to a 90-day supply with a copay for each 30-day supply. Tier 4 (specialty) drugs are not available through this extended supply pharmacy service. View the **SourceRx 1.0** and maintenance drug lists at – **AlabamaBlue.com/DrugList**	**Tier I – Generic:** Covered at 100% of the allowed amount; no calendar year deductible. **Tier 2 – Brand Name:** Covered at 80% of the allowed amount after calendar year deductible. **Tier 3 – Non-Preferred Brand Name:** Covered at 80% of the allowed amount after calendar year deductible. **Specialty drugs are not covered through this extended supply pharmacy**	**Not covered.**

Prescription Drug - Specific Conditions:

Refills are allowed only after 75% of the allowed amount of the previous prescription has been used (23 days of a 30 day supply).

The pharmacy network is the **Prime Participating Network – PreferredONE Retail Network. The PreferredONE Retail Network uses the Walgreens retail chain as the anchor and includes some independent pharmacies. A listing of participating pharmacies is available at AlabamaBlue.com/pharmacy.**

The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Prime Therapeutics Specialty Pharmacy.**

Prescription drug list is available at **www.AlabamaBlue.com/web/pharmacy/drugguide.html or AlabmaBlue.com/DrugList.**

Prescription drug coverage is subject to Drug Coverage Guidelines developed by the Claims Administrator.

Some specialty drugs may only be purchased as a contract pharmacy and may be subject to prior authorization.

Compound drugs must contain at least one FDA-approved ingredient and are subject to review and prior authorization.

Prior authorization is required for certain **physician-administered drugs**. A listing of physician-administered drugs can be found at **www.AlabamaBlue.com/web/pharmacy/drugguide.html** - prior authorization is required for benefit coverage - call customer service at the number on the back of your ID card for assistance.

MAJOR MEDICAL BENEFITS

Most medical services are paid at 100% with or without a deductible or copay. Other covered services are subject to the calendar year deductible and then the Plan pays 80% (70% for Out-of-Network) of the Allowed Amount up to the annual out-of-pocket limit. The annual out-of-pocket maximum is intended to help the member with major expenses and the benefit percentage paid by the Plan increases to 100% for the remainder of the calendar year when the member reaches the out-of-pocket maximum.

IMPORTANT: The Retiree-Only Health Plan does not accumulate the hospital deductible and copay amounts towards the annual out-of-pocket maximum as it is exempt from ACA requirements.

Calendar Year Deductible	**$250** per Member each calendar year; applies to each Member (no family maximum).	
Out-of-Pocket Maximum – Plan pays 100% for the remainder of the calendar year	**EMPLOYEE PLAN** Member maximum: **$ 2,750** Family maximum: **$ 5,250**	**RETIREE-ONLY PLAN** Member maximum: **$ 2,750** Family maximum: **$ 5,250**
The Major Medical calendar year deductible applies towards and is included in the out-of-pocket maximum.		

EMPLOYEE HEALTH PLAN: *Deductibles, copays, coinsurance, including prescription drugs, apply to the out-of-pocket maximum for In-Network services. Deductibles and coinsurance for In-Network dental services apply to the out-of-pocket maximum for members up to the end of the month in which the member turns 19. Only the coinsurance for Other Covered Services applies to the Out-of-Network out-of-pocket maximum.*

RETIREE-ONLY HEALTH PLAN: *Only the Major Medical calendar year deductible and coinsurance for Other Covered Services applies to the In-Network and Out-of-Network out-of-pocket maximum.*

In-Network and Out-of-Network out-of-pocket maximum amounts apply to each other.

After the calendar year out-of-pocket maximum has been reached, Covered Services for essential health services are covered at 100% for the remainder of the calendar year.

IMPORTANT: The Retiree-Only Health Plan accumulates only the Major Medical calendar year deductible and coinsurance amount paid for Other Covered Services to the in-network out-of-pocket maximum.

Maximize Benefits

- To maximize benefits, always use in-network providers for services covered by the Plan. To find in-network providers, check a provider directory, provider finder website (**AlabamaBlue.com**) or call **1-800-810-2583**.
- **Precertification** is required for some inpatient, outpatient hospital and physician-administered drugs. Confirm precertification with your physician or call 1-800-248-2342 and you can find additional information at www.AlabamaBlue.com/precert. Prescription drugs requiring precertification can be found at www.AlabamaBlue.com/web/pharmacy/drugguide.html.
- Inpatient and outpatient hospital services in an out-of-network hospital in the Alabama service area are not covered unless services are to treat an accidental injury or medical emergency.
- Take advantage of the preventive health services including: vaccines, immunizations and preventive care benefits. Additional information may be found at:

www.bcbsal.org/web/pharmacy-vaccine-network

www.AlabamaBlue.com/immunizations

www.AlabamaBlue.com/preventiveservices

BENEFITS FOR OTHER COVERED SERVICES		
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
Allergy Testing & Treatment	Covered at 100% of the allowed amount; copay will apply if there is a corresponding Physician office visit.	Not covered.
Accident-related Dental Services *Some limitations apply such as a 90 day benefit period.*	Covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount after the calendar year deductible.
Ambulance Services	Covered at 80% of the allowed amount subject to the calendar year deductible.	
Speech Therapy *Benefit available only when due to illness or injury, and limited to 60 visits per member each calendar year.*	Covered at 100% of the allowed amount after **$25** copay.	Not covered.
Physical & Occupational Therapy *Physical & Occupational Therapy limited to a combined maximum of 60 visits per member each calendar year.*	Covered at 100% of the allowed amount after **$25** copay.	Not covered.
Home Health Care – • Home Care Medical Supplies • Durable Medical Equipment • Intermittent Skilled Nursing Care • Hospice Care	Covered at 100% of the allowed amount subject to the calendar year deductible. *Pre-certification required for visits by home health professionals outside Alabama by calling 1-800-821-7231.*	Not covered.
Extended Care Facility or Skilled Nursing Facility *Limited to 60 days per member per calendar year.*	Covered at 80% of the allowed amount subject to the calendar year deductible. *Precertification is required by the Claims Administrator and confinement must be within 14 days of an inpatient hospital stay for at least 3 consecutive days with coverage limited to no more than 60 days in a calendar year.*	
Cardiac Rehabilitation *Limited to 36 treatment sessions in a 12-week period per cardiac episode.*	Covered at 100% of the allowed amount; no copay or deductible. *Only when ordered by your physician and provided at a BCBS-approved facility, following heart surgery and as a preventive measure for cardiac-related diagnosis.*	Not covered.
Chiropractor Services	Covered at 100% of the allowed amount after **$25** copay.	Not covered.
Dialysis Services *Renal dialysis facility*	Covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount.
TMJ Therapy	Covered at 100% of the allowed amount; no copay or deductible. *In-Network provisions apply to the following TMJ Phase I services: surgery, office visits, x-rays, and lab work.*	Not covered.
Physician-Administered Drugs	Prior authorization is required for certain physician-administered drugs to be covered. A list of physician-administered drugs or Specialty Drugs that require precertification can be found at AlabamaBlue.com/web/pharmacy/drugguide.html. Prior authorization can be verified by calling BCBS customer service at 1-877-345-6171. No benefits will be paid for physician-administered drugs if prior authorization is not obtained in advance of the expense.	
Tobacco Cessation Assistance **Quit for Life®**	The Plan provides a tobacco cessation program that provides support to the employee and spouse (if covered by the Plan) through telephone-based counseling and nicotine replacement therapy. Quit for Life® can be accessed at 1-888-768-7848.	

PREVENTIVE CARE BENEFITS		
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
The Plan complies with the ACA by providing benefits for preventive care services at 100%, with no deductible or copay, but only when received by an In-Network provider. The following lists some of the immunizations and preventive services available. Go to **www.AlabamaBlue.com/preventiveservices** for a complete listing or contact the Human Resources Department. In some cases the preventive service may be billed separately from the office visit or facility visit and in that case and in all cases where the primary purpose is non-routine, the office visit or facility copay will apply. In cases of illness or family history of cancer, services generally are not considered preventive and may be covered by other plan provisions.		
Routine Vision Exam	Covered at 100% of the allowance, no deductible or copay. *Limited to one routine vision exam and refraction each calendar year for children through the age of 17 and one routine vision exam and refraction per Member age 18 and older every two calendar years..*	Not covered.
Routine Preventive Services and Immunizations	Covered at 100% of the allowance, no deductible or copay. *In addition to the preventive services listed, the following services are also covered:* ▪ *One urinalysis (when necessary)* ▪ *CBS (when necessary)* ▪ *TB skin testing (when necessary)* ▪ *Cholesterol testing (once every 5 years)*	Not covered.
Preventive Services: Preventive Services includes all required by the Affordable Care Act plus others that have been determined by the Claims Administrator to be medically necessary. Preventive Services apply to the Employee and Retiree-Only Health Plans. A listing of Preventive Services and additional information can be found at – **Alabama/Blue.com/preventiveservices** **A listing of specific immunizations can be found at –** **AlabamaBlue.com/SourceRxACAPreventiveeDrugList** **Or call the Blue Cross Blue Shield customer service department for a printed copy.**		

Having a primary care physician is a good decision:

Although you are not required to have a primary care physician, it is a good idea to establish a relationship with a physician. Having a primary care physician has many benefits:

- Establishing your physician can result in early detection of disease.
- Seeing a physician who knows you and understands your medial history will improve your health.
- Your physician will assist you with understanding your health and any medical problems you may have.
- Your physician can coordinate care with specialty physicians and other medical providers.

Primary care physicians specialize in family medicine, internal medicine and pediatrics. Find a physician in your area by visiting AlabamBlue.com and choosing Find a Doctor.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS (Substance Abuse services limited to a lifetime maximum of $25,000)		
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
All eligible providers are considered In-Network Providers including a Licensed Professional Counselor (LPC) and Licensed Clinical Social Worker (LCSW).		
Inpatient Hospital, Psychiatric Specialty or Residential Facility	Covered at 100% of the allowed amount after a **$125** per admission deductible; no copay. *Limit of 20 days of inpatient treatment per calendar year, not subject to Out-of-Pocket maximum.* ***Pre-certification required – call 1-800-248-2342***	
Inpatient Physician	Covered at 80% of the allowed amount; no copay or deductible. *Limit of 20 days of inpatient treatment per calendar year, not subject to Out-of-Pocket maximum.*	
Outpatient Facility, Partial Hospitalization, Day Treatment Program & Intensive Outpatient Program	Covered at 80% of the allowed amount; no copay or deductible. *Limit of 20 visits (days of treatment) per member per calendar year, not subject to Out-of-Pocket maximum.* ***Pre-certification required – call 1-800-248-2342***	
Outpatient Physician	Covered at 100% of the allowed amount after **$25** copay. *Limit of 20 visits per member per calendar year – Benefits include the services of a LPC and LCSW.*	
Partial Hospitalization & Day Treatment Program	Mental health and substance abuse services provided by a licensed facility (free-standing or hospital-based) that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for less than 4 hours per day.	
Residential Facility	Mental health and substance abuse services provided in a licensed facility by a licensed provider with active psychosocial treatment and medication management under the control of a physician.	

HEALTH MANAGEMENT BENEFITS	
Individual Case Management	A program to assist members in coordinating care in the event of a long-term or chronic illness. A Registered Nurse may be assigned to work with you and your physician to coordinate care – contact the Health Management Department at **1-800-821-7231**.
Disease Management	A program that coordinates care for members with chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease – contact **1-800-253-9305** or email membermanagement@bcbsal.org.
Baby Yourself	Prenatal wellness program - contact **1-800-222-4379** or enroll online at **www.behealthy.com**.
Contraceptive Management	Covers prescription contraceptives which include: birth control pills, injectables, diaphragms, IUDs, and other non-experimental FDA-approved contraceptives; subject to applicable deductibles, copays and coinsurance.
Tobacco Cessation Assistance & Wellness Incentive **American Cancer Society Smoking Cessation Program** **Quit for Life®**	The Plan provides a tobacco cessation program that provides support to the employee and spouse (if covered by the Plan) through telephone-based counseling and nicotine replacement therapy. Quit for Life® can be accessed at **1-888-768-7848**. The Plan provides a Wellness Incentive in the form of a $50.00 credit on the monthly premium cost for the employee when the covered employee and spouse do not use tobacco products. The employee and spouse (if eligible under the Plan) who do not use tobacco products may file a Tobacco Attestation Form with the City's Human Resources Department and qualify for the Wellness Incentive credit. The Plan provides for an annual recertification if there is a change in tobacco status. The Plan provides an alternative method for obtaining the Wellness Incentive if you or your eligible spouse are unable to participate in the tobacco cessation program and you may contact the Human Resources Department for information on the alternative method. New employees must certify their tobacco status (and their spouse's tobacco status if covered as a dependent) upon enrollment for the Plan. Additional information about this program may be obtained from the City's Human Resources Department.

HEALTH BENEFITS - COVERED SERVICES

Some restrictions apply to Covered Services. An explanation of Plan provisions, limitations and exclusions are provided elsewhere in this booklet. It is important that you read and understand this benefits booklet and share it with your family.

PRECERTIFICATION – PRIOR AUTHORIZATION: All hospital admissions except maternity and some medical treatments, services and prescription drugs require prior authorization or precertification of medical necessity. Failure to obtain an authorization may result in a denial of benefits. Certain diagnostic imaging services require precertification. Information about these prior authorization requirements can be found at **www.bcbsal.com/providers/preferredRadiologyProgram**.

You and your physician or medical provider ultimately decide on the medical treatment that best manages your medical condition and this may include medical care that is not covered by the Plan.

Assistance with precertification and prior authorization is provided by the Claims Administrator:

Inpatient Hospital Precertification	1-800-248-2342
Outpatient diagnostic lab, X-ray, pathology	1-800-248-2342
Diagnostic Tests	1-800-248-2342
Home Health & Hospice	1-800-821-7231
Bariatric Surgery	www.AlabamaBlue.com
Required Precertification	www.AlabamaBlue.com/precert
Physician-administered Drugs	www.AlabamaBlue.com/web/pharmacy/drugguide.html

COVERED SERVICES

It is important that you read this booklet so you will understand the benefits available to you and the restrictions that apply to some Covered Services. Some Covered Services are available only when rendered by a Blue Cross Blue Shield Network Provider and some Covered Services are subject to benefit limitations. It is important for you to understand that the lowest Copay amounts are available only when the Covered Service is rendered by a Blue Cross Blue Shield Network Provider.

INPATIENT HOSPITAL COVERED SERVICES

The Plan covers the following services and supplies provided to a Member while a patient in a Hospital:

1. Bed, board and general nursing care in a semi-private room. A private room charge in excess of the semi-private rate is the responsibility of the Member.
2. Use of operating, delivery, recovery and treatment rooms, and the equipment in them.
3. Intensive care and other special care units (such as cardiac care and pediatric intensive care), including special equipment and concentrated nursing services provided by hospital employees. Benefits will not be provided for bed and board in another room while you are in a special care unit.
4. Anesthesia including supplies, use of equipment and administration by a hospital employee.
5. Casts and splints, surgical dressings, treatment and dressing trays.
6. Diagnostic tests, including but not limited to laboratory, metabolism, cardiographic, encephalographic, X-rays, and exams.
7. Physical therapy, radiation therapy, and chemotherapy when required to be provided on an inpatient basis.
8. All drugs and medicines, including oxygen, used in the hospital and administered by a hospital employee.
9. Blood transfusions administered by a hospital employee, including supplies and equipment.

OUTPATIENT HOSPITAL COVERED SERVICES

The following are Covered Services for outpatient treatment subject to all provisions, limitations, and exclusions of the Plan:

1. Hospital charges for treatment of an Accidental Injury or Medical Emergency.
2. Hospital charges for surgery in the outpatient department.
3. Hospital charges for hemodialysis and peritoneal dialysis for end-stage renal disease, when services are provided in a Medicare-approved facility.
4. Services for removal of impacted teeth or other dental processes when full surgical and support services are determined Medically Necessary due to the medical condition of the Member.
5. Hospital charges for pre-operative laboratory tests, x-rays, and other diagnostic related tests ordered by the attending Physician and conducted within seven days prior to surgery.
6. Charges by an ambulatory surgical facility.
7. IV therapy, chemotherapy, and radiation therapy.

The Claims Administrator may reclassify services based on medical necessity. This means that based on review outpatient hospital services may be reclassified as an inpatient admission. Services may also be denied if determined not to be medically necessary or furnished at an inappropriate level of care.

PHYSICIAN COVERED SERVICES

The following are Covered Services subject to all provisions, limitations, and exclusions of the Plan:

1. Medical care and treatment including office visits, second surgical opinions, inpatient hospital visits, and outpatient treatment of an Accidental Injury or Medical Emergency.
2. Surgical procedures, including the active services of an assisting surgeon when Medically Necessary.
3. Anesthetics and their administration, including supplies and use of equipment, when rendered by a Physician (other than the operating surgeon or obstetrician).
4. Diagnostic lab, x-ray and pathology services in the Physician's office (if lab results are generated in the outpatient department of a hospital or an independent lab, the charges may be subject to a Copay according to the provisions of the Plan).
5. Services of a radiologist or pathologist.
6. Chiropractic services.
7. Inpatient consultation by a specialist Physician for a medical, surgical or maternity condition, limited to one for each hospital stay.

SERVICES RELATING TO PREGNANCY AND DELIVERY

The following is provided to assist Members in understanding benefits related to pregnancy and delivery.

The following <u>are</u> Covered Services under the Plan:

1. The Baby Yourself pre-natal wellness program for high-risk pregnancy early intervention.
2. Obstetrical care, including Physician services, during pregnancy and childbirth.
3. Services of a certified nurse midwife.
4. Inpatient Hospital expenses for delivery. If care is rendered for multiple births during the same pregnancy, the Plan pays the largest Allowed Amount regardless of the number of babies delivered or method(s) of delivery.
5. Inpatient hospital expenses related to ordinary nursery care and diaper service for a newborn, when the mother is covered under the Plan.
6. Physician inpatient visits for routine newborn care.
7. In most cases, a well baby's charges will be listed under the mother's charges for an inpatient hospitalization. In the case of a sick baby, when the baby incurs charges under its own name, charges will be covered under inpatient Hospital benefits, subject to the inpatient Hospital Deductible and daily Copays. Pre-Certification is required for the baby's separate inpatient hospitalization.
8. Circumcision of a newborn baby.

The following are <u>NOT</u> Covered Services under the Plan:

1. Fertility testing and treatment, assisted reproductive technology, including but not limited to, tubal transfer, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pro-nuclear stage tubal transfer.
2. Genetic testing.
3. Expenses related to Pregnancy of an Eligible Dependent who is not the legal spouse of the Eligible Employee.
4. Ultrasound or related tests performed primarily to determine the sex of the unborn child.
5. Ambulance service to a Hospital for delivery when provided primarily for the comfort and convenience of the Member and not certified by a Physician as Medically Necessary.

OTHER COVERED SERVICES

The following are also Covered Services subject to all Plan provisions, limitations and exclusions:

1. **Allergy testing** and treatment, including serum.
2. **Ambulance** service to the nearest Hospital able to provide necessary care and transportation to a Hospital for specialty care when ordered by a Physician.
3. **Blood** and blood plasma; visualizing dyes and other injections into the circulatory system for diagnosis and treatment.
4. **Cardiac rehabilitation**, when ordered by a Physician following cardiac surgery or as a preventive measure for cardiac-related diagnoses, including but not limited to, stable angina, coronary artery bypass graft (CABG), myocardial infarction, hypertension, and coronary artery disease. Cardiac rehabilitation is limited to a Maximum Benefit of 36 treatment sessions in a 12-week period, per cardiac episode. Benefits are provided only when received from a facility approved by the Claims Administrator. Cardiac rehabilitation as a treatment for obesity is not a Covered Service.
5. **Certified Registered Nurse Anesthetist** (CRNA), only when billed by the Hospital or supervising Physician. The Plan will pay the Hospital or supervising Physician for services.
6. **Colorectal cancer screening**, as provided under the Plan's preventive care benefits. If additional colorectal cancer screenings are performed in connection with the diagnosis or treatment of a medical condition, and if the Physician files the claim with this information, the screening will be a Covered Service paid as a diagnostic procedure. If additional colorectal screenings are performed because you are at high risk of developing colon cancer or you have a family history of colon cancer, and if the Physician files the claim with this information, the screening will be a Covered Service paid as a diagnostic procedure.
7. **Contact lenses**, one pair, or one pair of eyeglasses, or one pair of each, if Medically Necessary to replace the human lens functions as a result of intraocular surgery or ocular injury or defect.
8. **Contraceptives**, including oral and injectable contraceptives, diaphragms, IUDs, and other FDA-approved contraceptives, and required Physician services associated with contraceptive management. Contraceptives are Covered Services only when provided through a Physician or Physician's prescription and not when available over-the-counter.
9. **Diagnostic tests**, including but not limited to, x-rays, laboratory exams, metabolism tests, and cardiographic and encephalographic exams.
10. **Diabetic supplies**, including insulin, needles, syringes, glucose strips, lancets and glucose monitors, provided under Major Medical benefits. Items may be purchased from a Durable Medical Equipment supplier or, when available, from a pharmacy. You may be required to file a claim for reimbursement.
11. **Durable Medical Equipment**, such as wheelchairs and hospital beds, prescribed by a Physician for use in a Member's home. Refer to the section titled "Home Health Care – Benefit Limitation" for additional information.
12. **Elective abortion**, only when ordered by a Physician to protect the mother's physical life or the Pregnancy resulted from a criminal act, or the mother has AIDS or is a drug addict.
13. **Elective sterilization**, including vasectomy when performed on an outpatient basis or tubal ligation when performed on an outpatient basis or in conjunction with delivery on an inpatient basis.
14. **Eye examinations**, limited to a Maximum Benefit of once each Calendar Year for Members up to the age of 18, and once every two Calendar Years for Members 18 and older.
15. **Extended Care Facility**, limited to a Maximum Benefit of 60 days per Calendar Year. Refer to the section titled "Extended Care Facility – Benefit Limitation" for additional information.
16. **Hemodialysis** and peritoneal dialysis treatment for end-stage renal disease.
17. **Home care medical supplies** ordered by a Network Physician for home use and required due to chronic illness. Refer to the section titled "Home Health Care – Benefit Limitation" for additional information.

18. **Home Health & Hospice Care**, including intermittent services of a registered nurse or licensed practical nurse. Refer to the section titled "Home Health Care – Benefit Limitation" for additional information.

19. **Immunizations**, A listing of immunizations can be found at www.bcbsal.com/immunizations or you may contact Blue Cross Blue Shield's customer service. Your physician will also know which immunizations are covered. Some age restrictions apply to specific immunizations. Immunizations required solely for foreign travel are not covered.

20. **Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW)**, covered under the benefits provided for Mental Health & Substance Abuse Treatment.

21. **Mammograms**, as provided under the Plan's preventive care services. If additional mammograms are performed in connection with the diagnosis or treatment of a medical condition, and if the Physician files the claim with this information, the mammogram will be a Covered Service paid as a diagnostic procedure. If additional mammograms are performed because you are at high risk of developing breast cancer or you have a family history of breast cancer, and if the Physician files the claim with this information, the mammogram will be a Covered Service paid as a diagnostic procedure.

22. **Mental Health Treatment & Substance Abuse Treatment**. Refer to the section titled "Mental Health Treatment and Substance Abuse Treatment – Benefit Limitation."

23. **Midwife** for at-home delivery. Services of a certified nurse midwife will be covered at 100% when the midwife is working in collaboration with a Network Physician.

24. **Morbid Obesity** surgery, only within the Claims Administrator's approved Network of Physicians for bariatric surgery and gastric restrictive procedures, when in compliance with the Claims Administrator's guidelines and when there is a documented history of unsuccessful attempts to reduce weight by more conservative measures. Limited to one surgical procedure for Morbid Obesity during a Member's lifetime, regardless of whether the first such surgery was covered by this Plan. Morbid Obesity surgery is not a Covered Service Out-of-Network.

25. **Nursing Care** includes only intermittent services (less than an eight-hour shift) provided by a registered nurse, licensed practical nurse or home health aide who is not related to the Member or regularly resides in the Member's household. The services must be ordered by a Physician and performed outside of a Hospital or any other acute care facility setting by a Blue Cross Blue Shield Provider. No benefits are provided for Custodial Care.

26. **Oral surgery & restorative dentistry** when necessary for the prompt, initial treatment of Injury to sound natural teeth, caused by a force outside the oral cavity and body. Coverage for initial treatment includes the first dental prosthesis, such as a crown or bridge if necessary, and initial treatment includes necessary services that are provided within 12 months of the date of the Injury.

27. **Organ & tissue transplant** limited to specific services, and limited to skin, cornea, kidney, liver, pancreas, small bowel, heart, heart-valve, heart/lung, lung and bone marrow including stem cells and autologous bone marrow. Refer to the section titled "Organ and Tissue Transplants – Benefit Limitation."

28. **Orthotic devices** placed inside or attached to a shoe to support, realign or change gait function, or to treat a varus or valgus deformity, calcaneal apophysitis, plantar fasciitis or calcaneal periostitis, including only gait plates, heel stabilizers, Whitman plates, Roberts plates, biomedical functional orthotics and Schaefer orthotics, and molded shoes to treat deformed or severely maligned or neuropathic sensitive feet, such as in diabetics. Orthotic devices are covered under Durable Medical Equipment benefits, limited to a Maximum Benefit of two pair each Calendar Year.

29. **Physical examinations,** but only as provided under the Plan's preventive care benefits.

30. **Physical therapy & occupational therapy** by a licensed therapist who is not related to the Member, limited to a combined Maximum Benefit of 60 sessions per Calendar Year.

31. **Physician Assistant (PA), Nurse Practitioner (NP), Certified Surgical Technician (CST)** or assistant surgical nurse services.

32. **Prescription drugs** and medicines that require a written prescription by a Physician, which must be dispensed by a licensed pharmacist and cannot be purchased over-the-counter (except Covered diabetic supplies that may be purchased over the counter). Drugs will be dispensed in a maximum of a 34-day supply for each drug or refill. Maintenance drugs may be dispensed in the greater of a 90-day supply or 100 unit doses. Refills are allowed only after 75% of the previous prescription has been used (for example, 23 days into a 30-day supply). There are no benefits for drugs purchased from a non-participating pharmacy in the state of Alabama. Prescription drugs purchased from a non-participating pharmacy out of state or out of the country will be processed at the participating pharmacy allowance and the Member will be responsible for any cost over the participating pharmacy allowance plus the applicable Copayment. The Member must file a claim including the pharmacy receipts.
33. **Prosthetic appliances**, such as artificial limbs and eyes, required as a result of Injury or Illness incurred while covered under the Plan, and replacements as determined to be Medically Necessary, are covered as Durable Medical Equipment under the Home Health Care benefit.
34. **Radiologist or pathologist** services, when ordered by a Physician, including radiation therapy and chemotherapy.
35. **Reconstructive Surgery** when determined to be Medically Necessary and not for Cosmetic purposes or related to complications of Cosmetic services or Cosmetic surgery. Cosmetic services and Cosmetic surgery are not covered even if medically necessary.
36. **Reconstructive surgery following mastectomy** for treatment of breast cancer including reconstructive surgery of the breast on which the mastectomy was performed, and of the other breast to produce a symmetrical appearance; prosthesis and coverage of physical complications resulting from all stages of the mastectomy, including lymphedemas. Coverage of prosthesis includes initial placement of the prosthesis and replacements as determined to be Medically Necessary. Coverage of prosthesis shall also include the brassiere required to hold the prosthesis, limited to a Calendar Year Maximum Benefit of four (4) brassieres.
37. **Sleep apnea,** including studies for diagnosis and treatment of infant apnea or Obstructive Sleep Apnea Syndrome (OSAS), when provided in a sleep disorder center accredited by the American Sleep Disorders Association and home sleep studies when determined to be Medically Necessary.
38. **Speech therapy & audiology services,** required due to an Illness or Injury or to correct speech deficiencies including but not limited to developmental articulation disorders and stuttering. Speech therapy includes treatment of speech, language, voice, communication and auditory processing disorders, including medical diagnostic evaluation, when provided by a licensed therapist who is not related to the Member, Maximum Benefit Limitation of 60 treatment sessions per Member each Calendar Year.
39. **Temporomandibular Joint (TMJ) Disorder** and other conditions of the joint linking the jaw bone and skull, inpatient and outpatient expenses, surgical and non-surgical treatment, are Covered Services under the Health Plan only; this is not a Dental Plan benefit.

PRECERTIFICATION

Some services require **Precertification** or **Prior Authorization** by the Claims Administrator to be eligible for coverage:

Inpatient Hospital Precertification	1-800-248-2342
Diagnostic Tests	1-800-248-2342
Home Health & Hospice	1-800-821-7231
Bariatric Surgery	www.AlabamaBlue.com
Required Precertification	www.AlabamaBlue.com/precert

HEALTH BENEFITS - LIMITATIONS & EXCLUSIONS

Some limitations apply to Covered Services and some medical services are not covered under the Plan. Benefit limitations that apply to both the Health Plan and the Dental Plan are explained in this section. An explanation of standard Plan provisions is provided elsewhere in this booklet. It is important that you read and understand this benefits booklet and share it with your family.

MAXIMUM BENEFIT LIMITATIONS

The Plan has no annual dollar limits on Essential Health Benefits, including home health services. Limitations do still apply on some non-Essential Health Benefits as noted below.

The following Maximum Benefit Limitations apply to these non-Essential Health Benefits:

1. Inpatient Hospital days and Physician inpatient visits for Mental Health Treatment and Substance Abuse Treatment have a limitation of 20 days and 20 visits per Member each calendar year.
2. Outpatient Hospital and Physician visits for Mental Health Treatment and Substance Abuse Treatment have a limitation of 20 visits per Member each calendar year.
3. Services of a Licensed Professional Counselor or Licensed Clinical Social Worker, for Mental Health Treatment and Substance Abuse Treatment have a limitation of 20 visits per Member each calendar year.
4. Surgery for the treatment of Morbid Obesity is limited to one per lifetime per Member and must be performed by a Bariatric Network Provider in Alabama approved by Blue Cross Blue Shield of Alabama as the Claims Administrator.
5. Physical and occupational therapy have a limitation of a combined maximum of 60 visits per Member each calendar year.
6. Speech therapy only when due to Illness or Injury has a limitation of 60 visits per Member each calendar year.
7. Routine vision examinations are limited to once each calendar year for Members under the age of 18, and once every other calendar year for Members age 18 and older.
8. Treatment in an Extended Care Facility has a Maximum Benefit Limitation of 60 days per Member each calendar year.
9. Cardiac rehabilitation following heart surgery and as a preventive measure for cardiac-related diagnoses, has a limitation of 36 treatment sessions in a 12-week period per cardiac episode.
10. Placement of approved orthotic devices has a limitation of two pair per Member each calendar year.
11. Coverage of prosthesis following a mastectomy includes the brassiere required to hold the prosthesis, with a limitation of four per Member each calendar year.
12. Prescription drugs are dispensed in a maximum 34-day supply, and prescription maintenance drugs are dispensed in a maximum 90-day supply or 100 unit doses. Refills on prescription drugs are allowed only after 75% of the previous prescription has been used.
13. Preventive care benefits have age and calendar year limitations. Refer to “Preventive Care Benefits” in the table of benefits for Covered Services.

MENTAL HEALTH TREATMENT & SUBSTANCE ABUSE TREATMENT – BENEFIT LIMITATION

The City of Mobile Health Plan has exercised its right, as a non-federal governmental entity, to be exempt from the Mental Health Parity and Addiction Equity Act of 2008.

Covered Services include inpatient and outpatient Mental Health and Substance Abuse Treatment. Services must be rendered or prescribed by a Psychiatrist, Psychologist, Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW).

Inpatient treatment in a Hospital is a Covered Service, paid at 100% of the Allowed Amount after a $125 Deductible, with a limitation of 20 days per Member each calendar year. Pre-Certification of inpatient Hospital admissions is required.

Outpatient treatment in an outpatient setting is also a Covered Service, paid at 80% of the Allowed Amount, with a limitation of 20 visits per Member each calendar year.

Outpatient treatment by a LPC or LCSW is paid at 100% of the Allowed Amount after a $25 per visit Copay, with a limitation of 20 visits per Member each calendar year.

The Member's payments made for Mental Health Treatment and Substance Abuse Treatment do not accrue toward the Major Medical Out-of-Pocket Maximum.

ORGAN & TISSUE TRANSPLANT – BENEFIT LIMITATION

The organs for which there are benefits include: 1) heart; 2) liver; 3) lungs; 4) pancreas/islet cell; 5) kidney; and, 6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on the list of approved facilities for that type of transplant and it must have advance written approval from the Claims Administrator. Approval of a facility for transplant services is limited to the specific types of transplants stated. Covered transplant benefits for the recipient includes medically necessary hospital, medical, surgical, and other services related to the transplant, including blood and blood plasma.

Transplant benefits for cadaveric donor organ costs are limited to search, removal, storage, and the transporting of the organ and removal team.

Transplant benefits for living donor expenses are limited to: 1) solid organs: testing for related and unrelated donors as approved by the Claims Administrator; 2) bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrow registry; 3) pre-diagnostic testing expenses of the actual donor for the approved transplant; 4) hospital and surgical expenses for removal of the donor organ and all such services provided to the donor during the admission; 5) transportation of a donor organ; and, 6) post-operative hospital, medical, laboratory, and other services for the donor related to the organ transplant limited to 90 days of follow-up care after date of donation.

All organ and bone marrow transplant benefits for covered recipient and donor expenses will be treated as benefits paid or provided on behalf of the Member and will be subject to the terms and conditions of the plan applicable to the Member, such as Deductibles, Copays, Copayments, Pre-Existing Condition exclusions, and other Plan limitations.

There are no transplant benefits for: 1) any artificial or mechanical devices; 2) transplants from animals; 3) donor costs available through other group coverage; 4) if any government funding is provided; 5) the recipient is not covered by the Plan; 6) donor costs if the recipient is not covered by this plan; 7) recipient or donor lodging, food, or transportation costs; 8) a condition or disease for which a transplant is considered investigational; 9) transplants (excluding kidney) performed in a facility not on the approved list for that type or for which the Claims Administrator has not given written approval in advance.

Tissue, cell, and other transplants not listed above are not included in this organ and bone marrow transplant benefit but may be covered under other provisions of the plan when determined to be Medically Necessary and not investigational. These transplants include but are not limited to: heart valves, tendon, ligaments, meniscus, cornea, cartilage, skin, bone, and veins.

EXTENDED CARE FACILITY – BENEFIT LIMITATION

Benefits for an Extended Care Facility are subject to a limitation of 60 days per Member each calendar year. Admission must be Pre-Certified by the Claims Administrator. Benefits are available only when the confinement in an Extended Care Facility begins within 14 days of the last day of an inpatient Hospital confinement.

Facilities for custodial, domiciliary care, Mental Health or Substance Abuse treatment are not covered.

HOME HEALTH CARE – BENEFIT LIMITATION

All services and expenses under this benefit must be submitted to the Claims Administrator for Pre-Certification and such services are not deemed Covered Services until precertification is obtained.

Home Health Care Covered Services include:

1. **Skilled Nursing Care:** Intermittent services (less than an eight-hour shift) provided by a registered nurse, licensed practical nurse, or home health aide who is not related to the Member or regularly resides in the Member's household. Skilled Nursing Care services must be ordered by a Physician and performed outside of a Hospital or any other acute care facility setting. No benefits are provided for Custodial Care.
2. **Durable Medical Equipment:** Equipment, such as wheelchairs, hospital beds, external insulin infusion pumps, and initial placement and replacement of prosthetic, orthotic and orthopedic devices, certified as Medically Necessary to treat an Illness or Injury, or to improve the functions of a malformed body member. Rental of Durable Medical Equipment is covered provided the aggregate rental charges do not exceed a reasonable purchase price. Purchase of Durable Medical Equipment may be approved if purchase is less costly than rental. Refer to the "Definitions" section for additional information.
3. **Home Care Medical Supplies:** Medical supplies ordered by a Network Physician for home use and required due to chronic illness, limited to only: oxygen, IV therapy solutions, crutches, splints, casts, trusses and braces, specialty dressings for open wounds, syringes and needles, tubing kits for insulin pumps, blood glucose strips, lancets and glucose monitors, diabetic supplies, catheters, colostomy bags, compression stockings and medical supplies required in conjunction with an authorized Home Health Care visit.
4. **Hospice Care:** Provided only to Terminally Ill Members and includes Physician home visits, home physical therapy and medical social services, or inpatient Hospice Care when there are no suitable caregivers available to provide care at home for a Terminally Ill Member or to provide temporary relief for a caregiver. Refer to the "Definitions" section for additional information.

CLAIMS FILING DEADLINE

In most cases, a Network Provider will file a medical claim. However, a claim must be filed before payment can be made for certain expenses, including but not limited to prescription drugs and Out-of-Network services.

You should file a claim for benefits with the Claims Administrator within 90 days of incurring a medical expense. **Failure to file a claim for benefits within 12 months of the date of service or date the expense was incurred will result in denial of benefits.** A claim is considered filed when all information necessary for processing the claim has been received by the Claims Administrator.

NO LIMITATIONS ON LENGTH OF STAY

The City of Mobile Health Plan does not restrict benefits to an established length of stay for any condition, except Mental Health and Substance Abuse Treatment. Benefits for an inpatient Hospital stay are based solely on the determination of the Claims Administrator based on Medical Necessity.

BENEFIT EXCLUSIONS

READ THIS SECTION CAREFULLY. The following situations, conditions, services, and expenses are **not** covered under any part of the Plan. Because it is impossible to create an all-inclusive list, the City of Mobile reserves the right to review and exclude any service or expense for conditions or procedures as necessary to avoid adverse selection and to protect the integrity of the Plan.

EXCLUSIONS BY PLAN PROVISION

Exclusions by Plan provision apply to both the Health Plan and the Dental Plan. Additional exclusions that apply to the services received under the Dental Plan are listed in that section. Services and expenses, even if Covered Services, are excluded from coverage under the Plan due to the following situations, conditions, and provisions:

1. Effective January 1, 2014, the Plan no longer has a waiting period for Pre-Existing Conditions.
2. Covered Services were received before the Member's Effective Date or after the date of coverage termination.
3. The Injury or Illness was incurred in connection with the commission of a crime, or participation in a riot or civil commotion, or while the Member was confined in a penal institution.
4. The service or expense is not specifically listed as a Covered Service, or is a complication arising from a condition or service that is not covered by the Plan.
5. The service or expense was not determined by the Claims Administrator to be Medically Necessary.
6. The service or expense is received Out-of-Network and is a Covered Service only when received from or authorized by a Blue Cross Blue Shield Network Provider.
7. The service or expense is received without required Pre-Certification.
8. Charges for Covered Services in excess of the Allowed Amount.
9. A claim for services and expenses has not been received by the Claims Administrator within 12 months of the date of service or the date the expense was incurred.
10. The claim for services or expenses was not properly submitted.
11. The service expense or treatment was not required, referred, prescribed or arranged by a Physician.
12. Services or expenses for Covered Services exceeding the stated limitation.
13. Services were provided after the earliest date the Claims Administrator is able to determine the individual ceased to be an Eligible Dependent or after your failure to provide verification of dependent status within 30 days of a request from the Human Resources Department or the Claims Administrator.
14. Services covered in whole or part by workers' compensation or employers' liability laws, whether or not you file for such benefits under applicable law, or if liability is enforced against or assumed by the Employer.
15. Treatment was received in a federal hospital or treatment facility owned or operated by the United States government or one of its agencies, except as provided by federal law.
16. Services or expenses of any kind to which a Member is, or upon application would be, entitled to coverage under Medicare, whether or not application has been made, except as provided by federal law.
17. The Injury or Illness resulted from war, declared or undeclared, or Uniformed Services duty.
18. Services for which the Member is under no legal obligation to pay or a service for which no charge would have been made if the Member had not had health benefits coverage.
19. Expenses for a Medicare eligible Retiree and dependent of a retiree.

HEALTH BENEFIT EXCLUSIONS

The following conditions, situations, expenses and services are not Covered Services under the Health Plan, whether or not recommended by a Physician and certified as Medically Necessary:

1. **Abortion**, an elective abortion, except to protect the physical life of the mother, or the Pregnancy was a result of a criminal act or the mother has AIDS or is a drug addict.
2. **Acupuncture or acupressure** treatment.
3. **Appliances** such as air-purification units, air conditioners, humidifiers, environmental control units, allergy-free bedding, orthopedic mattresses, vacuum cleaners, heating pads, swimming pools, hot tubs, exercise equipment, electro-magnetic bone stimulators, elevators or stair lifts, wheelchair lifts for automobiles, motorized transportation devices, non-hospital adjustable beds, safety rails, blood pressure or other monitoring equipment, and any equipment or supplies that do not meet the definitions of Durable Medical Equipment or Home Care Medical Supplies.
4. **Assisted Reproductive Technology (ART)** including but not limited to tubal transfer, in vitro fertilization, gamete intrafallopian transfer or zygote intrafallopian transfer, and pro-nuclear stage tubal transfer.
5. **Bed and board** in an empty Hospital bed when the patient is confined to a special care unit.
6. **Claims** received later than **12** months from the date of service.
7. **Cosmetic** treatments, including Cosmetic surgery or drugs for Cosmetic purposes and any complications or subsequent surgery related in any way to Cosmetic services or surgery.
8. **Court** ordered tests, treatment or therapy ordered as a condition of parole, probation, custody, or visitation.
9. **Custodial Care**, sanitarium care, convalescent care or rest cures, except as provided under the Extended Care Facility.
10. **Dental treatment**, or any services related to conditions of the teeth or supporting structures, including removal of impacted wisdom teeth, periodontal disease or gum disease, or Injury caused through the activities of daily living such as biting, chewing, clenching and grinding. Dental treatment considered a Covered Service under the Health Plan consists only of Physician's charges for initial treatment of Injury to sound natural teeth, when such Injury occurred while the Member was covered under the Plan and initial treatment includes necessary services that are provided within 12 months of the date of the Injury.
11. **Dental outpatient Hospital services** for the removal of impacted wisdom teeth are covered under the Health Plan only when required due to the medical condition of the patient and deemed Medically Necessary. Refer to the section titled "Dental Plan" for information on dental treatment considered to be a Covered Service.
12. **Drugs sold over the counter** that can be purchased without a written prescription and kits for home testing, including but not limited to HIV, Pregnancy or allergies, except for diabetic supplies, which may be purchased over the counter and are covered under the Plan.
13. **Drugs for Cosmetic or weight loss purposes**, nutritional or dietary supplements, including charges for megavitamin therapy.
14. **Drugs off-label**, not used for the specific treatment of Illness or Injury, prescriptions related to an otherwise non-Covered procedure, uses of drugs for purposes not specifically approved by the FDA, and drugs not approved by the Claims Administrator.
15. **Drugs prescribed for a work-related illness or injury**.
16. **Emergency room services** or use of an emergency room Physician for medical care that is not required as a result of a Medical Emergency.
17. **Experimental or Investigative** procedures, drugs, treatments, equipment or supplies. Refer to the "Definitions" section for additional information.

18. **Exercise or physical fitness** programs, weight reduction, weight control or dietary control procedures, or drugs for weight loss purposes, nutritional or dietary supplements, except for surgery to correct Morbid Obesity, when determined by the Claims Administrator to be Medically Necessary, based on criteria established by the Claims Administrator, to protect the life of the Member.
19. **Eyeglasses or contact lenses**, except for initial placement of contact lenses or eyeglasses if Medically Necessary to replace the human lens function as a result of intraocular surgery or ocular injury or defect.
20. **Foot treatments**, including non-surgical treatment of feet, orthotic devices designed to simply support the arch or pad of the foot and that are not functioning to change a pathological gait or stance problem, orthopedic shoes or prescription shoes (except molded shoes), and routine foot care such as removal of corns or calluses or the trimming of nails, except trimming of mycotic nails.
21. **Genetic testing** or counseling, or other analysis to identify a variant genetic code, to detect a genetic disease or to predict the likelihood of developing a genetic disease.
22. **Hearing aids** or the implantation of prosthetic devices to improve hearing, including but not limited to devices used in the treatment of tinnitus.
23. **Hospitalization determined to be unnecessary** because the services could have been provided on an outpatient basis, such as admissions primarily for diagnosis, diagnostic study or medical observation, or that portion of an inpatient stay primarily for rehabilitation or rehabilitative services including, but not limited to physical therapy, occupational therapy and speech therapy. If the service would have been a Covered Service if rendered on an outpatient basis, benefits will be paid, but at a reduced benefit level.
24. **Immunizations**, except as provided under preventive care benefits. Immunizations for the purpose of foreign travel are not covered.
25. **Infertility** studies, tests to determine fertility or the use of fertility drugs.
26. **Learning disability** therapy, testing, or treatment including treatment for communication delay, perceptual disorders and behavioral disorders including ABA therapy.
27. **Mental Health Treatment** except as specified in the section titled Mental Health Treatment & Substance Abuse Treatment.
28. **Mental retardation** and behavior conditions such as autism spectrum disorder and specifically ABA therapy.
29. **Nursery care** in the Hospital for a newborn dependent if the mother does not have coverage under the Plan.
30. **Occupational therapy**, recreational therapy or educational therapy. Occupational therapy is covered only when Medically Necessary due to Illness or Injury as part of a regimen of physical therapy.
31. **Organ or tissue transplants** not specifically listed in the section titled Organ & Tissue Transplant.
32. **Physical examinations** required for insurance policies, employment or educational institution screening, recreational activities or government licensing, except when such purposes are incidental to the routine preventive care benefits provided.
33. **Prosthetic device replacements** that have not been certified as Medically Necessary.
34. **Pre-operative lab tests** not conducted within seven days prior to surgery.
35. **Pregnancy** services, including complications, and postpartum period of any **Eligible Dependent** other than the legal spouse of the Eligible Employee.
36. **Prescription drugs** purchased at a non-participating pharmacy in the state of Alabama.
37. **Private duty nursing** care, except as provided for in the section titled Home Health Care.
38. **Private room** charges while hospitalized, except when required by a Physician due to Medical Necessity.
39. **Psychological testing**, counseling, educational or vocational testing or training, testing for or treatment of learning disabilities or behavioral problems.

40. **Reversal of elective sterilization**.
41. **Self-care or self-help** therapy or training, including but not limited to hypnosis, stress management, bio-feedback or behavior modification therapy.
42. **Self-inflicted injury** or sickness, or suicide or attempted suicide.
43. **Sexual dysfunction or inadequacy** not related to organic disease, including progesterone or testosterone or their derivatives, or drugs prescribed to treat impotence, sexual dysfunction or inadequacy that is not directly related to organic disease.
44. **Smoking cessation treatments**, including drugs and nicotine replacements, except when provided through the City of Mobile Health Plan's tobacco cessation program for employees and spouses.
45. **Speech therapy** to correct pre-speech deficiencies or delayed speech development, to improve speech skills that have not fully developed, to overcome learning disabilities, or to provide lessons in sign language when a Member's ability to speak has been lost or impaired for any reason. Speech therapy is a Covered Service only when prescribed by a Physician for treatment of an Injury or Illness.
46. **Substance Abuse Treatment** except as specified in the section titled Mental Health Treatment and Substance Abuse Treatment.
47. **Surgical sex transformations** or treatment for complications resulting from surgical sex transformations.
48. **Transcutaneous Electrical Nerve Stimulation** (TENS) units and associated supplies.
49. **Travel and lodging** for any physical condition, whether or not required by a Physician.
50. **Ultrasound** when performed primarily to determine the sex of an unborn child.
51. **Vision therapy**, visual training, or orthoptics, or any eye surgery, including but not limited to refractive keratoplasty in all forms when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
52. **Weight reduction – Bariatric surgery**, weight control or dietary control treatment, or drugs for weight loss purposes, nutritional or dietary supplements. The only exception is surgery to correct Morbid Obesity, within the Claims Administrator's approved **Network of Physicians** for bariatric surgery and gastric restrictive procedures, when determined to be Medically Necessary and performed according to the guidelines of the Claims Administrator and limitations of the Plan.

Precertification – Prior Authorization: Some medical treatments, services and prescription drugs require prior authorization or precertification of medical necessity. Failure to obtain an authorization may result in a denial of benefits.

Precertification is required for all hospital admissions except maternity admissions. Emergency admissions must be precertified within 48 hours of admission. If you are unable to communicate and no one is available to call for you, the deadline for precertification is extended to 48 hours after you regain the ability to communicate. You should check with your admitting Physician to ensure your admission has been precertified. Failure to Pre-certify a Hospital admission may result in a denial of benefits, call 1-800-248-2342.

Certain diagnostic imaging services require precertification. Information about these prior authorization requirements can be found at **www.bcbsal.com/providers/preferredRadiologyProgram**.

All Home Health Care services and Extended Care require precertification, call **1-800-821-7231**.

All organ and bone marrow transplants require precertification.

Some prescription drug medications and Specialty Drugs require Prior Authorization.

You and your physician or medical provider ultimately decide on the medical treatment that best manages your medical condition and this may include medical care that is not covered by the Plan.

DENTAL BENEFITS

EMPLOYEE HEALTH & DENTAL PLAN

This Plan complies with all provisions of the Affordable Care Act.

RETIREE-ONLY HEALTH PLAN

This plan is exempt from the Affordable Care Act and does not provide the following:

a) Dependent child coverage is limited to age 19 and the extension of coverage to age 26 does not apply.
b) Deductibles and copay amounts do not accumulate towards the annual out-of-pocket maximum.
c) Not all preventive services are covered; only those stated in this benefits booklet.
d) Third party independent review of appeals is not provided.

MEDICARE ADVANTAGE PLAN

Retirees and dependents enrolled in the Medicare Advantage Plan are **not** eligible for dental benefits.

If you or your Eligible Dependent, while covered under the Plan, incurs an expense for Dental Plan Covered Services, the Plan will pay for that expense as described in this section. Some limitations and exclusions apply.

ABOUT THE DENTAL PLAN

The Dental Plan is administered by Blue Cross Blue Shield of Alabama and allows the Plan to use its purchasing power to negotiate with Network Providers. Negotiated savings are passed on to you through increased benefits when you use a Preferred Dentist.

The level of benefits you receive will vary depending on whether services are received from a Network Provider (Preferred) or an Out-of-Network Provider (Non-Preferred). To maximize your benefits, receive services from a Network Provider. Refer to the Dental Benefit table of benefits for additional information on benefit levels.

IN-NETWORK PROVIDER DENTAL BENEFITS

Services rendered and received from a dentist who participates in the Preferred Dentist program are eligible for Network Provider Benefits. There are several advantages to using a Network Provider:

1. The Network Provider will file your claim for you and will arrange for precertification of all dental services, if required.
2. The Network Provider has agreed to accept a negotiated fee for dental services as payment in full, except for any applicable calendar year Deductible or Copay.
3. The Network Provider will not collect fees for services from you, except for any applicable calendar year Deductible or Copay.

OUT-OF-NETWORK DENTAL BENEFITS

Benefits are reduced if you receive services from an Out-of-Network Provider. If you use an Out-of-Network Provider, you must be aware of the following:

1. It will be your responsibility to arrange for Precertification of dental services, if required.
2. You must pay for your dental services up front, directly to the Out-of-Network Provider and then file for reimbursement, less any applicable Calendar Year Deductible and Copay, from Blue Cross Blue Shield of Alabama. An Out-of-Network Provider may offer to file your claim for you but it is your responsibility to see that the claim is filed correctly and in a timely manner.
3. Blue Cross Blue Shield of Alabama pays only the Network Provider Allowed Amount. You will be responsible for paying the difference between the Network Provider Allowed Amount and the actual charges of the Out-of-Network Provider plus any applicable Calendar Year Deductible and Copay.

PREFERRED DENTIST DIRECTORY

A provider directory listing the Network Providers (Preferred) is available from the website www.bcbsal.com. From time to time Network Providers are added and deleted from the network of providers. It is your responsibility to check with your provider prior to treatment to determine if the provider is still a Network Provider (Preferred).

FREEDOM OF CHOICE

You are not required to use a Network Provider under the Dental Plan. You may choose to use a dentist who does not participate in the Preferred Dentist program, or you may live outside the Network Provider area and find it inconvenient to use a Network Provider. The increased benefits are not available with Out-of-Network Providers.

DENTAL BENEFIT PLAN

Employee Health Plan: Deductible, copayment and charges in excess of the allowed amount do accumulate towards the out-of-pocket maximum under the major medical benefit.

Retiree-Only Health Plan: Deductible, copayment and charges in excess of the allowed amount do not accumulate towards the out-of-pocket maximum under the major medical benefit.

The member is responsible for any charges over the allowed amount for Non-Preferred Dental services.

GENERAL PROVISIONS	
Calendar Year Deductible	**$25** per member each calendar year (does not apply to diagnostic and preventive services).
Benefit Maximum per Calendar Year	**$1,500** per member each calendar year (no family maximum) – does not apply to orthodontic services which has a separate **$1,000** lifetime maximum benefit.
Pediatric Dental Services	No maximum up to age 19.

BASIC – DIAGNOSTIC & PREVENTIVE SERVICES

Covered at 100% of the Preferred Dental Schedule, with no deductible, includes:

- Dental exams up to twice per calendar year.
- Dental X-ray exams.
- Full mouth X-rays, one set during any 36 consecutive months.
- Bitewing X-rays, up to twice per calendar year.
- Other dental X-rays, used to diagnose a specific condition.
- Routine cleanings, twice per calendar year.
- Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to the first and second permanent molars of children up to age 13 and only when the teeth have not been treated with sealants for at least four years.
- Fluoride treatment for children through age 18, twice per calendar year.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

RESTORATIVE & SUPPLEMENTAL SERVICES

Covered at 80% of the Preferred Dental Schedule, after the calendar year deductible, includes:

- Fillings made of silver amalgam and synthetic tooth color materials.
- Simple tooth extractions.
- Direct pulp capping, removal of pulp and root canal treatment.
- Repairs to removable dentures.
- Emergency treatment for pain.
- Oral surgery to treat fractures and dislocations of the jaw, to diagnose and treat mouth cysts and abscesses, and for tooth extractions and impacted teeth.
- General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.
- Treatment of the root tip of the tooth including its removal.

PROSTHETIC SERVICES

Covered at 80% of the Preferred Dental Schedule, after the calendar year deductible, includes:

- Full or partial dentures.
- Fixed or removable bridges.
- Inlays, onlays, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings are not adequate.

PERIODONTIC SERVICES

Covered at 80% of the Preferred Dental Schedule, after the calendar year deductible, includes:

- Periodontic exams twice each 12 months.
- Removal of diseased gum tissue and reconstructing gums.
- Removal of diseased bone.
- Reconstruction of gums and mucous membranes by surgery.
- Removing plaque and calculus below the gum line for periodontal disease.

ORTHODONTIC SERVICES

LIMITED TO A SEPARATE $1,000 LIFETIME MAXIMUM BENEFIT

Covered at 50% of the Preferred Dental Schedule, after the calendar year deductible, includes:

- Initial and subsequent treatment and installation of orthodontic equipment for eligible dependent children up to age 19. Orthodontia performed exclusively on primary teeth is not covered.

DENTAL BENEFITS – LIMITATIONS & EXCLUSIONS

When there are two or more methods of treating a condition, payment for a Covered Service will be based upon the charges for the least expensive course of treatment.

The following situations, conditions, services, and expenses are not covered under any part of your Dental Plan:

1. Anything excluded under the section of this booklet titled "Exclusions by Plan Provision."
2. Any service or expense that is not performed by a dentist, oral surgeon, or a dental hygienist.
3. Any service or expense for which supporting proof of loss has not been properly submitted.
4. Any service or expense related to the treatment of Temporomandibular Joint (TMJ) disorders; refer to the section titled "Health Plan Covered Services" for additional information.
5. Anesthetic services performed by a dentist other than the attending dentist or the attending dentist's assistant.
6. Gold fillings, gold foil restorations or space maintainers made of precious metals. The Plan covers fillings of silver amalgam only and composite (tooth-colored) fillings in the smile line.
7. Prosthetics, including bridges and crowns, started or under way prior to the Member's Effective Date.
8. Re-basing or re-lining of a denture less than six months after the first placement and not more than one re-basing or re-lining in any two-year period.
9. Replacement of lost or stolen prosthetics or replacement of prosthetics less than five years after a placement.
10. A new denture or bridgework if the existing device can be made serviceable.
11. Procedures, restorations, and appliances to change vertical dimension or to restore proper contact.
12. Any expense paid in whole or in part by any other provision of the Health Plan.
13. Any expense for oral hygiene or dietary information.
14. Any expense for plaque or infection control.
15. Any expense for implants or implantology.

GENERAL PROVISIONS

The information in this section applies to all benefits. Please read these important Plan provisions. In addition, this section contains information on how to file a claim for benefits and your rights and responsibilities under federal laws.

IDENTIFICATION CARD

The Blue Cross Blue Shield identification card contains information that is vital to filing a claim for benefits under the Plan. ID cards are issued to Eligible Employees, with the name of the Eligible Employee printed on the card, in sufficient number that each Member of your family may carry an ID card. You should show your ID card to your physician and pharmacy for proper claim filing. The back of your ID card contains information for providers to assist in the correct routing of your claims and customer service numbers.

MEDICAL NECESSITY & PRECERTIFICATION

Medical Necessity or Medically Necessary are defined terms. Benefits are provided only for Covered Services determined by the Claims Administrator to be Medically Necessary. In some cases, such as inpatient hospital admission, the Plan requires that you pre-certify the Medical Necessity of your care. Look on the back of your ID card for the phone number that you or your provider should call to obtain precertification. The provider may initiate the precertification process for you, but you are responsible for making sure that your provider complies with any precertification requirements under the Plan. Medical Necessity determinations are made solely for the purpose of determining whether to pay for a medical service or supply. Medical necessity standards are published and available at www.AlabamaBlue.com/providers/policies. All decisions concerning treatment must be made solely by the attending physician, medical provider and the patient.

ALLOWED AMOUNT or ALLOWANCE

The "Allowed Amount" or "Allowance" for all Covered Services is determined by the Claims Administrator. The Claims Administrator relies on in-network provider negotiated rates to determine the relative value of services. The Allowed Amount may not correspond to the usual or customary charge made by a Physician, Hospital, Dentist, or other medical provider or by other Physicians and medical providers in any geographic area. In no case will the Allowed Amount exceed the limits established in this Plan. Charges for Covered Services in excess of the Allowed Amount are the responsibility of, and must be paid by, the Member. If you receive services from an Out-of-Network provider and you are balance billed for the difference between the Allowed Amount and the actual billed charges, only the Allowed Amount is credited toward meeting your calendar year Deductible or annual out-of-pocket maximum.

Benefits for Covered Services are paid at the Allowed Amount or Allowance based on the fee schedule the Claims Administrator has contracted with its Network Providers. A participating provider has agreed to accept a negotiated fee for Covered Services. Members receiving benefits for Covered Services from Network Providers are not responsible for amounts billed in excess of this fee, except for any Deductible, Copay or Coinsurance. The Member is responsible for the amount billed in excess of the Allowed Amount, plus any applicable Deductible, Copay or Coinsurance for services obtained from Out-of-Network providers.

If surgical care rendered consists of two or more related procedures performed during the same operative session, the Plan will pay only for the procedure with the largest Allowed Amount.

If the surgical care consists of two or more separate and unrelated procedures performed during the same session, the Plan will pay only for the procedure with the largest Allowed Amount, and one-half (1/2) of the Allowed Amount for the other procedures.

When two surgeons in different specialties operate in the same operative field as co-surgeons with each assisting the other, the Plan's payment will be made at 150% of the Allowed Amount for the surgical procedure, in which case the services of an assisting surgeon would not be Covered Services, as the co-surgeons assist each other.

If care is rendered for multiple births during the same Pregnancy, the Plan will pay the largest Allowed Amount regardless of the number of babies delivered or method(s) of delivery.

LIMITATION OF LIABILITY

The City of Mobile's Health & Dental Plan benefits are paid as a general obligation of the City of Mobile.

The City of Mobile has the power and authority to make additional rules and regulations concerning eligibility and benefits and reserves the right to interpret the Plan and make final determinations with regard to all matters.

The City of Mobile reserves the right to change, modify, reduce and terminate any and all benefits, self-funded or insured, at its sole discretion. The City of Mobile reserves the right to change, modify, and terminate any and all benefits for any class of employees, dependents, or retired employees at its sole discretion. Eligibility and benefits are not guaranteed and continue on a month to month basis subject to change by the City of Mobile.

The City of Mobile has in this booklet tried to summarize as accurately as possible all pertinent provisions of the Plan as of the date this booklet was prepared. However, in the event of any conflict between this booklet and the official plan, policy of insurance, regulations or administrative procedures, the City of Mobile reserves the right to make final and conclusive determination.

The relationship between the City of Mobile, the Plan, Network Providers, other participating providers, and the Claims Administrator are independent contractor relationships. Network providers and the Claims Administrator are not agents or employees of the City of Mobile or the City of Mobile Health & Dental Plan.

The City of Mobile or the City of Mobile Health & Dental Plan is not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider or any other provider.

RIGHT TO RECEIVE AND RELEASE INFORMATION

To ensure that benefits are paid correctly, the Claims Administrator must receive information from providers of medical services and from insurance companies with whom benefits are coordinated. To determine if a claim should be paid or denied, or whether other parties are legally responsible for some or all of the expense, the Claims Administrator may exchange information with medical providers or other health claims administrators.

By enrolling in this Plan, you authorize the Claims Administrator to obtain, use, and release all records about you and your Eligible Dependents that are needed in the administration of the Plan. By enrolling in the Plan, you accept your obligation to provide to the Claims Administrator information on other group health insurance, other parties who may be legally responsible for medical expenses, Change-In-Status Events, and other reasonable information requested or required.

If you or any medical provider refuses to provide information requested, this Plan may deny benefits until requested information is received.

COORDINATION OF BENEFITS

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

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

A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of Benefit Determination:

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

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

Employee/Dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require reversal of 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 not a court decree allocating responsibility for the child's health care expenses or health 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 health care expenses or health 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 health 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. Third, the plan of the spouse of the non-court-ordered parent.

   If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of “Dependent Child – Parents Not Separated or Divorced” (the “birthday rule”) 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 health care expenses or health care coverage of the 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 pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
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, claims will not be processed until they have been filed with the primary plan and the primary plan has made its benefit determination.

If this plan is required to make a secondary payment according to the above rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

COORDINATION OF BENEFITS WITH MEDICARE – ACTIVE EMPLOYEES AND DEPENDENTS

The active Eligible Employee and Eligible Dependent eligible for Medicare will continue to be covered for the same benefits available to all Eligible Employees. This Plan will be primary and will pay its benefits first. Medicare will then pay for Medicare eligible expenses, if any, not paid by the Plan. Refer to the section titled "Creditable Drug Coverage Notice" for additional information.

If an Eligible Employee or Eligible Dependent becomes eligible for Medicare benefits based solely on End Stage Renal Disease (ESRD), this Plan will be primary for the first 30 months of eligibility for Medicare. After the first 30 months of eligibility for Medicare, if the Eligible Employee or Eligible Dependent is still eligible for Medicare due to ESRD or for any other reason, Medicare will be primary.

The Employee or Dependent may elect Medicare as primary coverage, in which case this Plan will <u>not</u> pay any benefits. An Employee electing Medicare as primary coverage may have a Medicare supplemental contract but the City of Mobile is not allowed under law to pay for such a contract.

SUBROGATION – THE RIGHT TO RECOVER FROM A RESPONSIBLE THIRD PARTY

If the Plan pays or provides any benefits for a Member under this Plan, the Plan is subrogated to all rights or recovery which you have in contract, tort, legal liability, settlement or otherwise against any person, entity, or organization for the amount of benefits the Plan has paid or provided. This means the Plan may use your right to recover money from that other person or organization.

In the event a third party may be legally liable for expenses for which the Plan provides benefits, the City of Mobile may – at its discretion – pay benefits to the Member and be entitled to subrogate any claim the Member may have against the third party to the full extent of the benefits.

RIGHT OF REIMBURSEMENT

In addition to the right of subrogation, this Plan has a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury, illness or condition for which the Plan paid benefits. This means that you promise to repay the amount the Plan has paid or provided in benefits from any money you recover. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay the Plan. And, if you are paid by any person or company besides the Plan, including the person who injured you, that person's insurer, or your own insurer, you must repay the Plan. In these and all other cases, you must repay the Plan.

This Plan has the right to be reimbursed or repaid first from any money you recover, even if you are not paid for your entire claim for damages and you aren't made whole for your loss. This means that you promise to repay the Plan first even if the money you recover is for (or said to be for) a loss besides Plan benefits, such as pain and suffering. It also means that you promise to repay the Plan first even if another person or company has paid for part of your loss. And it means that you promise to repay the Plan first even if the person who recovers the money is a minor or dependent covered under the Plan. In these and all other cases, the Plan has the right to first reimbursement or repayment out of any recovery you receive from any source.

If the Member collects any sums as damages from a third party or parties, whether by action, settlement or any other manner, the Member shall be liable to the City of Mobile for any payments made by the Plan. Any payment from a third party suit, settlement or otherwise, shall be deemed to be for medical services and supplies received by the Member from the Plan. This provision applies to all Plan benefits and medical or dental expenses incurred in connection with an automobile accident, civil disturbance or other event causing Injury or Illness. In addition to benefits paid, this Plan shall be entitled to recover from the Member reasonable attorney’s fees and costs incurred in collecting proceeds held by a third party or by the Member.

RIGHT TO RECOVERY

You agree to furnish the Claims Administrator all information that you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with the Claims Administrator in protecting and obtaining the Plan’s reimbursement and subrogation rights.

You or your attorney will notify the Claims Administrator before filing any suit or settling any claim, to enable the Plan to participate in the suit or settlement to enforce the Plan’s rights. If you notify the Claims Administrator so the Plan is able to recover the amount of Plan benefit payments for you, the Plan will share proportionately with you the cost of any attorneys' fees charged you by your attorney for obtaining the recovery.

If you do not give the Claims Administrator that notice, reimbursement or subrogation recovery under this section will not be decreased by any fee for your attorney. You further agree not to allow the Plan’s reimbursement and subrogation rights to be limited or harmed by any other act or failure to act on your part and, if you do, the Plan may suspend or terminate payment of any further benefits.

Every effort is made to process claims promptly and correctly. If payments are made to you or to a provider who furnished services or supplies to you, and the Plan finds at a later date that the payments were incorrect, you or the provider will be required to repay any overpayment or the Plan may deduct the amount of the overpayment from any future payment to you or the provider.

RIGHT TO RECOVER PAYMENTS MADE IN ERROR

The City of Mobile has the right to recover any benefit amount paid in error, in excess of Plan Benefit Limitations or due to failure of the Member to provide timely information concerning eligibility and specifically information that a Member is no longer an Eligible Dependent, such as in the case of divorce or a child no longer meeting the definition of an Eligible Dependent.

If incorrect payments are made to you or to a medical provider, the amount of the overpayment must be refunded, or will be deducted from any future payment to you or the provider. The Claims Administrator is authorized and empowered to recover payments made in error by any appropriate method, including legal action for collection.

If you fail to provide timely information concerning a dependent ceasing to be an Eligible Dependent, the City of Mobile is authorized and empowered to recover payments made in error through payroll deduction.

RECEIPT OF PAYMENT SATISFIES PLAN OBLIGATION

The Claims Administrator's agreements with some providers require the Plan to pay benefits directly to them. On all other claims, the Plan may choose at its option to pay either you or the provider. You may assign benefits to a provider and the Plan may pay directly to the provider. Payment to you or the provider will be considered to satisfy the Plan's obligation to you. The Plan does not have to honor any assignment of your claim to anyone, including a provider. If you die or become incompetent, or are a minor, the Plan will pay your estate, your guardian or any relative which in the Plan's judgment is entitled to the payment. Payment of benefits to one of these people will satisfy the Plan's obligation.

HOW TO FILE A CLAIM FOR BENEFITS

In all cases, you should file a written claim with the Claims Administrator listed below within **90 days** of incurring charges. Failure to file a claim for benefits within **12 months** of the date the expense was incurred will result in denial of benefits.

Health Plan: In most cases the Network Provider will file a claim for you. You will need to file a claim yourself if you use an Out-of-Network Provider or for some expenses such as prescription drugs. Mail claims to:

Blue Cross Blue Shield of Alabama
P. O. Box 995
Birmingham, AL 35298

In all cases, the Member is responsible for ensuring that the claim has been filed in a timely manner.

Dental Plan: The Dental Plan does not require that you file a claim when you use a Network Provider (Preferred Dentist). If you use an Out-of-Network Provider (Non-Preferred Dentist), a claim must be filed before payment can be made. Refer to the section titled "Dental Benefits" for information on Pre-Certification of dental services and filing a claim for benefits. In all cases, the Member is responsible for ensuring that the claim has been filed in a timely manner.

Prescription Drug: You must pay for the prescription and then file for reimbursement. A Claim Authorization Number is provided at the time of purchase and required for reimbursement. Claims for reimbursement may be mailed to the address below, faxed to 1-800-526-8529, or filed online at www.bcbsal.com under "Pharmacy." In all cases, the Member is responsible for ensuring that the claim has been filed in a timely manner.

CLAIM INQUIRIES

If you have a question about a claim, you should contact the Claims Administrator:

Blue Cross Blue Shield of Alabama
Attention: Customer Service
P.O. Box 12185
Birmingham, Alabama 35202-2185
1-800-946-3979

APPEALS TO THE CLAIMS ADMINISTRATOR

There are a number of reasons why your claim may be denied in whole or in part. You should carefully read any correspondence received from the Claims Administrator, and review this benefit booklet to ensure that you understand the reason for the denial.

If you are not satisfied with the Administrator's handling of a claim or have any questions, you may do one or more of the following:

1. Contact the Administrator's Customer Service Department. The Administrator will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
2. File an appeal if you have received an adverse benefit determination.
3. Claims involving medical judgment and rescissions of coverage may be filed for an independent, external review of the appeal decision (does not apply to the Retiree-Only Health Plan).

MEDICAL & DENTAL

Medical and dental benefit appeals are performed by Blue Cross Blue Shield and it is recommended that you use the form provided by the Claims Administrator available at –

www.AlabamaBlue.com

ELIGIBILITY & SECONDARY REVIEW

Eligibility is managed by the City's Human Resources Department and inquires should be sent direct to that Department. Also, after you have followed the procedure for review by the Claims Administrator, if you are not satisfied with the response you may request a review by the City of Mobile. This secondary review requires that you:

- First comply with an appeal to the Claims Administrator;
- Provide a copy of all records concerning your appeal and the response from the Claims Administrator and specifically a copy of the explanation of benefit form and appeal response;
- The review request must be filed within 60 days of the Claims Administrator's response or the denial of a benefit or coverage.

All information must be submitted in writing to –

CITY OF MOBILE
HUMAN RESOURCES DEPARTMENT

205 Government Street
4th Floor, South Tower
Mobile, AL 36602

P.O. Box 1827
Mobile, AL 36633-1827

In all cases, you have **180 days** following the Claims Administrator's adverse benefit determination within which to submit an appeal. No action may be brought against the Plan, the Employer, or the Claims Administrator unless, as a condition precedent thereto, the Member and any provider of services, has fully complied with all the terms and provisions of the City of Mobile Health & Dental Plan. Additionally, you must have fully complied with the review procedure for a claim denial prior to filing suit, and no action may be brought until the claim for benefits has been denied in writing. Further, no legal action may be commenced against the Plan, the Employer, or the Claims Administrator, individually or collectively, more than **12 months** after the date of the final decision on your appeal.

Notwithstanding any statement herein to the contrary, the City of Mobile does not waive any sovereign immunity provided by state and federal constitutions, or other laws or provisions of law. The agent for the service of legal process shall be the Claims Administrator, Blue Cross Blue Shield of Alabama.

DELEGATION OF AUTHORITY TO BLUE CROSS BLUE SHIELD OF ALABAMA

The City of Mobile has delegated to Blue Cross Blue Shield of Alabama, the Claims Administrator, the discretionary responsibility and authority to determine claims under the Plan, to construe, interpret and administer the Plan, and to perform every other act necessary or appropriate in connection with the provision of administrative services under the Plan. When the Claims Administrator makes reasonable determinations that are neither arbitrary nor capricious in administration of the Plan, those determinations will be final and binding upon the Members, subject only to the appeals procedure and review procedure stated in this booklet, and thereafter to judicial review to determine whether the determination was arbitrary or capricious.

RELATIONSHIP OF PARTIES

The relationship between the Employer, the Plan, Network Providers, other participating providers, and the Claims Administrator are independent contractor relationships. Network providers and the Claims Administrator are not agents or employees of the Employer or the Plan.

Neither the Employer nor the Plan is liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any Network Provider or any other provider.

UTILIZATION REVIEW

Utilization review refers to the process conducted by the Claims Administrator to ensure the appropriate management and utilization of medical resources. Review may be performed prior to, concurrent with or retrospective of service in order to determine the most appropriate treatment setting for the patient's severity of Illness. Review will also occur to determine Medical Necessity and clinical outcome. Payment of services may be denied if the services fall outside the utilization review guidelines or are not part of the schedule of benefits.

After the initial Pre-Certification of Hospital admission, the Claims Administrator may contact the attending Physician to determine if continued in-patient days are Medically Necessary. Any days not certified as Medically Necessary will not be covered by the Plan.

You may submit a request for review of a treatment or medical resource by contacting the Claims Administrator or through your treating physician, hospital or other medical provider. You may submit a request to extend your approved care as follows:

- Inpatient hospital care – call 1-800-248-2342.
- Chiropractic, physical, speech and occupational therapy – call 1-205-220-7202.

FEDERAL LAWS AFFECTING YOUR BENEFITS

FEDERAL LAWS AFFECTING YOUR BENEFITS

COBRA CONTINUATION OF COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), allows former employees and dependents to continue their health coverage under this Plan in certain circumstances beyond the date on which their coverage would otherwise have ceased. If COBRA applies, you may be able to temporarily continue coverage under the Plan beyond the point at which coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage may 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 Plan is lost because of a qualifying event.

COBRA coverage can be particularly important for several reasons. First, it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it. Second, it can prevent you from incurring a break in coverage (persons with 63-day breaks in creditable coverage may be required to satisfy pre-existing condition exclusion periods if they obtain health coverage elsewhere). And third, it could allow you to qualify for coverage under the Alabama Health Insurance Program (AHIP). See the section below titled "When COBRA Coverage Ends" for additional information. You do not have to demonstrate evidence of insurability to qualify for COBRA coverage.

You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the Plan changes. If the City of Mobile stops providing health care through Blue Cross Blue Shield of Alabama, Blue Cross Blue Shield of Alabama will stop administering your COBRA benefits. If this happens, you should contact the Human Resources Department to determine if you have further rights under COBRA.

COBRA RIGHTS FOR EMPLOYEES: If you are an Eligible Employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events happens: (1) your hours of employment are reduced, or (2) your employment ends for any reason other than your 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, apart from COBRA, the City of Mobile continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the Plan), the extended coverage you receive will reduce the time period over which you may buy COBRA benefits.

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 your employer that you do not intend to return to work, whichever occurs first.

COBRA RIGHTS FOR DEPENDENT SPOUSES: If you are covered under the Plan as a spouse of an Eligible Employee, you will become a qualified beneficiary if you would otherwise lose coverage under the Plan as a result of any of the following events: (1) your spouse dies; (2) your spouse's hours of employment are reduced; (3) your spouse's employment ends for any reason other than his or her gross misconduct; (4) your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or (5) you become divorced from your spouse.

If your spouse cancels your coverage in anticipation of divorce and a divorce later occurs, your divorce may be a qualifying event even though you actually lost coverage under the Plan earlier. If you timely notify the Human Resources Department of your divorce and can establish that your spouse canceled your coverage in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce). See the section below titled "Notice of Qualifying Events" and "Notice Procedures" for more information about your responsibility to give timely notice of your divorce and the procedures for doing so.

COBRA RIGHTS FOR DEPENDENT CHILDREN: If you are covered under the plan as a dependent child of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events: (1) the parent-employee dies; (2) the parent-employee's hours of employment are reduced; (3) the parent-employee's employment ends for any reason other than his or her gross misconduct; (4) the parent-employee becomes enrolled in Medicare (under Part A, Part B, or both); (5) your parents become divorced; or (6) you lose Eligible Dependent status under the Plan.

If you are a child of the Eligible Employee or former Employee and you are receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order, you are entitled to the same rights under COBRA as a dependent child of the covered employee.

LENGTH OF COVERAGE FOR DEPENDENTS: If you are an Eligible Dependent, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time.

If, however, the covered employee became enrolled in Medicare before the end of his or her employment or reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last. For example, if an Eligible Employee becomes enrolled in Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event that is termination of employment (36 months minus 8 months).

NOTICE OF QUALIFYING EVENTS: You will be offered COBRA coverage only after the Human Resources Department has been notified that a qualifying event has occurred. When the qualifying event is a divorce or a child losing dependent status under the Plan, you must timely notify the Human Resources Department of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. Refer to the section below titled "Notice Procedures" for information about the notice procedures you must use to give this notice. If you do not follow these notice procedures or if you do not give the Human Resources Department notice of your divorce or a child losing dependent status under the plan within the 60-day notice period, you will not be permitted to buy COBRA coverage as a result of divorce or a child losing dependent status.

EXTENSION OF COVERAGE FOR DISABILITY: In certain circumstances you can take advantage of a special disability extension. 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 Human Resources Department, the 18-month period of COBRA coverage for the disabled person may be extended 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 spouses and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under "Extension of COBRA for a Second Qualifying Event" for additional information.

For this disability extension of COBRA coverage to apply, you must give the Human Resources Department 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, or (3) the date of Social Security's determination.

You must also notify the Human Resources Department within 30 days of any revocation of Social Security disability benefits. See the section below titled "Notice Procedures" for additional information. If you do not follow these notice procedures or if you do not give the Human Resources Department notice of Social Security's disability determination within the required notice period, you will not be entitled to this disability extension of COBRA coverage.

EXTENSION OF COBRA FOR A SECOND QUALIFYING EVENT: In certain circumstances spouses and children can take advantage of a special second qualifying event extension. For spouses and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the Human Resources Department timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to spouses and children receiving COBRA coverage if the covered Employee or former Employee dies, becomes enrolled in Medicare (under Part A, Part B, or both), or gets divorced, or if the child stops being eligible under the plan as an Eligible Dependent, but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred. For example, if an Eligible Employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because, for almost all plans that are subject to COBRA, this event would not cause the spouse or dependent children to lose coverage under the Plan if the covered employee had not been terminated from employment.

NOTICE OF SECOND QUALIFYING EVENTS: For this 18-month extension to apply, you must give the Human Resources Department timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the section below titled "Notice Procedures" for additional information. If you do not follow these notice procedures or if you do not give the Human Resources Department notice of the second qualifying event within the required 60-day notice period, you will not be entitled to an extension of COBRA coverage as a result of the second qualifying event.

NOTICE PROCEDURES: Any notices that you give must be in writing. Verbal notice, including notice by telephone, is not acceptable. Your notice must be received by the Human Resources Department no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the Plan and for your notice of a second qualifying event, you must mail or hand deliver your notice to the Human Resources Department at the address listed on page 1 of this booklet. Your notice must state (1) the name of the Plan, (2) the Eligible Employee's or Retiree's name and address, (3) the name(s) and address(es) of all qualified beneficiary(ies), (4) the initial qualifying event and the date of the event, and (5), when applicable, the second qualifying event and the date of the event. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree.

For your notice of Social Security's disability determination, if you are instructed to send your COBRA premiums to Blue Cross, you must mail or hand deliver your notice to Blue Cross Blue Shield of Alabama at the following address: Blue Cross, Attention: Customer Accounts, 450 Riverchase Parkway East, Birmingham, AL 35298-0001, or fax your notice to Blue Cross at (205) 220-6884 or (toll-free) 1-888-810-6884.

Your notice must state (1) the name of the Plan, (2) the Eligible Employee's or Retiree's name and address, (3) the name(s) and address(es) of all qualified beneficiary(ies), (4) the qualifying event and the date of the event, (5) the name of the disabled person, (6) the date the disabled person became disabled, and (7) the date of Social Security's determination of disability. Your notice must also include a copy of Social Security's disability determination.

ADDING NEW DEPENDENTS TO COBRA: You may add new dependents to your COBRA coverage under the same eligibility rules that apply to Eligible Employees. In addition, except as explained below, any new dependents that you add to your coverage will not have independent COBRA rights. That means, for example, that if you die, they will not be able to continue coverage.

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

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the Human Resources Department of Social Security's disability determination as explained above. The election should be made on the child's behalf by the child's legal guardian.

MEDICARE & COBRA COVERAGE: If you are eligible for both Medicare and COBRA coverage, you should consider whether it is more beneficial to purchase a Medicare supplement contract instead of COBRA coverage. Your COBRA coverage may be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Parts A or B of Medicare. This means that, regardless of whether you have enrolled in Medicare, your COBRA coverage may not cover most of your hospital and medical expenses. If you think you will need both Medicare and COBRA, you should enroll in Medicare on or before the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your retirement or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months. If you do not enroll in Medicare on or before the date on which you make your election to buy COBRA coverage, your COBRA benefits will end when your Medicare coverage begins.

Your covered dependents will have the opportunity to continue their own COBRA coverage. If you do not want both Medicare and COBRA for yourself, your covered family members will still have the option to buy COBRA.

COBRA ELECTION RULES: After the Human Resources Department receives timely notice that a qualifying event has occurred, the Human Resources Department is responsible for (1) notifying you that you have the option to buy COBRA, and (2) sending you an application to buy COBRA coverage.

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 plan, or (2), the date on which the Human Resources Department 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 postmarked when sent back to the Human Resources Department.

Once the Human Resources Department has notified the Claims Administrator that your coverage under the Plan has ceased, the Claims Administrator will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, the Claims Administrator will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the Plan ends and the time the Claims Administrator learns of your loss of coverage, it is possible that claims incurred during the 60-day election period may be paid. If this happens, you should not assume that you have coverage under the Plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time. Should you not elect COBRA you will be responsible for claims incurred.

EARLY TERMINATION OF COBRA COVERAGE: Your COBRA coverage will terminate early if any of the following events occurs: (1) the Employer no longer provides group health coverage to any of its Employees; (2) you do not pay the premium for your continuation coverage on time; (3) after electing COBRA coverage, you become covered under another group health plan that does not contain any exclusion or limitation on any pre-existing condition you may have or you have sufficient creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you; (4) after electing COBRA coverage, you become enrolled in Medicare (under Part A, Part B, or both); or, (5) you are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

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

If you are buying COBRA coverage and you become covered under a group health plan that contains a pre-existing condition limitation or exclusion that does apply to you (for example, you do not have enough creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you), you should discuss the situation with the sponsor of the new plan (usually the new employer) to determine whether it makes sense for you to enroll in the new plan while continuing to pay for COBRA coverage at the same time. Since some plans limit the circumstances under which employees and their families may enroll, it is best to consult with the new employer concerning the interaction of COBRA and the new employer's group health coverage.

CHANGES IN COBRA BENEFITS: COBRA benefits will change when benefits under the Plan change. By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the Employer changes the group coverage, coverage will also change for you.

COBRA PREMIUM PAYMENT: Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the Human Resources Department to confirm the correct amount of your first payment.

After you make your first payment for COBRA coverage, you must make periodic payments for each subsequent coverage period. Each of these periodic payments is due on the first day of the month for that coverage period. There is a grace period of 30 days for all premium payments after the first payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the Plan only when the periodic payment is received. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

Payment of your COBRA premiums is deemed made on the day post-marked.

WHEN COBRA COVERAGE ENDS: If you exhaust your COBRA coverage you may buy a conversion health contract from Blue Cross. Contact Blue Cross to determine whether a conversion contract is available. Conversion contracts have more limited coverage than COBRA coverage.

You may also qualify for coverage under state law or through The Health Insurance Marketplace. In Alabama, you can continue coverage through the Alabama Health Insurance Plan (AHIP). You can reach AHIP by calling the State Employees' Insurance Board in Montgomery. In other states, you should call the state insurance department.

If you elect to buy a conversion contract instead of enrolling in AHIP, you will not be able to enroll at a later date in AHIP. You may also qualify for a tax subsidy to assist with paying premiums for coverage purchased through The Health Insurance Marketplace at www.healthcare.gov.

By contrast, if COBRA coverage ends because you stop paying for it, then you will not have any further coverage under the group health plan and you will not be eligible to buy conversion coverage (if available) and you may not qualify for continued coverage under any applicable state law program. For example, in Alabama, you would not qualify for continued coverage under AHIP.

If you have any further questions about COBRA or **if you change marital status, or you or your spouse or child changes address, please contact the Human Resources Department.** Additional information about COBRA can also be found at the website of the Employee Benefits Security Administration of the United States Department of Labor, www.dol.gov/ebsa.

CERTIFICATES OF CREDITABLE COVERAGE: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) creates a concept known as "creditable coverage." Your coverage under this Plan is considered creditable coverage. If you have sufficient creditable coverage under this Plan and you do not incur a break in coverage (63 continuous days of no creditable coverage), you may be able to reduce or eliminate the application of a pre-existing illness exclusion in another health plan. At any time up to 24 months after the date on which your coverage ceases, you may request a copy of a certificate of creditable coverage. To request this certificate, you or someone on your behalf must call or write Blue Cross Blue Shield of Alabama Customer Service.

FAMILY AND MEDICAL LEAVE

You may be eligible for family or medical leave and to continue health coverage if you have been employed for at least 12 months, and have worked a minimum of 1,250 hours during the 12 month period immediately preceding the commencement of the leave.

If you become eligible for a family or medical leave in accordance with the Family and Medical Leave Act of 1993 (FMLA) as amended, your health coverage may be continued for a maximum of 12 weeks during a 12 month period. The FMLA also provides certain military family leave entitlements. Eligible employees may take FMLA leave for specified reasons related to certain military deployments of their family members and may take up to 26 weeks of FMLA leave in a single 12-month period to care for a covered service member with a serious injury or illness. You may be eligible for FMLA leave for any of the following reasons:

1. The birth of a son or daughter, and to bond with the newborn child;
2. The placement with the employee of a child for adoption or foster care, and to bond with that child;
3. To care for an immediate family member (spouse, child, or parent – but not a parent "in-law") with a serious health condition;
4. To take medical leave when the employee is unable to work because of a serious health condition;
5. For qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on covered active duty or call to covered active duty status as a member of the National Guard, Reserves, or Regular Armed Forces.

Under FMLA, a "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

To qualify for continuation of health and dental coverage under FMLA, you must notify your immediate supervisor and the Human Resources Department of your intention to take an FMLA leave, 30 days in advance of a foreseeable leave, and as soon as practicable of taking an unplanned leave. The employee must comply with the City's normal call-in procedure.

To continue coverage during your FMLA leave, you must continue to pay the Contribution.

You and your Eligible Dependents are subject to all provisions and limitations of the Plan during your leave; anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA. If there are any changes to the Plan during your leave, you will be notified in writing.

Continuation of coverage under FMLA terminates the earlier of:

1. The date you return to work.
2. The date you notify your supervisor you are not returning, in which case this date will be considered your COBRA qualifying event.
3. The first day of the month for which you fail to make payment of the Contribution within a 30-day grace period.
4. The date coverage has been continued for a maximum of 12 weeks or 26 weeks in the case of military leave provisions.

If you are considering FMLA leave, or believe you qualify for FMLA leave, you should contact your supervisor and the Human Resources Department for additional information.

NATIONAL DEFENSE AUTHORIZATION ACT

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

UNIFORMED SERVICES LEAVE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) applies to Employees who perform duty, voluntarily or involuntarily, in the Uniformed Services.

The Uniformed Services include the U.S. Army, Navy, Marine Corps, Air Force, Coast Guard, Army National Guard, Air National Guard and Public Health Service Commissioned Corps, and any other category of persons designated by the President of the United States in time of war or emergency.

Uniformed Service includes active duty, active duty training, inactive duty training, and any time away from employment for the purpose of an examination to determine fitness for duty.

Eligible Employees who will be absent from employment for more than 30 days due to Uniformed Services duty may elect to continue coverage for themselves and their Eligible Dependents for up to 24 months. Employees who will be absent for less than 30 days will have their coverage continued under the same provisions as if they had remained under active employment.

If you are eligible for rights under USERRA, you must follow the procedure provided below:

1. Notify the Human Resources Department that you are leaving your job for temporary duty in the Uniformed Services. You may notify the Human Resources Department verbally or in writing, but you must do so in advance of leaving employment unless it is an emergency call-up or impossible by military necessity.
2. Notify the Human Resources Department of your intention to continue your health and dental coverage under USERRA. You will be notified in writing of the required Contribution to maintain coverage under the Plan.

3. Make arrangements to pay monthly, or make payment in advance of the required Contribution to maintain coverage.

In the event you choose not to pay the Contribution during your leave, your coverage will not be continued during the leave. Following your discharge from Uniformed Service, you may be eligible to apply for re-employment in accordance with USERRA.

You will be able to reinstate your coverage on the day you return to work, subject to all provisions of the Plan in effect at the time your coverage reinstates.

Continuation coverage under USERRA terminates the earlier of:

1. The date you return to work.
2. The date you notify your supervisor you are not returning to work, in which case you may be eligible to continue coverage for any COBRA period remaining.
3. The first day of the month for which you fail to make payment of the required Contribution within a 30-day grace period.
4. The date coverage has been continued for a maximum of 24 months.

HEROES EARNINGS ASSISTANCE AND RELIEF TAX ACT OF 2008

The HEART ACT of 2008 provides a number of new required and permissive benefits under employer-sponsored benefit plans for individuals called to active duty from their civilian workplace. The HEART ACT provisions include: a) individuals who die during qualified military service must be treated as having been actively employed on the date of their death; b) employers may provide additional benefit accruals and contributions to individuals who die during qualifying military service; c) employer may allow employees who are called to active duty to receive a cash distribution from a health flexible spending account equal to the balance in the account before the end of the plan year.

CHILDREN'S HEALTH INSURANCE PLAN

Effective April 1, 2009, an employee or dependent who loses coverage under Medicaid or a State Children's Insurance Plan (CHIP) because of loss of eligibility for coverage may enroll in the Plan provided the employee or dependent requests enrollment within 60 days of the termination of coverage. An employee or dependent who becomes eligible for premium assistance under Medicaid or CHIP for coverage under the Plan may also enroll in the Plan provided that the employee or dependent request enrollment within 60 days of becoming eligible for such premium assistance. Coverage will be effective no later than the first day of the first calendar month beginning after the date the Plan receives the request for a Special Enrollment. A member who enrolls under this paragraph is called a "special enrollee."

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan will, under certain circumstances, provide coverage for children named in a court order as your dependents. If you receive such an order, in cases of divorce or assignment of paternity, it should be submitted to the Human Resources Department for review to determine that it is a Qualified Medical Child Support Order (QMCSO).

A QMCSO is any judgment, decree or order, including approval of a settlement agreement, issued by a court of competent jurisdiction which:

1. Relates to health benefits and provides for the named child(ren)'s health benefit coverage under the Employee's plan of benefits, pursuant to a state domestic relations law, community property law, or enforcement of a law relating to medical child support as described in Section 1908 of the Social Security Act;
2. Creates or recognizes the existence of the named child(ren)'s right to be enrolled and receive medical benefits under the Employee's plan of benefits;
3. States the period to which the order applies;

4. States the name and last known mailing address of the Employee and each child covered by the order; and
5. Does not require this Plan to provide any type or form of benefit or any option not otherwise provided by the Plan.

A medical child support order must be filed with the Human Resources Department within 60 days of the date of the order to be considered by the Plan. When the Human Resources Department receives a medical child support order, the order will be reviewed to determine if it meets the definition of a QMCSO. Within 30 days of receipt of the order, or within a reasonable time thereafter, written notice will be provided to the Employee of the Plan's decision. This notice will also be sent to the other party or representative named in the order.

If a determination is made that the order is not qualified, the notice will provide the specific reasons for that decision and the opportunity to correct the order or appeal the decision.

A medical support order filed on behalf of the Employee's stepchild, who is not permanently residing in the home of the Employee, is not a QMCSO under this Plan.

If a determination is made that the order is a QMCSO, the notice will provide instructions for enrolling each child named in the order, and the Plan provisions, limitations and exclusions that apply. The Employer will impose a payroll deduction for Dependent Coverage, if applicable.

This will be considered a Change-In-Status Event for the purpose of enrolling the child(ren) with an Effective Date the first of the month following the date of the QMCSO.

As part of its authority, the Plan has the discretion and final authority to decide if an order meets or does not meet the definition of a QMCSO, and the decision will be binding and conclusive on all persons. If the order requires that expenses for Covered Services, when reimbursed, be paid to the child's custodial parent, legal guardian, or someone other than the Employee, these expenses will be reimbursed to the individual identified in the QMCSO.

PRIVACY NOTICE

This notice gives you information required by law about the duties and privacy practices of the Plan to protect the privacy of your medical information. The Plan receives and maintains your medical information in the course of providing benefits to you. The Plan hires business associates to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan. The City of Mobile is the Plan Sponsor.

The Plan is required to follow the terms of this notice until it is replaced. The Plan reserves the right to change the terms of this notice at any time. If the Plan makes changes to this notice, the Plan will revise it and send a new notice to all subscribers covered by the Plan at that time. The Plan reserves the right to make the new changes apply to all your medical information maintained by the Plan before and after the effective date of the new notice. The effective date of the following Privacy Notice is September 23, 2013.

This Notice applies to the health benefits provided by the City of Mobile Health & Dental Plan, hereafter referred to as "the Plan." References to "we" and "us" throughout this Notice mean the Plan. This Notice has been drafted to comply with the HIPAA Privacy Rules under federal law. Any terms that are not defined in this Notice have the meaning specified in the HIPAA Privacy Rules.

How We Protect Your Privacy

We are required by law to protect the privacy of your Protected Health Information (PHI), to provide you with this notice of our privacy practices and to notify you if there has been a breach of your unsecured PHI. We will not disclose confidential information without your authorization unless it is necessary to provide your health benefits and administer the Plan, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this Notice.

We maintain and have procedures for accessing and storing confidential records. We restrict internal access to your confidential information to employees who need that information to provide your benefits. We train those individuals on policies and procedures designed to protect your privacy. Our Privacy Officer monitors how we follow those policies and procedures and educates our organization on this important topic.

How We May Use and Disclose Your PHI

We will not use confidential information or disclose it to others without your written authorization, except for the purposes detailed below. When required by law, we will restrict disclosures to the Limited Data Set, or otherwise as necessary, to the minimum necessary information to accomplish the purpose.

Treatment: We may disclose your PHI to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your PHI to a health care provider when the provider needs that information to provide treatment to you. We may also disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

Payment: We may use or disclose your PHI to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your PHI to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your PHI to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the services provided to you. We may also use and disclose your PHI to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your PHI to adjudicate your claims. Also, we may disclose your PHI to other health care providers or entities that need your protected health information to obtain or provide payment for your treatment.

Health Care Operations: We may use or disclose your PHI health information for our health care operations. We may use or disclose your PHI to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. Please note that we will not use any of your genetic information when performing underwriting activities.

We may use or disclose your PHI to provide you with customer service activities or develop programs. We may also provide your PHI to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your PHI to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your PHI to these entities if they have or have had a relationship with you and your PHI pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

Disclosures to the Plan Sponsor: The City of Mobile is the Plan sponsor. We may disclose your PHI to the Plan sponsor. The Plan sponsor is not permitted to use PHI for any purpose other than the administration of the Plan. The Plan sponsor must certify, among other things, that it will only use and disclose your PHI as permitted by the Plan, it will restrict access to your PHI to those individuals whose job it is to administer the Plan and it will not use PHI for any employment-related actions or decisions. The Plan may also disclose enrollment information to the Plan sponsor. The Plan may also disclose summary health information to the Plan sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan.

Disclosures to Business Associates: We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your PHI to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

Disclosures to Family Members or Others: Unless you object, we may provide relevant portions of your PHI to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose PHI (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

Other Uses and Disclosures: The law allows us to disclose protected health information without your prior authorization in the following circumstances:

1. **Required by law:** We may use and disclose your PHI to comply with the law.
2. **Public health activities:** We will disclose PHI when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.
3. **Reports about victims of abuse, neglect or domestic violence:** We will disclose your PHI in these reports only if we are required or authorized by law to do so, or if you otherwise agree.
4. **To health oversight agencies:** We will provide PHI as requested to government agencies that have the authority to audit or investigate our operations.
5. **Lawsuits and disputes:** If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the PHI requested.
6. **Law enforcement:** We may release PHI if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).
7. **Coroners, medical examiners and funeral directors:** We may disclose PHI to facilitate the duties of these individuals.
8. **Immunization Records:** We may disclose immunization records to schools where state law allows for such disclosures.
9. **Organ procurement:** We may disclose PHI to facilitate organ donation and transplantation.
10. **Medical research:** We may disclose PHI for medical research projects, subject to strict legal restrictions.
11. **Serious threat to health or safety:** We may disclose your PHI to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.
12. **Special government functions:** We may disclose PHI to various departments of the government such as the U.S. military or U.S. Department of State.
13. **Workers' compensation or similar programs:** We may disclose your PHI when necessary to comply with worker's compensation laws.

Uses and Disclosures With Your Written Authorization

We will not use or disclose your PHI for any purpose other than the purposes described in this Notice without your written authorization. For example, we will not (1) supply PHI to another company for its marketing purposes (unless it is for certain limited Health Care Operations), (2) sell your PHI (unless under strict legal restrictions), (3) sell your PHI for marketing purposes, (4) disclose your psychotherapy notes or (5) provide your PHI to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions we already have taken.

Right to inspect and copy your protected health information: Except for limited circumstances, you may review and copy your protected health information. Your request must be addressed to the Privacy Officer. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

If you request copies of your PHI, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your PHI, upon your request if you agree to the rules and cost (if any) in advance.

Right to correct or update your protected health information: If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Privacy Officer. To process your request, you must use the form we provide and explain why you think the amendment is appropriate.

We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

We may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person who created the information is no longer available to make the amendment;
2. Is not part of the protected health information we keep about you;
3. Is not part of the protected health information that you would be allowed to see or copy; or
4. Is determined by us to be accurate and complete.

If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your PHI.

Right to obtain a list of the disclosures: You have the right to get a list of PHI disclosures, which is also referred to as an accounting. You must make a written request to the Privacy Officer to obtain this information.

The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, disclosures to law enforcement personnel or disclosures made before April 14, 2003. The list we provide will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Right to choose how we communicate with you: You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Right to request additional restrictions on health information: You may request restrictions on our use and disclosure of your PHI for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket, unless otherwise required by law.

Right to be notified of a breach: You have the right to be notified if there is a breach of your unsecured protected health information, as defined under the HIPAA Privacy Rules.

Questions and Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services.

To file a complaint with us, put your complaint in writing and address it to the Privacy Officer listed below. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

Future Changes to Our Practices and This Notice

We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the Human Resources Department.

CREDITABLE DRUG COVERAGE NOTICE - PRESCRIPTION DRUG COVERAGE & MEDICARE

APPLIES TO ACTIVE EMPLOYEES AND DEPENDENTS ELIGIBLE FOR MEDICARE

Please Read this notice carefully - it explains the options you have under the Medicare prescription drug plan and can help you decide whether or not you want to enroll.

This notice has information about your current prescription drug coverage with the City of Mobile Health Plan (the Plan) and the prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

This information applies to active employees and covered dependents eligible for Medicare – it does not apply to Retirees and their dependents.

The City of Mobile has determined that the prescription drug coverage offered by the Plan is, on average, expected to pay out as much as the standard Medicare prescription drug plan will pay.

Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is, on average, at least as good as the standard Medicare prescription drug plan, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

The City of Mobile Health Plan actually offers Medicare-eligible participants a Health Plan that provides greater benefits for prescription drugs than does the Medicare Part D prescription drug benefit. The Plan offers valuable coverage for other health care services that may or may not be covered by Medicare.

There is no benefit on average for a participant to take the Medicare Part D benefit and pay an extra premium for that benefit.

Each year you will have the opportunity to enroll in a Medicare prescription drug plan from October 15th through December 31st.

However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

If you do decide to enroll in a Medicare prescription drug plan and drop the Plan coverage, be aware that you will not be able to get this coverage back at a later date. You should compare your current coverage with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You should also know that if you drop or lose your coverage with the Plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage, that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up 1% per month for every month you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll.

For more information about this notice or your current prescription drug coverage, contact the Human Resources Department. You may receive this notice at other times in the future such as before the next period you can enroll in a Medicare prescription drug plan and if this coverage changes. You may also request a copy.

For more information about your options, read the "Medicare & You" handbook from Medicare. You will get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see the Medicare & You handbook for their telephone number),
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help, visit SSA online at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

ANNUAL FEDERAL NOTICES

Each year the Plan sends to all participants the Annual Federal Notices. New employees receive this notice with enrollment information. Contained in the Annual Federal Notices:

- ▲ Medicare Creditable Drug Coverage Notice
- ▲ Summary of Benefits and Coverage
- ▲ Children's Health Insurance Program Notice
- ▲ Information on the Affordable Care Act
- ▲ Where to obtain Privacy Policies
- ▲ Information on the City's "opt-out" of certain federal acts and the affect on benefits including:
  - ✓ Mental Health Parity Act of 1996 and Mental Health Parity and Addiction Equity Act of 2008
  - ✓ Health Insurance Portability & Accountability Act
  - ✓ Newborns' and Mothers' Health Protection Act
  - ✓ Women's Health and Cancer Rights Act
  - ✓ Michelle's Law

A copy of the notice may be obtained from the City's Human Resources Department.

THE PLAN'S OPT-OUT OF SOME FEDERAL REGULATIONS

The Plan has elected to opt-out of certain federal regulations including: the Health Insurance Portability & Accountability Act of 1996 (HIPAA), as amended by the Affordable Care Act; the Newborns' & Mothers' Health Protection Act of 1996 (NMHPA); the Mental Health Parity Act of 1996 (MHPA); the Mental Health Parity & Addiction Equity Act of 2008; and Michelle's Law (2008). The Plan does comply with the HIPAA provisions for special enrollment rules and the discrimination based on health status rules.

HEALTH FLEXIBLE SPENDING ACCOUNT

FLEXIBLE SPENDING ACCOUNT

USING PRE-TAX DOLLARS FOR EXPENSES

The City of Mobile sponsors an employee benefit program for active Employees known as a Health Flexible Spending Account (FSA). The Health FSA allows you to set aside a certain amount of your pay each year, on a pre-tax basis, for health-related expenses not reimbursed by any other program or plan. You then use pre-tax dollars to reimburse yourself for Out-of-Pocket health care expenses. Participation in the FSA is voluntary.

Under the FSA, your contribution will be deducted from your paycheck. Your contribution will be deducted from your pay before taxes. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary reduction.

This is a summary of the FSA. You can obtain additional information and forms at:

www.HealthEquity.com/QME **info@healthequity.com** **or call 1-877-288-0719**

CITY OF MOBILE HUMAN RESOURCES DEPARTMENT (251) 208-7059

PARTICIPATION IN THE PLAN

You may participate in the FSA if you are an Employee. You do not have to enroll in the Health & Dental Plan to participate in the FSA.

Each year the City determines the maximum amount that Employees may contribute to the FSA. During the Open Enrollment Period, usually the month of November, you may complete an election form determining the amount, up to the maximum, that you wish to contribute to your FSA beginning the first of the following year. The amount you elect will be divided equally depending on your pay schedule and will be deducted from your pay before taxes are withheld. This amount will be deposited into your spending account.

USE-IT-OR-LOSE-IT POLICY

The FSA can save you money by using pre-tax dollars and can benefit you by allowing you to save for health care expenses that are not covered by your Plan. However, the amount you choose to contribute requires careful planning. **Money you contribute to your FSA must be used during the Calendar Year.** Money left in an account does not carry over to the next year, and is not refundable at the end of the year. In other words, if you do not use it, you will lose it.

ELIGIBLE EXPENSES

Your Health FSA can be used to reimburse you for your own expenses, as well as those of your eligible dependents, as long as the expenses are:

1. Amounts paid for "medical care" as described in Internal Revenue Code Section 213(d);
2. Not reimbursable under any other health plan in which you participate; and
3. Incurred after the date of your enrollment and during the Calendar Year; however, if your employment terminates during the Calendar Year, health care expenses must be incurred before your termination date (unless you elect continuation of coverage under COBRA).

Expenses eligible under the FSA program are those not paid in full under any health care plan in which either you or your Eligible Dependents participate, including Deductibles, Copays, Copayments, and charges over the Allowed Amount. Eligible expenses do not include health, dental or life insurance premiums.

The following are examples of health care expenses that are reimbursable by the Health FSA. This is a partial list extracted from IRS publications and is subject to change. Eligible health care expenses include:

- acupuncture
- ambulance transportation expenses
- artificial limbs
- artificial teeth
- birth control pills
- braille books and magazines
- car controls for handicapped
- chiropractors
- Christian Science practitioners
- contact lenses
- crutches
- dental fees
- doctors' fees
- drug and alcohol addiction treatment
- eyeglasses eye examinations, and laser eye surgery
- fertility enhancement
- guide dogs
- hearing aids and hearing aid batteries
- hospital services
- lab fees
- lead-based paint removal
- learning disability tuition
- nursing services
- optometrists
- oxygen
- psychoanalysis
- special schools for the handicapped
- sterilization
- surgery (other than cosmetic surgery)
- therapy (medical)
- transplants of organs
- transportation to/from health care provider
- weight-loss plans prescribed by a Physician to treat a specific disease
- wheelchairs
- x-rays
- prescribed medicines, over the counter medicines with a doctor's prescription, and insulin

For a more complete list of eligible expenses, consult your personal tax advisor or refer to IRS publication 502, Medical and Dental Expenses which contains a list of Deductible expenses. This publication can be obtained through your local IRS office or accessed over the internet at –

www.irs.gov/pub/irs-pdf/p502.pdf

NOTE**:** Misuse of spending account funds is a violation of Internal Revenue Service regulations.

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Although the Health FSA covers a wide variety of health care expenses, there are some expenses that are not eligible for payment. For example, expenses you incur in connection with activities that are merely beneficial to your general health and not directly related to specific health care are not reimbursable. And, as already noted, eligible expenses do not include health, dental, or life insurance premiums. Other types of health care that are not eligible include:

1. Expenses incurred for health clubs, spas and weight loss programs (unless prescribed by a physician solely for the purpose of treating an illness or accident);
2. Expenses for which you receive benefits from any health, dental, vision or other health care plan;
3. Most kinds of cosmetic health services and supplies (unless medically necessary and not covered by a health plan), hair transplants, electrolysis, and teeth whitening;
4. Dietary and herbal supplements such as vitamins, fiber, and minerals (unless prescribed by a physician solely for the purpose of treating an illness).

Expenses are eligible for reimbursement under the FSA only if they are expenses paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

REIMBURSEMENT PROCEDURE

Your FSA is administered by HealthEquity. Out-of-Pocket expenses under the Health Plan such as copays and deductibles for Eligible Employees and their Eligible Dependents must be filed in writing with HealthEquity and must include any required documentation. In addition, you will be able to file to reimburse yourself from your FSA for expenses for approved non-Covered Services (such as over-the-counter drugs and eyeglasses). You also have the option of using the HealthEquity **Visa Reimbursement Account Card** for qualified expenses. This is a debit card issued by The Bancorp Bank with a balance equal to your FSA allocation election.

You may obtain a Request for Reimbursement form from the website **www.HealthEquity.com**. Simply fill it out and attach the Explanation of Benefits (EOB) forms, bills, invoices, receipts, or other supporting statements showing the amount of the health-related expenses for which you are claiming reimbursement. Send the Request for Reimbursement form and attachments to –

HealthEquity
15 West Scenic Pointe Drive, Suite 100
Draper, UT 84020

Info@healthequity.com
www.HealthEquity.com

If the Health Equity receives a submission that does not qualify as a Request for Reimbursement, it will notify you of the additional information needed.

Requests for Reimbursement for eligible expenses incurred in a Calendar Year must be submitted by the close of the calendar year. After the close of that period any money in the account is forfeited unless subject to a properly filed Request for Reimbursement or appeal.

SECTION 125 PREMIUM CONVERSION PLAN

SECTION 125 PREMIUM CONVERSION PLAN

The City of Mobile sponsors an employee benefit program for active Employees known as a Section 125 Premium Conversion Plan. The purpose of the Plan is to increase your spendable income by reducing your taxes. Current tax legislation allows employers to offer Employees the benefit of having their Employee Contribution for qualified benefit plans deducted from their paychecks before taxes are taken out. Participation in the Section 125 Premium Conversion Plan is automatic, unless you elect not to participate.

Under the Premium Conversion Plan, your cost will be deducted from your paycheck. The difference is that your cost will be deducted from your pay before taxes. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary reduction.

PARTICIPATION IN THE PLAN

You may participate in the Section 125 Premium Conversion Plan if you are an employee of the Employer who is eligible to participate in the City of Mobile Health & Dental Plan. You become a participant in the Section 125 Premium Conversion Plan at the time you enroll in the Health & Dental Plan.

You may request a benefit election form from the Human Resources Department during the Open Enrollment Period. At that time you may confirm or change your choices made from the previous 12 month period for the coming 12 months beginning on the first day of the next Calendar Year. You may at that time elect to terminate your participation in the Section 125 Premium Conversion Plan, with changes effective the first of the following Calendar Year. If you fail to file a benefit election form as required, you shall be deemed to have elected to continue the same coverage by the same proportion of pre-tax or after-tax premiums then in effect.

The City of Mobile also allows the Mobile Public Library, Emergency Management Agency and Mobile Museum Board to participate in the City of Mobile Health & Dental Plan for eligible employees. If you are an employee of one of these employers you must check with your employer to obtain information on its Section 125 Premium Conversion Plan.

ENROLLMENT PERIODS

The Open Enrollment Period usually begins on November 1st of each year and ends on November 30th of each year, for coverage effective at the beginning of the following Calendar Year.

BENEFITS OFFERED

The Section 125 Premium Conversion Plan permits you to pay your Employee Contribution for the City of Mobile Health & Dental Plan with pre-tax dollars through salary reduction rather than regular pay.

Since Social Security taxes are not withheld from Employee Contributions paid under the Section 125 Premium Conversion Plan, your Social Security retirement benefit may be slightly reduced.

Alternatively, you can pay for the same benefit with after-tax dollars on a salary deduction basis. If you elect not to participate in the plan, after-tax premium coverage will be funded by an amount deducted from your compensation which is sufficient to pay for the coverage after withholding any applicable federal, state, or Social Security taxes.

TERMINATION OF EMPLOYMENT

If your employment with the Employer is terminated during the Calendar Year, your active participation in the Section 125 Premium Conversion Plan will cease, and you will not be able to make any more contributions to the plan, other than as may be permitted under the COBRA continuation of coverage provision.

Your coverage under the City of Mobile Health & Dental Plan will terminate effective the first of the month for which no Employee Contribution was withheld from your paycheck.

CHANGE OF ELECTION

You may change your election for pre-tax premiums only during the Open Enrollment Period, which is usually the month of November each year, and then only for the coming Calendar Year. There is an important exception to this general rule: You may change or revoke your previous election for pre-tax premiums at any time during the Calendar Year due to a Change-In-Status Event, provided that both the revocation and new election are made on account of and are consistent with one of the following Change-In-Status Events:

1. A change in your marital status (marriage, divorce, or death of your spouse).
2. A change in the number of your dependents: birth or adoption of a child, death of a child, or obtaining legal custody of a child who permanently resides in your home and who is not a foster child, or obtaining legal guardianship.
3. A change in your employment status (starting/ending employment, changing from part-time to full-time or vice versa, taking or returning from an Approved Leave).
4. A change in your spouse's employment status (starting/ending employment, changing from part-time to full-time or vice versa, a strike or lockout, or your spouse taking or returning from an unpaid leave of absence or leave under the Family and Medical Leave Act or USERRA).
5. Exhaustion of your coverage period under a previous employer's COBRA continuation.
6. A significant change in the costs of or coverage provided by your spouse's employer-sponsored health plan.
7. A significant change in the costs of or coverage provided by this Plan.
8. A change in the eligibility status of a dependent child, child reaching the maximum age for coverage under the Plan.
9. An end to the Disability of a Disabled child enrolled as your dependent under the Plan.
10. A change in your residence or work site, or that of a spouse or dependent, which affects ability to access benefits under this or another employer-sponsored health plan.
11. A required change due to a court order.
12. Your, or your dependent's, entitlement to Medicare or Medicaid.

You must be able to provide written documentation to verify the Change-In-Status Event.

If you have a Change-In-Status Event and wish to change your election, you must submit an Application and Change-In-Status Event form to the Human Resources Department within **60 days** of the Change-In-Status Event. Failure to do so within 60 days will result in the changes in your election being applicable only to months during which, or after, you have notified the Human Resources Department.

No Contribution refunds can be made retroactive from the date the Change-In-Status Event Application has been received and approved by the Human Resources Department.

Elections for after-tax premiums through salary reduction outside of the Section 125 Premium Conversion Plan may be changed as permitted by the City of Mobile.

REVIEW PROCEDURE

A participant in the Premium Conversion Plan who believes that a service, expense or determination of eligibility has been wrongly denied in whole or in part may request a review pursuant to the Review Procedure as explained in this benefits booklet.

ADMINISTRATION

The Section 125 Premium Conversion Plan is administered by the City of Mobile. All costs associated with the administration of this plan are paid for by the City of Mobile.

DEFINITIONS

Certain words and terms have a specific meaning and are capitalized when used in this benefits booklet. It is important that you read this section to fully understand your benefits, rights and responsibilities under this Plan.

Definitions will help you understand the benefits provided by the Plan. A defined term does not mean that coverage is provided by the Plan. All benefits are subject to Plan provisions, limitations and exclusions as stated in this benefits booklet. The City of Mobile reserves the right to interpret the Plan, amend and terminate the Plan as determined to be necessary for the financial stability of the Plan.

DEFINITIONS

1. **Affordable Care Act (ACA), Patient Protection and Affordable Care Act (PPACA), the Act:** The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.
2. **Allowed Amount or Allowance:** See General Provisions.
3. **Application:** The Employee's or dependent's written application form requesting coverage under the Plan and authorizing the required Contribution along with all Required Documentation. The application requires all Eligible Dependents be listed by name and Social Security number with evidence of dependent status and other information as required by the Human Resources Department. Acceptance of the Application is evidenced by the issuance of an identification card or by other written notice of acceptance to the Employee.
4. **Approved Leave:** A leave of absence approved by the Employer that allows the Employee to continue coverage under Plan based on certain provisions and restrictions. An Approved Leave includes a leave of absence due to family or medical leave or Uniformed Services leave.
5. **Assisted Reproductive Technology (ART):** Any combination of chemical or mechanical means of obtaining gametes and placing them into a medium to enhance the chance that reproduction will occur. This includes but is not limited to: in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.
6. **Bariatric:** Refers to any service or expense to affect weight reduction or treat obesity including bariatric surgery, gastric restrictive procedures and complications arising from bariatric surgery and gastric restrictive procedures.
7. **Blue Cross Blue Shield Provider:** A Hospital, Physician, outpatient clinic, health center, pharmacy or other provider of medical services which has a written agreement with the Claims Administrator to provide services under the Plan.
8. **Calendar Year:** The calendar year period of January 1st through December 31st of any given year.
9. **Change-In-Status Event:** A change in the employment or personal status of an Employee or Eligible Dependent that permits or requires enrollment or termination of coverage during a Special Enrollment Period. The Human Resources Department must be notified within 60 days of a Change-In-Status Event.
10. **Claims Administrator (Administrator):** The entity retained by the City of Mobile to be responsible for the functions and administration of the Plan. The Claims Administrator is Blue Cross Blue Shield of Alabama.
11. **COBRA:** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which provides specific circumstances allowing a limited continuation of a Member's coverage beyond the date it would otherwise terminate and requires payment of a monthly premium.
12. **Complications of Pregnancy:** Any condition resulting in Hospital confinement, the diagnosis of which is distinct from pregnancy but is adversely affected or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar conditions of comparable severity, non-elective cesarean delivery, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible. False labor, occasional spotting, Physician prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and conditions associated with a difficult pregnancy are not Complications of Pregnancy.
13. **Contract Number:** Your Contract Number is an identifying number assigned by the Claims Administrator to your individual contract with Blue Cross Blue Shield of Alabama. Your Contract Number is on your ID card. It must be used when filing all claims.

14. **Contribution:** The amount required to be paid by the Employee, Retiree, Surviving Dependent or COBRA participant for single and/or Dependent Coverage. Only Members for whom the required Contribution is actually received by the City of Mobile (or Claims Administrator when required) shall be entitled to eligibility under the Plan. All rights of the Member under the Plan shall terminate as of the last day of the month for which the required Contribution has not been properly received by the City or the Claims Administrator.

15. **Cosmetic:** Any service, expense, or surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, Injury, or congenital anomalies. Improvement of physical bodily function does not include improvement of psychological effects caused by physical defects or conditions. The exclusion of Cosmetic treatment does not include Reconstructive Surgery. In some circumstances, a surgical procedure or a portion of a surgery may not be considered Cosmetic. You and your Physician are encouraged to contact the Claims Administrator prior to any treatment for determination of whether a procedure will be treated as Cosmetic or Reconstructive.

16. **Covered Services:** Includes only those services, supplies and expenses which are listed herein as eligible for reimbursement. Covered Services do not include any service, supply or expense which is not specifically stated as a Covered Service herein or eligible for reimbursement; any service, supply or expense which is specifically excluded; any amount in excess of the Allowed Amount; and any charge or amount in excess of a specifically stated limitation.

17. **Custodial Care:** Care comprised of services and supplies which are provided to assist in the activities of daily living for a Member who is mentally or physically Disabled.

18. **Dependent Coverage:** Coverage for an Eligible Dependent when the Employee has made Application, including all Required Documentation, and payment of the required Contribution.

19. **Disability or Disabled:** A total incapacitation resulting from an Illness or Injury which occurs while the individual is covered under this Plan and results in the complete inability of an Employee to perform any and every duty pertaining to any occupation or the complete inability of a dependent child to perform the activities of daily living of a person of like age and sex as evidenced by a Social Security Award Letter for entitlement to disability benefits.

20. **Durable Medical Equipment:** Equipment certified by the Claims Administrator as Medically Necessary to treat an Illness or Injury, to improve the functions of a malformed body member, or to prevent or retard further deterioration of the patient's medical condition. To be Durable Medical Equipment, an item must be: (1) made to withstand repeated use; (2) mainly for a medical purpose rather than for comfort or convenience; (3) useful only if the Member is sick or injured; (4) ordered and prescribed by a Physician for use in the Member's home; and (5) directly related to the patient's physical disorder. The Plan will consider the equipment as a Covered Service only when the item in question is the least costly available to provide Medically Necessary treatment (for example, a manually operated wheelchair rather than a motorized wheelchair). Durable Medical Equipment must be Pre-Certified by the Claims Administrator and must be provided by a Blue Cross Blue Shield Provider.

21. **Effective Date:** The date the Employee and/or Eligible Dependent becomes covered under the Plan based on the eligibility rules and approval of the written Application by the Human Resources Department. Verification of the Effective Date is made through issuance of an identification card or other written notification. Payment of the Contribution is not evidence or verification of the Effective Date.

22. **Eligible Employee:** An Employee who has made timely Application to the Human Resources Department for coverage and proper authorization for payroll deduction of the Employee Contribution and has had such Application approved and acknowledged through the issuance of an identification card or some other written notification of coverage.

23. **Emergency Admission:** An admission to a Hospital, made through the emergency department of the Hospital, when the Member requires immediate medical intervention as a result of a severe, life threatening or potentially disabling condition (a type 1 emergency as defined in the manual of the Health Care Financing Administration (Centers for Medicare and Medicaid Services).

24. **Employee:** An employee of the City of Mobile, Mobile Public Library, Emergency Management Agency, or the Mobile Museum Board and elected officials and approved administrative appointees. For purposes of explaining provisions of the Plan, the term Employee may also include Retirees and Surviving Dependents who participate in the Plan, unless stated otherwise.

25. **Contribution:** The amount required to be paid by the Employee, Surviving Dependent or COBRA participant for single and/or Dependent Coverage. Only Members for whom the required contribution, applicable funding rate, or COBRA premium is received by the Employer (or Claims Administrator when required) shall be entitled to eligibility under the Plan. All rights of the Member under the Plan shall terminate as of the last day of the month for which the required payment has been properly received.

26. **Employer:** The City of Mobile, Mobile Public Library, Emergency Management Agency, and the Mobile Museum Board.

27. **Experimental or Investigative:** Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies either not recognized by the Claims Administrator as having scientifically established medical value or not in accordance with generally accepted standards of medical practice. Covered Services include only technology or treatment which meet all of the following criteria: (1) have final approval from the appropriate governmental regulatory bodies for the specific use for which it is intended; (2) permit conclusions concerning the effect on health outcomes; (3) improve net health; (4) be as beneficial as any established alternatives; and (5) be classified and approved by the Claims Administrator.

28. **Extended Care Facility:** A Medicare-approved facility providing non-acute care for patients requiring 24-hour nursing services. An Extended Care Facility: (1) is engaged in providing skilled care under the supervision of Physicians; (2) maintains clinical records on all patients; (3) provides 24-hour nursing services; and (4) provides appropriate procedures for dispensing and administering drugs and is duly licensed. Facilities for custodial, domiciliary care, Mental Health or Substance Abuse treatment are not covered.

29. **Family and Medical Leave Act (FMLA):** The Family and Medical Leave Act of 1993, as amended, which requires that employers who offer group health coverage to their employees continue to make that coverage available while an Eligible Employee is on qualified leave.

30. **Generic Drug:** One that has been approved by the Food and Drug Administration (FDA) as therapeutically equivalent to the original "name brand" drug. The FDA approves the generic equivalent as interchangeable with the brand-name drug under all approved indications and conditions for use.

31. **Home Care Medical Supplies**: Medical supplies ordered by a Blue Cross Blue Shield Network Physician for home use and required due to chronic Illness, limited to only: oxygen, IV therapy solutions, crutches, splints, casts, trusses and braces, specialty dressings for open wounds, syringes and needles, blood glucose strips, lancets and glucose monitors, tubing kits for insulin pumps, catheters, colostomy bags, compression stockings and medical supplies required in conjunction with an authorized Home Health Care visit.

32. **Hospice Care:** Care provided by an agency or organization which: (1) administers and provides hospice care; (2) is licensed or certified as such by the state; and (3) meets the standards established by the National Hospice Organization. Hospice Care is a coordinated, interdisciplinary program to meet the physical, psychological, and social needs of Terminally Ill persons by providing palliative and supportive medical, nursing and other health services through home or inpatient care. Hospice Care may include short-term (limited to five days during any 90 day period) inpatient hospital stays required for the Terminally Ill person in order to give temporary relief to a caregiver who regularly assists with home care. Caregiver means only a person not associated with the hospice agency who resides in the home and provides non-medical services and companionship, including a family member. Hospice Care services must be Pre-Certified by the Claims Administrator. See the section on "Home Health Care - Benefit Limitation" for additional information.

33. **Hospital:** A facility licensed as a hospital, operated for the care and treatment of resident inpatients, which has a laboratory, registered graduate nurses always on duty and an operating room where major surgical operations are performed. In no event shall the term hospital include an institution or that part of an institution which is used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, drug addicts, or alcoholics.

34. **Illness:** A disease, disorder, or condition that requires treatment by a Physician, occurring while the Member is covered under the Plan.

35. **Injury or Accidental Injury:** A traumatic injury requiring immediate medical attention caused solely by accident occurring while the Member is covered under the Plan.

36. **Management Committee:** Those individual appointed by the Mayor of the City of Mobile. Current members include: Executive Director of Finance, Director of Human Resources, Deputy Director of Human Resources.

37. **Medical Emergency:** A life endangering Injury or a sudden unexpected onset of an Illness which requires immediate diagnosis or medical or surgical treatment. This condition must require that the Member seek immediate medical attention from the nearest available facility, and which if not performed without delay would jeopardize or impair the Member's life or health (a type 1 emergency or a type 2 urgent care condition as defined in the manual of the Health Care Financing Administration - Centers for Medicare and Medicaid Services).

38. **Medical Necessity or Medically Necessary:** Benefits are provided only for those services and supplies determined by the Claims Administrator to be Medically Necessary. To be Medically Necessary the service or supplies must be: (1) appropriate and necessary for the symptoms, diagnosis, and treatment of your medical condition; (2) provided for the diagnosis or direct care and treatment of your medical condition; (3) in accordance with standards of good medical practice accepted by the organized medical community~~;~~ (4) not primarily for the convenience and/or comfort of you, your family, your Physician, or another provider of services; (5) not Experimental or Investigative; (6) performed in the least costly setting, method, or manner, or with the least costly supplies required by your medical condition. Evidence to help determine whether the services are Medically Necessary may be required before benefits are provided. The fact that the treating physician finds that the treatment is medically necessary is not binding on the Plan. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

39. **Medicare:** Title XVIII of the Social Security Act, as amended, titled the Health Insurance for the Aged Act, which provides health benefits to participants based on age or disability.

40. **Member:** An Eligible Employee, Retiree or Eligible Dependent based on the established eligibility provisions and payment of the Contribution, for whom Application has been approved by the Human Resources Department.

41. **Mental Health Treatment:** Treatment for a mental condition which includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, irrespective of cause, basis or inducement) a mental disorder, mental Illness, psychiatric Illness, nervous condition, neurotic disorder, schizophrenic disorder, affective disorder, personality disorder, psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

42. **Morbid Obesity**: Morbid Obesity occurs when the individual is 100% over the medically desired weight and the obesity is a threat to the individual's life due to complicating health factors. The determination of whether treatment for Morbid Obesity will be a Covered Service is made based on guidelines of the Claims Administrator, and whether there is a documented history of unsuccessful attempts to reduce weight by more conservative measures. A Covered Service to treat Morbid Obesity through surgical means is limited to treatment by a Physician within the Claims Administrator's approved Network of Physicians for bariatric surgery and gastric restrictive procedures.

43. **Nursing Care**: Only intermittent services (less than an eight-hour shift) provided by a registered nurse, licensed practical nurse or home health aide who is not related to the Member nor regularly resides in the Member's household. The services must be ordered by a Physician and performed outside of a Hospital or any other acute care facility setting by a Blue Cross Blue Shield Provider. No benefits are provided for Custodial Care.

44. **Open Enrollment Period:** The one-month period, usually the month of November, during which Employees may enroll in the Plan and/or add Eligible Dependents for coverage beginning the first of the following Calendar Year. During this period Eligible Employees may terminate coverage for one or more dependents. This is also the period during which Eligible Employees may enroll or terminate participation in the Section 125 Premium Conversion Plan.

45. **Participating Employer:** Includes the City of Mobile, Mobile Public Library, Emergency Management Agency and the Museum of Mobile except that Museum of Mobile employees are excluded from eligibility for the Retiree-Only Plan.

46. **Physician:** One of the following when duly licensed and acting within the scope of that license: Doctor of Medicine (MD), a Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Medical Dentistry (DMD), Doctor of Chiropractic (DC), Doctor of Podiatry (DPM), or a Doctor of Optometry (OD). Registered Nurse Practitioners, Certified Nurse Midwives, and Psychologists (PhD, PsyD, EdD), as defined in Section 27-1-18 of the Alabama Code, 1975, as amended. The term Physician also includes a licensed Physician Assistant (PA) or Surgeon Assistant (SA) when: (1) employed by and acting under the direct supervision of a Blue Cross Blue Shield Preferred Provider MD; (2) acting within the scope of his or her license and in compliance with local law; and, (3) the services of the PA or SA would have been covered if provided directly by the MD.

47. **Plan:** The City of Mobile Life, Health & Dental Plan as described in this benefits booklet. The Plan is three separate plans including: City of Mobile Active Employee Health & Dental Plan, Retiree-Only Health Plan and the Retiree-Only Medicare Advantage Plan.

48. **Pre-Certification:** The administrative procedure whereby the Member or Physician is required to submit information or have the Physician submit a treatment plan to the Claims Administrator before the treatment or expense is initiated. The services and expenses that require Pre-Certification are included in this booklet and coverage for services or expenses requiring Pre-Certification is provided only when they have been Pre-Certified by the Claims Administrator. Pre-Certification of a service or expense does not automatically mean that benefits are payable.

49. **Pregnancy:** The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body, usually but not always in the uterus, lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

50. **Qualified Medical Child Support Order (QMCSO):** A QMCSO is a judgment, decree or order issued by a court of competent jurisdiction that requires the Plan to enroll dependents named in the order. A medical support order must be filed with the Human Resources Department within 60 days of the date of the order and must meet certain criteria, as explained in this benefits booklet, to be considered a QMCSO.

51. **Primary Care Physician:** Primary Care Physician includes General Practitioner, Internal Medicine, Family Practitioner, OB/GYN, Pediatrician, and Nurse Practitioner. All other Physician Specialties not listed as a Primary Care Physician will be considered a Specialty Care Physician.

52. **Reconstructive:** Reconstructive Surgery or other Reconstructive services are Covered Services when: (1) determined by the Claims Administrator to be Medically Necessary; (2) intended to primarily improve or restore physical bodily function or correct deformities resulting from Illness, Injury or congenital anomalies; and, (3) does not serve primarily to improve or change appearance. In some circumstances, a surgical procedure may be considered Reconstructive, or a portion of a Cosmetic surgery would be covered as Medically Necessary Reconstructive Surgery. Your Physician must contact the Claims Administrator prior to any treatment for determination of whether a procedure will be treated as Cosmetic or Reconstructive.

53. **Required Documentation:** Acceptable proof of dependent status is stated in the Table of Required Documentation included in this booklet. Proof must be filed within 60 days of enrollment or when requested by the Human Resources Department to be deemed Required Documentation.

54. **Retiree:** An Eligible Employee who has met the eligibility requirements for enrollment and participation in the Retired Life, Health & Dental Plan.

55. **Skilled Nursing Facility:** A Medicare-approved facility providing non-acute care for patients requiring 24-hour nursing services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities. A Skilled Nursing Facility: (1) is engaged in providing skilled care under the supervision of Physicians; (2) maintains clinical records on all patients; (3) provides 24-hour nursing services; and (4) provides appropriate procedures for dispensing and administering drugs and is duly licensed. Facilities for custodial, domiciliary care, Mental Health or Substance Abuse treatment are not covered.

56. **Special Diagnostic Procedures:** CAT Scan, MRI, PET/SPECT, ERCP, Angiography, Arteriography, Cardiac Catheter, Arteriography, Colonoscopy, UGI endoscopy, Muga-gated Cardiac Scan performed in the physician's office or free-standing diagnostic center.

57. **Special Enrollment Period:** The 60-day period following a Change-In-Status Event that allows an Eligible Employee to enroll in the Plan and/or add Eligible Dependents, or terminate coverage for one or more dependents, without having to wait for the Open Enrollment Period. The Special Enrollment Period also applies to Change-In-Status Events that allow Employees to change their election under the Section 125 Premium Conversion Plan.

58. **Specialty Care Physician:** Specialty Care Physician includes all Physicians not listed as a Primary Care Physicians. Members should receive the majority of medical care from a Primary Care Physician. Services of a Specialty Care Physician will require a higher Copay under the Plan.

59. **Substance Abuse Treatment:** Treatment for a chronic disorder or illness in which the Member is unable, for psychological or physical reasons, or both, to refrain from the frequent consumption of alcohol, drugs, intoxicants or narcotics in quantities sufficient to produce intoxication or overdose and, ultimately, injury to health and effective functioning.

60. **Surviving Dependent:** Eligible Dependent(s) of a deceased Eligible Employee or Retiree who have met the eligibility requirements for continuation of coverage under the Surviving Dependent benefit. Individuals are eligible for the Surviving Dependent benefit only if they are not eligible for coverage under any other group health plan, including Medicare.

61. **Terminally Ill:** A patient who is determined by a Physician to have a terminal illness with no reasonable prospect of cure and who is expected by a Physician to have less than six months to live.

62. **Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA):** Public Law 103-353, which requires that employers who offer group health coverage to their employees continue to make that coverage available while an Eligible Employee is on duty, voluntarily or involuntary, in the Uniformed Services. Uniformed Services include the U.S. Army, Navy, Marine Corps, Air Force, Coast Guard, Army National Guard, Air National Guard and Public Health Service Commissioned Corps, as well as the reserve components of each of these services. Uniformed Service includes the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which such person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty, and a period for which a person is absent from a position of employment for the purpose of performing funeral honors duty.

LIFE INSURANCE BENEFITS

ELIGIBILITY

- **The employee life insurance benefits apply to all Employees regardless of whether they participate in the Employee Health Plan.**
- **Dependent life insurance benefits are available only if the Employee is enrolled in the Employee Health Plan and has selected Dependent Coverage.**
- **Life insurance benefits are provided through and governed by a policy of insurance.**
- **Life insurance benefits are not guaranteed and continue from year to year at the discretion of the City of Mobile.**

EMPLOYEE LIFE INSURANCE SUMMARY

LIFE INSURANCE POLICY GOVERNS

This is a summary of the life insurance benefit. This is an insured benefit, subject to the terms and conditions of the insurance policy. A copy of the policy providing a description of the benefits, conditions and limitations, and all forms to apply for benefits, are available from the Human Resources Department.

The City of Mobile may change the life insurance policy terms and conditions and the insurance carrier and the benefits are not guaranteed except for the term of the in-force policy.

The annual salary amount for payment of the Employee life benefit is determined by the City of Mobile in accord with the policy of insurance.

EMPLOYEE LIFE BENEFIT

The City of Mobile provides life insurance for Employees in the following amounts:

1. Life benefits in an amount equal to two times annual salary, not to exceed $75,000.
2. Accidental Death & Dismemberment (AD&D) benefits in an amount equal to two times annual salary, not to exceed $75,000. Dismemberment benefits are scheduled.
3. AD&D benefits terminate at retirement.
4. Life insurance benefits are **not** in effect for Employees of the Mobile Police or Fire-Rescue Departments who are on deferred retirement.

DEPENDENT LIFE BENEFIT

The City of Mobile provides life insurance for your spouse and child in the amount of $2,000. Dependent life benefits apply only when the Employee has Dependent Coverage under the Health Plan and paid the required Contribution. In the event of death of an Employee who is also covered by the Plan as a Dependent, only the Employee life benefit will apply. Dependent status for the purpose of eligibility for life insurance benefits is governed by the policy of insurance in-force. Dependent means your spouse or child, but does not include a person who is a full-time member of the armed forces of any country. The term “child” is specifically defined in detail in the policy of insurance which may be obtained from the Human Resources Department.

EXTENDED DEATH BENEFIT FOR TOTAL DISABILITY

An Employee who becomes totally disabled while insured under the group policy and under the age of 65 may have coverage extend for 12 months after the date life insurance would terminate. The extended death benefit for disability is explained in the policy of insurance which may be obtained from the Human Resources Department.

CONVERSION

Upon termination or a reduction in your group term life insurance policy, you may be eligible to convert to an individual policy. When your coverage terminates or is reduced due to a Qualifying Event and you apply in writing within 31 days of the Qualifying Event you may convert to an individual policy of insurance. Conversion information and the application may be obtained from http://www.standard.com/eforms/1598a.pdf. You may also contact the City’s Human Resources department for assistance.

KEEP BENEFICIARY DESIGNATION CURRENT

At the time you enroll in the Plan, you will name the beneficiary of your life insurance benefit. You may change your beneficiary designation at any time, but the individual(s) you have most recently designated will by law receive your life insurance benefit in the event of your death. You must keep your beneficiary designation current. You may obtain a beneficiary designation form from the Human Resources Department.