



State Employees' Insurance Board

Southland Cancer Policy

Administered by
Southland Benefit Solutions

Effective January 1, 2021

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

STATE EMPLOYEES' INSURANCE BOARD CANCER POLICY
NOTICE OF PRIVACY PRACTICES

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

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

THE SEIB'S RESPONSIBILITIES

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

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

Effective Date of Notice: This notice is effective as of January 1, 2021.

HOW THE SEIB MAY USE AND DISCLOSE HEALTH INFORMATION

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

Uses and disclosures related to payment, health care operations, and treatment.

The SEIB and its business associates may use your health information without your permission to carry out payment or health care operations. The SEIB may also disclose health information to the Plan Sponsor, the State of Alabama, for purposes related to payment or health care operations.

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

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

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

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

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

- To persons and entities that provide services to the SEIB and assure the SEIB they will protect the information;
- If it constitutes summary health information, and it is used only for modifying, amending, or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan;
- If it constitutes de-identified information;
- If it relates to workers' compensation programs;
- If it is for judicial and administrative proceedings;
- If it is about decedents;
- If it is for law enforcement purposes;
- If it is for public health activities;
- If it is for health oversight activities;
- If it is about victims of abuse, neglect, or domestic violence;
- If it is for cadaveric organ, eye, or tissue donation purposes;
- If it is for certain limited research purposes;
- If it is to avert a serious threat to health or safety;

- If it is for specialized government functions;
- If it is for limited marketing activities.

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

Uses and disclosures requiring your written authorization. In all situations other than those described above, the SEIB will ask for your written authorization before using or disclosing your health information. If you have given the SEIB written authorization, you may revoke it at any time, if the SEIB has not already acted on it. If you have questions regarding authorizations, contact the SEIB's Privacy Officer at (334) 263- 8300.

YOUR PRIVACY RIGHTS

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

Notice of Breach. You have a right to notice of a breach of protected health information (PHI).

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

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

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

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

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

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

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

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

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

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

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

THIS NOTICE IS SUBJECT TO CHANGE. The terms of this notice and the SEIB's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the SEIB. If any material

changes are made, the SEIB will distribute a new notice to participants and beneficiaries.

YOUR QUESTIONS AND COMMENTS. If you have questions regarding this notice, please contact the SEIB's Privacy Officer at (334) 263-8300.

Revision 11-2020

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Introduction

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

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

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

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

Eligibility and Enrollment Requirements

Eligible Employees

- Full-time state employees and employees of county health departments who are paid by the State Comptroller, Historic Blakeley, Ft. Payne Improvement Authority, Historic Ironworks Commission, Bear Creek Development Authority, International Motorsports Hall of Fame, Space and Rocket Center, the Alabama Sports Hall of Fame, the State Docks, St. Stephens Historical Commission, USS ALABAMA Battleship Commission, Red Mountain Greenway Commission, County Soil & Water Conservation Districts, and the Alabama Community College System.
- Part-time employees working at least 10 hours per week if they agree to have the required premium paid through payroll deduction and if they are enrolled in the State Employees' Health Insurance Plan (SEHIP).
- Members of the Legislature and the Lieutenant Governor during their term of office.

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

Eligible Retired State Employee

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

Eligible Dependent

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

- Your spouse (excludes divorced or common-law spouse);
- A child under age 26, only if the child is:
 - your son or daughter,
 - legally adopted by you or your spouse,
 - or your stepchild;
- Your grandchild, niece, or nephew:
 - under 19 years of age, and
 - for whom the court has granted custody to you or your spouse;
- Your incapacitated child* over age 25 will be considered for coverage provided the incapacitation occurred prior to the child's 26th birthday and the child is:
 - unmarried,

- permanently mentally or physically incapacitated,
- so incapacitated as to be incapable of self-sustaining employment,
- dependent on you for 50% or more support,
- otherwise eligible for coverage as a dependent except for age,
- covered as a dependent on your Policy immediately prior to the child's 26th birthday, and
- not eligible for any other group health insurance benefits.

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

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

Ineligible Dependents

- Your dependents, other than your spouse, if they are independently covered as a state employee unless they are employed as a professional civil engineer trainee with ALDOT and their employment is part of their educational training
- An ex-spouse, regardless of what the divorce decree may state
- Ex-stepchildren, regardless of what the divorce decree may state
- Children age 26 and older
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements listed above under Eligible Dependent
- A child of a dependent child
- A daughter-in-law or son-in-law
- Grandchildren or other children related to the member by blood or marriage for which the member does not have legal custody
- Grandchildren or other children age 19 and older regardless of whether the member has legal custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

Changes in Dependent Eligibility

It is the responsibility of the subscriber to notify the SEIB immediately when the eligibility of a covered dependent changes. If it is determined that an act (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) of the subscriber results in or contributes to the

payment of claims for persons ineligible for coverage, the subscriber will be personally responsible for all such overpayments and shall be subject to disciplinary action, including termination of coverage.

Enrollment of Employee or Retiree

To be covered by the Policy, an SEIB Enrollment Form must be completed by the employee and submitted to the SEIB, subject to SEIB rules and procedures. Coverage for new employees will be effective on their date of employment, subject to appropriate premium payment, or on the first day of the month following their first payroll deduction. Existing employees and retirees may enroll at any time. Coverage will be effective no later than the first day of the second month following receipt and approval of the enrollment application by the SEIB and receipt of the appropriate premium.

Participants must maintain the Policy for at least 12 consecutive months. If enrollment is effective on any day other than January 1, coverage will remain in effect through the end of the next full Policy year. Once enrolled in the Policy for 12 consecutive months, you can decline coverage during Open Enrollment for an effective date of January 1.

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

Enrollment of Dependents

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

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

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

A direct payment for dependent coverage premium must be submitted with the enrollment form for any coverage period before payroll deduction. The deduction from your payroll check or the deposit by the SEIB of your direct payment does not constitute acceptance of coverage.

Enrolling an Incapacitated Child

If your child meets the other Incapacitated Child eligibility requirements listed

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

1. When a new employee requests coverage for an incapacitated child within 60 days of employment; or
2. When an employee's incapacitated child is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
 - a. the employee's spouse loses the other coverage because:
 - the spouse's employer ceases operations, or
 - of termination of employment or reduction of hours of employment, or
 - spouse's employer stopped contributing to coverage,
 - b. a change form is submitted to the SEIB within 30 days of the incapacitated child's loss of other coverage, and
 - c. Medical Review approved incapacitation status.

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

Open Enrollment

The open enrollment period is November 1 through November 30 for an effective date of January 1.

Special Enrollment

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

- the employee declined to enroll in the Policy; and
- the employee gains a new dependent through marriage, birth or adoption; or
- the employee or dependent loses other employer group coverage because:
 - COBRA coverage (if elected) is exhausted; or
 - loss of eligibility (including separation, divorce, death, termination of employment or reduction of hours of employment); or
 - employer stopped contributing to coverage.

A letter requesting special enrollment must be submitted to the SEIB within 30 days of the loss of other coverage or within 60 days of gaining a new dependent, along with a completed enrollment form or status change form if only adding dependents. In addition, the following documentation must be submitted within 60 days of the qualifying event:

- proof of gaining a new dependent (e.g., marriage certificate, birth certificate, adoption papers); or
- proof of coverage loss listing the reason and the date of the coverage loss for all individuals affected (e.g., employment termination on company letterhead).

Insurance Commences

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

General Provisions

Privacy of Your Protected Health Information

The confidentiality of your personal health information is important to the SEIB. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations. This section of the booklet explains some of HIPAA's requirements. Additional information is contained in the Notice of Privacy Practices at the front of this booklet. You may also request a copy of this notice by contacting the SEIB.

Use and Disclosure of Your Personal Health Information

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

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

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

Disclosures of Protected Health Information to the Plan Sponsor

For your benefits to be properly administered, your protected health information must be shared with the plan sponsor (the state of Alabama). Your protected health information may be shared with the plan sponsor under the following circumstances:

- The Plan may disclose your PHI to the plan sponsor for plan administrative purposes, as required by law, or as permitted under HIPAA regulations. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the Plan.

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

- The plan sponsor will only use or disclose your protected health information for Policy administrative purposes, as required by law, or as permitted under HIPAA regulations. See the SEIB's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. HIPAA regulations set forth the rules that you must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow you to amend, any portion of your protected health information to the extent permitted or required under HIPAA regulations.
- Concerning some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years. You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain Policy related purposes, such as payment of benefits or healthcare operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the U.S. Department of Health and Human Services, or its designee.

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

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

- Benefits Administration and Operations
- Legal
- Finance

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

Security of Your Personal Health Information

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

- The plan sponsor will have in place appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor have access to use or disclose your electronic protected health information in accordance with HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by HIPAA regulations.

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

Responsibility for Actions of Providers of Services

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

Misrepresentation

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

Obtaining, Use and Release of Information

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

Responsibility of Members and Providers to Furnish Information

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

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

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

Applicable State Law

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

I.D. Card

An identification card will be provided by Southland.

Claim Forms

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

Claims Administrator

The claims administrator for the Policy is:

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

Payment and Claim Filing Limitation

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

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

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

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

Change of Benefits

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

Termination of Coverages

Coverage under the Policy will terminate:

- On the last day of the month in which your employment terminates. The SEIB may continue your coverage if you are absent from work because of injury or sickness, or if you are absent from work due to leave of absence or temporary

layoff, but only for a limited period. Premiums may be required from the employee by direct pay. For details, contact the SEIB.

- Once enrolled in the Policy for 12 consecutive months, you can decline coverage during Open Enrollment for an effective date of January 1.
- When the Policy is discontinued.
- If you fail to timely make a premium payment.

Coverage under the Policy will also terminate for a dependent:

- On the last day of the month in which such person ceased to be an eligible dependent.
- If the dependent, other than a spouse, becomes covered as an employee.
- When premium payments cease for coverage of a deceased active or deceased retired employee.
- When dependent premium payments cease.

When dependent coverage is terminated, it is your responsibility to notify the SEIB to discontinue payroll deductions. If deductions are still being made from your paycheck after the month of termination, this does not mean that your dependents have coverage. It is your responsibility to request a refund from the SEIB.

In many cases, you will have the option to choose continuation of group benefits as provided by the Public Health Service Act. (See COBRA Section.)

Incorrect Benefit Payments

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

Fraudulent Claims

Any person, who knowingly and with intent to defraud any insurance company or other person, files a statement containing any materially false information or conceals any material information, commits a fraudulent insurance act, which is a crime. In addition to any disciplinary action already in place, any employee or retiree knowingly and willfully submitting false information to

the SEIB will be required to repay all claims and other expenses related to the false or misleading information.

Coordination of Benefits

There is no coordination of benefits for the Cancer Policy.

Customer Service

If you have questions about your coverage or need additional information about how to file claims, you should contact Southland. Southland Customer Service, located in Tuscaloosa, is open for phone inquiries from 8:00 a.m. to 5:00 p.m. Monday through Friday. The phone number is 1-866-327-6674.

Southland Appeal Process

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

1. To appeal, you must submit a request for review, in writing, to Southland within 60 days from the date of the notice from Southland denying payment of a claim. This request must contain the specific reasons you contend the claim denial was improper. Within the same time period, you may submit any other evidence in support of your position.
2. Southland will review the request and advise you of its final determination. The Southland decision will be final and will exhaust all administrative remedies.

SEIB Appeal Process

General Information

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

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

Note: Medical decisions will not be questioned.

All requests must be sent to the following address:

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

Informal Review

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

Administrative Review

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

Formal Appeal

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

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

Continuation of Group Health Coverage (COBRA)

Introduction

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

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

What is COBRA Continuation Coverage?

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

Who is a Qualified Beneficiary?

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

COBRA Rights for Covered Employees

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

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

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

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

COBRA Rights for a Covered Spouse and Dependent Children

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

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

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

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

What Coverage is Available?

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

When is COBRA Coverage Available?

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

- When Should Your Agency Notify the SEIB?

Your agency is responsible for notifying the SEIB within 30 days of the following qualifying events:

- end of employment;
- reduction of hours of employment; or

- the death of an employee.
- When Should You Notify the SEIB?

The employee or a family member has the responsibility to inform the SEIB within 60 days of the following qualifying events:

- divorce;
- legal separation; or
- a child losing dependent status.

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

How is COBRA Coverage Provided?

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

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

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

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the Policy, or (2) the date on which the SEIB notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage.

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

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

Because there may be a lag between the time your coverage under the Policy ends and the time we learn of your loss of coverage, the Policy may pay

claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the Policy. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

What will be the Length of COBRA Coverage?

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

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

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

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

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

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

For this disability extension to apply, the disability must have started at sometime 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 Policy, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

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

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

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

Can New Dependents be added to Your COBRA Coverage?

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

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

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

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

If you are on a leave of absence covered by FMLA, and you do not return to work, you will be given the opportunity to elect COBRA continuation coverage. The period of your COBRA continuation coverage will begin when you fail to return to work following the

expiration of your FMLA leave or you inform your employer that you do not intend to return to work, whichever occurs first.

How Much Does my COBRA Coverage Cost?

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

When is my COBRA Coverage Premium Due?

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

When Does my COBRA Coverage End?

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

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

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Keep the SEIB Informed of Address Changes

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

If You Have Any Questions

Questions concerning your COBRA continuation coverage rights may be addressed by calling the SEIB at 1-866-836-9737 or 334-263-8341 or by mail at the contact listed below. For more information about your COBRA rights, visit the Centers for Medicare & Medicaid Services' (CMS) website at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/COBRA.html> For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

SEIB Contact Information

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

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

Cancer Program

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

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

- B. **Hospice Care:** Actual charges to a maximum of \$50.00 per day for care provided by a licensed Hospice agency, organization, or unit that provides to persons terminally ill and to their families, a centrally administered and autonomous continuum of palliative and supportive care. The care must be directed and coordinated by the Hospice organization in the patient or family home. This benefit does not apply to non-terminally ill patients, nor does it apply to home health care or custodial care benefits. Lifetime maximum of \$3,000 per insured.
- C. **Cancer Surgery:** Actual charges for operation depending on the type of surgery (see schedule of policy), to a maximum of \$2,400.00. Hospitalization is not required. No limit on the number of operations.
- D. **Anesthesia:** Actual charges to a maximum of \$400.00 per operation. No limit on the number of operations.
- E. **Radiation & Chemotherapy:** Actual charges to a lifetime maximum of \$10,000.00 for cobalt therapy, x-ray therapy, or chemotherapy injections. Hospitalization is not required. Diagnostic tests are not included.
- F. **Blood & Plasma:** Actual charges to a lifetime maximum of \$2,000.00. Includes transfusions, administration, processing and procurement, and cross-matching (excludes other laboratory expenses). Hospitalization not required.
- G. **Nursing Service:** Actual charges for full-time private care and attendance to \$80.00 per day for RN or LPN for each day the insured is eligible for Hospital Confinement Benefit.
- Such services to be rendered by a person who does not ordinarily reside in the same household with the covered person, and who is not related by blood, marriage, or legal adoption to the covered person. No lifetime maximum.
- H. **Attending Physician:** Actual charges to a maximum of \$20.00 per day for physician other than the surgeon for each day the insured is eligible for Hospital Confinement Benefit. No lifetime maximum.

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

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

Schedule of Operations

(Maximum Amounts Payable)

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

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

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

MOUTH:	
Hemiglossectomy	\$400.00
Glossectomy	\$800.00
Resection of Palate	\$800.00
Tonsil/Mucous membrane	\$600.00
PANCREAS	
Jejunostomy	\$1,000.00
Pancreatotomy	\$2,400.00
Whipple Procedure	\$2,400.00
PENIS:	
Amputation	
(Partial)	\$300.00
(Complete)	\$600.00
(Radical)	\$800.00
PROSTATE:	
Cystoscopy	\$150.00
TUR Prostate	\$600.00
Radical Prostatectomy	\$1,400.00
SALIVARY GLANDS:	
Biopsy	\$400.00
Parotidectomy	\$800.00
Radial Neck Dissection	\$1,600.00
SKIN:	
Excision of lesion of skin	\$150.00
With flap or graft	\$400.00
SPINE:	
Laminectomy	\$1000.00
Cordotomy	\$600.00
STOMACH:	
Gastroscopy	\$300.00
Partial Gastrectomy	\$1,000.00
Gastrectomy	\$1,400.00
Gastrojejunostomy	\$1,000.00
TESTIS:	
Orchiectomy	\$400.00
THROAT:	
Laryngoscopy	\$300.00

Laryngectomy	
(Without neck dissection)	\$800.00
(With neck dissection)	\$1,600.00
Tracheostomy	\$300.00
THYROID:	
Thyroidectomy	
Partial (one lobe)	\$600.00
Total (both lobes)	\$800.00
VULVA:	
Partial	\$1,200.00
Radical	\$600.00

Limitations and Exclusions

- A. This policy pays only for loss resulting from hospitalization for definitive cancer treatment including direct extension, metastatic spread, or recurrence. Pathologic proof must be submitted to support each claim. This policy does not cover any other disease, sickness, or incapacity, and benefits are not provided for premalignant conditions with malignant potential or human immunodeficiency virus.
- B. No benefits are payable for certain charges, including, but not limited to, charges for:
- Expenses incurred by or on account of an individual prior to such person's effective date of coverage under the Policy;
 - Hearing aids and examinations for the prescription or fitting of hearing aids;
 - Cosmetic surgery or treatment, specifically but not limited to, coverage for reconstruction that is prescribed as a direct result of cancer surgery except as provided in Paragraph J. "Prosthetic Devices" under the Cancer Program.
 - Benefits for treatment in a United States government hospital unless the covered individual is actually charged for the treatment and is legally required to pay such charge;
 - Services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after the effective date of this Policy;
 - Expenses for which the individual is not required to make payment, including but not limited to, reductions or readjustments to the charges made by the health care provider;
 - Expenses to the extent of benefits provided under any employer group plan other than this Policy in which the state of Alabama participates in the cost thereof;
 - Such other expenses as may be excluded by regulations of the Board;
 - Expenses due to Convalescent Long-Term Care, Nursing Home confinement or rehabilitation (the recovery of health and strength after disease, sickness, or injury);
 - All claims not submitted in writing, not completed, without the requisite certification of the health care provider or received by Southland more than 365 days following the claim incurrence.

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

Definitions

A. Cancer Defined - Positive Pathology Required

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

Such cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology to practice Pathologic Anatomy, or an Osteopathic Pathologist. Diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis does not meet this standard.

B. Hospital Defined

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

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

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

State Employees' Insurance Board

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