BlueCross BlueShield of Alabama

2018 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state. Plans E, H, I and J are no longer available for sale. Blue Cross and Blue Shield of Alabama offers Plan A, Plan B and Plan F.

BASIC BENEFITS

Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses – Part B coinsurance (generally 20% of the Medicare approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
Blood – Covers the first three pints of blood each year.
Hospice – Part A coinsurance.

A	B	C	D	F / F*	G	K	L	M	N
Basic, Including 100% Part B coinsurance	Basic, Including 100% Part B coinsurance	Basic, Including 100% Part B coinsurance	Basic, Including 100% Part B coinsurance	Basic, Including 100% Part B coinsurance	Basic, Including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, Including 100% Part B coinsurance	Basic, Including 100% Part B coinsurance, except up to $20 copayment for office visit and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5,240; paid at 100% after limit reached	Out-of-pocket limit $2,620; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible. Blue Cross and Blue Shield of Alabama does not offer a high deductible Plan F option.

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Premium Information

PLAN A: $115 per month.	We will not increase your premiums unless we increase premiums for all Plan A members.

C Plus Plan B and Plan F premiums are age-rated based on age category on the date the policy is issued.

Entry Category		PLAN B	PLAN F
Age 65	(Category A)	$140 per month	$176 per month
Age 66-69	(Category B)	$155 per month	$194 per month
Age 70 & Above	(Category C)	$171 per month	$217 per month
On Medicare Disability	(Category D)	$226 per month	$286 per month

You can benefit from our issue age-rated system by applying for C Plus Select Plan B or Plan F when you turn 65 or as soon after as possible. For example, if you are 65, your C Plus Select Plan B premium will be $140 each month. You will always stay in Category A, even after you reach age 70. However, your neighbor or spouse who is also enrolling in C Plus Select Plan B may already be 70 years or older when they apply. In this case, they would enter in Category C and pay their C Plus Select Plan B premiums at a rate of $171 each month. If you cancel your C Plus policy to enroll in another Medicare supplement policy or a Medicare Advantage plan and then elect to re-enroll in C Plus, you will re-enroll at the age category that applies to you at the time of re-enrollment. This is true even if the Medicare supplement or Medicare Advantage plan is a Blue Cross and Blue Shield of Alabama plan.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE: This policy may not fully cover all of your medical costs.

Neither Blue Cross and Blue Shield of Alabama, nor its agents, are connected with Medicare. Blue Cross and Blue Shield of Alabama acts as the Medicare Carrier and Intermediary in Alabama.

This Outline of Medicare Supplement Coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

If your address changes, please call Blue Cross and Blue Shield of Alabama Customer Service to notify us.

Plan A Medicare Supplement

Plan A provides Basic Benefits only

PLAN A IS NOT AGE-RATED. You must be at least 65 years of age to be eligible for Plan A.

PLAN A HAS A 180-DAY WAITING PERIOD FOR PRE-EXISTING CONDITIONS. If you decide to purchase Plan A, you must serve a waiting period of 180 consecutive days before benefits for "pre-existing conditions" are available to you under the Plan A contract. The 180-day waiting period begins with your effective date. To be entitled to benefits, the entire 180-day waiting period must be served before you receive coverage for services and/or supplies, or to be admitted to the hospital for pre-existing conditions.
A "pre-existing condition" includes any condition, disease, disorder or ailment (including those present at birth) for which there was any medical or surgical treatment, advice or diagnosis within 180 days prior to your effective date.

This provision applies unless you have completed a waiting period under any other Medicare supplement contract besides this one. The time you completed under any other Medicare supplement contract shall be credited toward the 180-day waiting period required by Plan A. If you were covered by another health plan before becoming covered by Plan A, we will credit the time toward the 180-day waiting period, if there was no greater than a 63-day break in coverage, and the plan was "creditable coverage." Creditable coverage means coverage under a health plan, including a group health plan, health insurance coverage, COBRA, Medicare, Medicaid, U.S. Military, Tricare (Champus), Federal Employee Program, Indian Health Service, Peace Corps Service, Children's Health Insurance Program (CHIP), a state risk pool or public health service plan. If you had 180 days of continuous creditable coverage and enroll within 63 days of the end of that coverage, you will not have to serve a waiting period under Plan A.

PLAN A MEDICARE SUPPLEMENT	Medicare (Part A) — Hospital Services — Per Benefit Period

SERVICES ** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

HOSPITALIZATION*	MEDICARE PAYS	PLAN A PAYS	YOU PAY
Coverage includes semi-private room and board, general nursing and miscellaneous hospital services and supplies.			
First 60 days	All but $1,340	$0	$1,340 (Part A deductible)
61st to 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- Beyond the additional 365 days	$0	$0	All Costs
Note: Medicare coverage for inpatient Mental Health Care is limited to 190 days per lifetime in a Medicare approved psychiatric hospital			
SKILLED NURSING FACILITY CARE*	**MEDICARE PAYS**	**PLAN A PAYS**	**YOU PAY**
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All Costs
BLOOD (INPATIENT)	**MEDICARE PAYS**	**PLAN A PAYS**	**YOU PAY**
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	**MEDICARE PAYS**	**PLAN A PAYS**	**YOU PAY**
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN A MEDICARE SUPPLEMENT	Medicare (Part B) — Medical Services — Per Calendar Year

SERVICES * *Once you have been billed $183 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

MEDICAL EXPENSES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $183 of Medicare approved amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0

PART B EXCESS CHARGES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
Above Medicare approved amounts	$0	$0	All Costs

BLOOD (OUTPATIENT)	MEDICARE PAYS	PLAN A PAYS	YOU PAY
First 3 pints	$0	All Costs	$0
Next $183 of Medicare approved amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
Tests for diagnostic services	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE	MEDICARE PAYS	PLAN A PAYS	YOU PAY
Medicare approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment:			
• First $183 of Medicare approved amounts*	$0	$0	$183 (Part B deductible)
• Remainder of Medicare approved amounts	80%	20%	$0

C Plus Medicare Select Plan Highlights

- **No waiting periods for pre-existing conditions**
- **Freedom of Choice**
  - No referrals needed to see a specialist †
  - Access to our comprehensive network of providers, including choice of hospitals and more than 11,000 Alabama physicians
- **$0 copays for Medicare-eligible doctor visits, outpatient hospital stays and emergency room visits ††**

† Higher costs for out-of-network services may apply.
†† You must meet your Part B deductible on Plan B.

- **Medicare-eligible inpatient hospital stays - covered in full**
- **SilverSneakers® Fitness Program -** A fun and innovative health, exercise, and wellness program for Medicare-eligible adults. SilverSneakers® Fitness Program is provided by Tivity Health Inc.™ ©2017, an independent company with subsidiaries and affiliates worldwide. All rights reserved.
- **No paperwork or claim filing.** Providers file claims to Medicare and C Plus for you.
- **Air Medical Service**
- **C Plus Healthcare Hotline available 24 hours a day, seven days a week**

C PLUS MEDICARE SELECT PLAN B — Medicare (Part A) — Hospital Services — Per Benefit Period

SERVICES * *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

HOSPITALIZATION*	MEDICARE PAYS	PLAN B PAYS	YOU PAY
Coverage includes semi-private room and board, general nursing and miscellaneous services and supplies in a C Plus Preferred Hospital.			
First 60 days	**All but $1,340**	**$1,340**** (Part A deductible)	**$0**
61st to 90th day	**All but $335** a day	**$335** a day	**$0**
91st day and after:			
• While using 60 lifetime reserve days	**All but $670** a day	**$670** a day	**$0**
• Once lifetime reserve days are used:			
- Additional 365 days	**$0**	**100% of Medicare eligible expenses****	**$0** ***
- Beyond the additional 365 days	**$0**	**$0**	All Costs
Note: Medicare coverage for inpatient Mental Health Care is limited to 190 days per lifetime in a Medicare approved psychiatric hospital.			
SKILLED NURSING FACILITY CARE*	**MEDICARE PAYS**	**PLAN B PAYS**	**YOU PAY**
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	**All approved amounts**	**$0**	**$0**
21st thru 100th day	**All but $167.50 a day**	**$0**	Up to **$167.50** a day
101st day and after	**$0**	**$0**	All Costs
BLOOD (INPATIENT)	**MEDICARE PAYS**	**PLAN B PAYS**	**YOU PAY**
First 3 pints	**$0**	3 Pints	**$0**
Additional amounts	**100%**	**$0**	**$0**

** *Or hospital's contractually agreed upon amount. Inpatient hospital services must be received in a C Plus Preferred Hospital unless services are for emergency treatment or it is not reasonable to obtain such services through a C Plus Preferred Hospital.*

*** ***NOTICE:*** *When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

C PLUS MEDICARE SELECT PLAN B	Medicare (Part A) — Hospital Services — Per Benefit Period (Cont.)		
HOSPICE CARE	**MEDICARE PAYS**	**PLAN A PAYS**	**YOU PAY**
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

C PLUS MEDICARE SELECT PLAN B	Medicare (Part B) — Medical Services — Per Calendar Year

SERVICES * *Once you have been billed $183 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

MEDICAL EXPENSES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $183 of Medicare approved amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES	**MEDICARE PAYS**	**PLAN B PAYS**	**YOU PAY**
Above Medicare approved amounts	$0	100%**	$0**
BLOOD (OUTPATIENT)	**MEDICARE PAYS**	**PLAN B PAYS**	**YOU PAY**
First 3 pints	$0	All Costs	$0
Next $183 of Medicare approved amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES	**MEDICARE PAYS**	**PLAN B PAYS**	**YOU PAY**
Tests for diagnostic services	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE	MEDICARE PAYS	PLAN A PAYS	YOU PAY
Medicare approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment:			
• First $183 of Medicare approved amounts *	$0	$0	$183 (Part B deductible)
• Remainder of Medicare approved amounts	80%	20%	$0

** *If you use a Preferred Medical Doctor (PMD).*

C PLUS MEDICARE SELECT PLAN F	Medicare (Part A) — Hospital Services — Per Benefit Period

SERVICES ** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

HOSPITALIZATION*	MEDICARE PAYS	PLAN F PAYS	YOU PAY
Coverage includes semi-private room and board, general nursing and miscellaneous services and supplies in a C Plus Preferred Hospital.			
First 60 days	All but $1,340	$1,340** (Part A deductible)	$0
61st to 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses**	$0***
- Beyond the additional 365 days	$0	$0	All Costs
Note: Medicare coverage for inpatient Mental Health Care is limited to 190 days per lifetime in a Medicare approved psychiatric hospital.			
SKILLED NURSING FACILITY CARE*	**MEDICARE PAYS**	**PLAN F PAYS**	**YOU PAY**
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD (INPATIENT)	**MEDICARE PAYS**	**PLAN F PAYS**	**YOU PAY**
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	**MEDICARE PAYS**	**PLAN F PAYS**	**YOU PAY**
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** *Or hospital's contractually agreed upon amount. Inpatient hospital services must be received in a C Plus Preferred Hospital unless services are for emergency treatment or it is not reasonable to obtain such services through a C Plus Preferred Hospital.*

*** *NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

C PLUS MEDICARE SELECT PLAN F	Medicare (Part B) — Medical Services — Per Calendar Year

SERVICES * *Once you have been billed $183 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

MEDICAL EXPENSES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $183 of Medicare approved amounts*	$0	$183 (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES	**MEDICARE PAYS**	**PLAN F PAYS**	**YOU PAY**
Above Medicare approved amounts	$0	100%	$0
BLOOD	**MEDICARE PAYS**	**PLAN F PAYS**	**YOU PAY**
First 3 pints	$0	All Costs	$0
Next $183 of Medicare approved amount*	$0	$183 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES	**MEDICARE PAYS**	**PLAN F PAYS**	**YOU PAY**
Tests for diagnostic services	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE	MEDICARE PAYS	PLAN F PAYS	YOU PAY
Medicare approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment:			
• First $183 of Medicare approved amounts*	$0	$183 (Part B deductible)	$0
• Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE	MEDICARE PAYS	PLAN F PAYS	YOU PAY
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
– First $250 each calendar year	$0	$0	$250
– Remainder of charges	$0	**80%** to a lifetime benefit maximum benefit of $50,000	**20%** and amounts over the $50,000 lifetime maximum

Payment Options

AUTOMATIC PREMIUM PAYMENT THROUGH E-CHECK OR CREDIT/DEBIT CARD – You can be free from worrying that your premium is paid on time by letting us take that worry from you. You may elect to pay your premium through Automatic Premium Payment by authorizing an E-Check recurring payment from your personal checking or savings account. Just complete the Automatic Payment Authorization Agreement and include it with your application along with a blank, voided check.

If you prefer to pay your premiums by credit or debit card, just complete and return the Automatic Payment Authorization Agreement for Automatic Bank Card Payment. Your monthly premium can be automatically charged through your credit or debit card and sent directly to Blue Cross and Blue Shield of Alabama for payment of your healthcare coverage.

The form must be fully completed and signed.

E-STATEMENT – With E-Statement you will receive a monthly reminder when your statement is ready. Sign up to receive free electronic statements for your C Plus plan.

MONTHLY BILLING REQUEST – You will be mailed a billing statement each month which includes an invoice to return with your premium payment. Please make a note on your application to indicate monthly payment of premium.

Plan A, Plan B and Plan F Exclusions

What is not covered

- Services, care or treatment for which Medicare does not make a determination and which we determine not to have been medically necessary.
- Services, care or treatment received by you during the 30-day grace period if we do not actually receive the required amount of your fees during the grace period.
- Services, care or treatment you receive before the effective date or after the end of the Contract. If you are in the hospital when the Contract ends, we will not provide benefits during the remainder of your hospitalization. Services, care or treatment you receive before the effective date or after the end of the Contract (except as otherwise provided in the Contract).
- Services or expenses for cosmetic surgery not covered by Medicare.
- Services or expenses not covered by Medicare for the care, treatment, filling, extraction, removal, replacement or augmentation of teeth or structures directly supporting teeth. “Structures directly supporting the teeth” mean the periodontium, which includes the gingivae, dentogingivial junction, periodontal membrane, cementum and aveolar process. Also excluded are periodontal care, prosthodontal care, endodontic care, orthodontic care or any other dental care. Services or expenses for hydro-xylapatite or any material with a similar purpose are also excluded.
- Services or expenses that are paid for directly or indirectly by a governmental entity except as otherwise required by section 411.8 of the Medicare regulations.
- Services or expenses in cases covered in whole or in part by workers’ compensation or employers’ liability laws, state or federal. This applies regardless of whether or not: you fail to file a claim under that law. It applies regardless of whether the law is enforced against or assumed by the employer. It applies regardless of whether the law provides for hospital or medical services as such. Finally, it applies regardless of whether the employer has insurance coverage for benefits under the law.
- Services or expenses furnished by a Federal provider of services or other Federal agency, or furnished at public expense under Federal law or a Federal contract, except as otherwise required by Sections 411.6 and 411.7 of the Medicare regulations.
- Services or expenses for routine physical examinations, convalescent care, rest cures, or sanatorium care.

Plan A, Plan B and Plan F Exclusions

What is not covered

- Services or expenses for custodial care, meaning care primarily for providing room and board (with or without nursing care, training in personal hygiene or self care, or supervisory care by a physician) for a person physically or mentally disabled even if covered by Medicare.
- Any medical or surgical treatment or procedures, any facilities, drugs, drug usage, equipment or supplies which are experimental or investigative.
- Services or expenses for a claim not properly filed.
- Hearing aids, eyeglasses or contact lenses or for their examination or fittings. We will pay for eyeglasses or contact lenses that replace the human lens function and are required by surgery in the eye or an eye injury defect. Our payment in these cases is limited to one pair of eyeglasses or contact lenses or one pair of each if both are medically necessary.
- Travel, whether or not recommended by a physician.
- Private duty nurses and their board.
- Prescription drugs and medicines, except those drugs and medicines covered under Parts A and/or B of Medicare.
- Services or expenses for home health (except for the 20% copayment for durable medical equipment).
- Any difference (due to federal law, regulations, or both) in the amount of Medicare benefits paid and the Medicare-approved amount, except for deductible and copayment amounts covered by the Contract.

Additional Exclusions for Plan A

- Services or expenses which are excluded by Medicare.
- Services or expenses of any kind covered under Part A of Medicare for skilled nursing facility, nursing home, assisted living facility or intermediate care facility. (Except for the Part A coinsurance/copayment amounts for hospice and respite care covered by Part A of Medicare).
- Charges in excess of the reasonable and allowable charge under Medicare.
- The annual Medicare Part B deductible.
- Plan A does not cover any portion of the Medicare Part A deductible.

Additional Exclusions for Plan B

- Services or expenses which are excluded by Medicare.
- Services or expenses of any kind covered under Part A of Medicare for skilled nursing facility, nursing home, assisted living facility or intermediate care facility. (Except for the Part A coinsurance/copayment amounts for hospice and respite care covered by Part A of Medicare).
- Services or expenses in a non-participating or non-C Plus Preferred Hospital for inpatient or outpatient treatment, except as otherwise allowed under the benefit portions of the Contract.
- Charges in excess of the reasonable and allowable charge under Medicare.
- The annual Medicare Part B deductible.

Additional Exclusions for Plan F

- Services or expenses in a non-participating or non-C Plus Preferred Hospital for inpatient or outpatient treatment, except as otherwise allowed under the benefit portions of the Contract.
- Services or expenses which are excluded by Medicare, except for the limited foreign travel benefit described in this Outline of Medicare Supplement Coverage.
- Charges in excess of the reasonable and allowable charge under Medicare, except for the Medicare Part B excess charges.

C Plus Select Quality Assurance Standards

We use advice from providers and national organizations to develop our quality standards. Each hospital in our network is participating under Medicare and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Each hospital or other provider in our network is also duly licensed by the appropriate regulatory authorities. Periodically, our network providers go through a re-credentialing process by us.

C Plus Select Grievance Procedures

If we accept your application for C Plus Select Plan B or Plan F, you will have the right to seek and obtain full and fair review by us of any determination we make under your C Plus contract. The following is a summary of the review and appeal procedures you must use to do this. More detailed information about these procedures is included in the C Plus contract.

REQUESTING A REVIEW:
If you believe that we incorrectly denied all or part of your benefits or made an incorrect decision relating to anything else under your C Plus contract, and you want us to review our determination, you should submit to us a written request for review at the address set forth in your C Plus contract. Your written request must state your full name and subscriber identification number. If your request relates to a claim, you must state the number of the claim that you want reviewed and include a copy of the C Plus Claim Report. Your envelope should be marked "C Plus Request for Review." We will send you a copy of our determination upon review with the reason for it.

DISPUTE RESOLUTION PROCEDURES:
If you have a complaint or dispute that has not been adequately addressed under the review procedures just described, you may submit an appeal to us at the address set forth in your C Plus contract. Your appeal must be submitted to us in writing within 30 days. Your envelope should be marked **"C Plus Dispute Resolution."** Upon receipt of your appeal, we will examine the facts fully and fairly. You will receive a written decision from us within 30 days.

C Plus Select Plans and Plan A Arbitration

In consideration of coverage under the contract and payment of the premiums, you (and we) agree to binding arbitration. This means that any and all claims whether in contract, tort, or otherwise, whether arising before, on, or after the date of your contract, and including without limitation any statutory, common law, intentional tort, or equitable claims will be settled by arbitration – not a court. The arbitrator's decision is final and binding and can not be reviewed by a court.

As outlined more fully in the contract, the arbitration will be conducted in accordance with the American Arbitration Association's dispute resolution procedures for insurance claims (a copy of which may be obtained by written request to us), except as modified in the contract. The claimant is responsible for starting the arbitration proceedings. We will bear all costs of arbitration other than your costs of representation. If you initiate arbitration, and if the arbitrator finds that the dispute is without substantial justification, the arbitrator has the authority to order that you bear the cost of the arbitration proceedings.

The arbitration will be conducted before a single arbitrator in the county in which you reside unless you and we agree to conduct the arbitration in some other county. Prior to the arbitration, if all parties consent to mediate the claim, the arbitrator will refer the claim to a separate mediator, but arbitration will follow if no settlement is reached. A claimant's claim(s) must be arbitrated separately from the claims of others, and may not be consolidated with the claims of others or arbitrated on a class-wide basis.

For more detailed information about these arbitration procedures, please refer to the Arbitration section in the Contract.

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

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

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-216-3144（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

450 Riverchase Parkway East, Birmingham, Alabama 35244
1-888-417-4775 • TTY 711

Customer Service Hours:

Monday through Friday, 8 a.m. - 5 p.m.

www.bcbsalmedicare.com

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