Short Term Blue Plus

SINGLE AND FAMILY COVERAGE FOR 36 MONTHS

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of pre-existing conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

BlueCross BlueShield of Alabama

We cover what matters.

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OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits please contact our Customer Service Department at 1-855-249-3659. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor
Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-855-249-3659. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.

Purpose and Limited Contract Term of the Plan

The plan is intended to help you and your covered dependents temporarily pay for some of the cost of medical care when other more comprehensive health coverage is unavailable to you. **You may purchase this plan for an initial period of up to 364 days with an option to renew to extend the contract term for a period of up to 36 months. All you have to do to renew is to continue to timely pay your premiums in full. At the end of the 36 month period,** you may reapply for a new contract but there must be a minimum of a one (1) day lapse in coverage before the effective date of the new contract.

Using *my*BlueCross to Get More Information

By being a member of the plan, you get exclusive access to *my*BlueCross – an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at AlabamaBlue.com/Register. With *my*BlueCross, you have 24 hour access to personalized healthcare information, PLUS easy-to-use online tools that can help you save time and efficiently manage your healthcare:

- Pay your bill online and set up recurring payments.
- Download and print your benefit booklet.
- Download and print your ID card.
- View all your claim reports in one convenient place.
- Find a doctor.
- Track your health progress.
- Take a health assessment quiz.
- Get fitness, nutrition and wellness tips.
- Get prescription drug information.

BlueCare Health Advocate

By being a member of the plan, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you, and much more. To find out more or

to contact your BlueCare Health Advocate, call our Customer Service Department at the number on the back of your ID card.

Nature of Coverage

The plan is not a Medicare supplement policy. If you are enrolled in Medicare, you are not eligible for this plan. If you later become enrolled in Medicare, your coverage will terminate.

The plan is not group insurance or COBRA. Since the plan is not group insurance coverage, employers are not permitted to endorse or sponsor the plan (your employer may not pay for or reimburse you for your premiums).

Free Review Period

If for any reason you are not satisfied with the plan, you may return it to us with your identification card within 30 days following your effective date. If you do this, we will refund any fees you have paid and obtain refunds for any benefits that we have paid to you or your provider.

Plan Year

The initial plan year of the plan is the effective date of the plan through December 31. Thereafter, the plan year of the plan is January 1 through December 31 of each year but in no case longer than 36 months from the initial effective date of the plan.

Definitions

Near the end of this booklet you will find a section called Definitions, which identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with the plan's defined terms so that you will understand your benefits.

Receipt of Medical Care

Even if this plan does not cover an expense or service, you and your physician are responsible for deciding whether you should receive the care or treatment.

Generally, after-hours care is provided by your physician. They may have a variety of ways of addressing your needs. You should call your physician for instructions on how to receive medical care after the physician's normal business hours, on weekends and holidays, or to receive non-emergency care for a condition that is not life threatening but requires medical attention.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room.

Having a primary care physician is a good decision:

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

- Seeing a physician who knows you and understands your medical history.
- Having someone you can count on as a key resource for your healthcare questions.
- Help when you need to coordinate care with specialists and other providers.

Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics. Find a physician in your area by visiting AlabamaBlue.com/FindADoctor and choosing Find a Doctor.

Seeing a specialist or behavioral health provider is easy:

If you need to see a specialist or behavioral health provider, you can contact their office directly to make an appointment. If you choose to see a specialist or behavioral health provider in our networks in Alabama, you will have in-network benefits for services covered under the plan. If you choose to see an out-of-network specialist or behavioral health provider, your benefits could be lower or you could have no benefits at all.

Beginning of Coverage

The section of the booklet called Eligibility will tell you and your dependents what is required to become covered under the plan and when your coverage begins.

Even if you have purchased a family contract, new dependents are not automatically added to the plan. You must submit an application for coverage.

Pre-Existing Condition Exclusions, Limitations and Other Exclusions

In order to maintain the cost of the plan at an overall level that is reasonable for all plan members, the plan contains a number of provisions that limit benefits. The plan does not cover pre-existing conditions for the first 365 days you are covered under the plan. This does not apply to children properly enrolled in a family plan within 30 days of birth, placement for adoption or placement as an eligible foster child. Pre-existing conditions are defined in the Definitions section of this booklet. Any condition that you listed in your application as pre-existing will not be covered, nor will any other condition which we determine to be pre-existing. There are also exclusions that you need to pay particular attention to as well. These provisions are found throughout the remainder of this booklet. You need to be aware of the limits and exclusions to determine if the plan will meet your healthcare needs.

Medical Necessity and Precertification

The plan will only pay for care that is medically necessary and not investigational, as determined by us. We develop medical necessity standards to aid us when we make medical necessity determinations. We publish many of these standards at AlabamaBlue.com. The definitions of medical necessity and investigational are found in the Definitions section of this booklet. In some cases, the plan requires that you or your treating provider precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered. The section called Medical Necessity and Precertification later in this booklet tells you when precertification is required and how to obtain it.

In-Network Benefits in the State of Alabama

One way in which the plan tries to manage your costs is through negotiated discounts with in-network providers in the State of Alabama. As you read the remainder of this booklet, you should pay attention to the type of provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. The plan provides limited benefits for services rendered by an out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost sharing. Additionally, out-of-network providers have not contracted with us for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the plan.

Examples of the plan's Alabama in-network providers are:

- Participating Hospitals
- Preferred Outpatient Facilities
- Participating Ambulatory Surgical Centers
- Participating Renal Dialysis Providers
- Preferred Medical Doctors (PMD)
- Preferred Medical Laboratories
- Blue Choice Behavioral Health Network
- Participating Chiropractors
- Participating Nurse Practitioners
- Participating Physician Assistants
- Preferred Home Health Network
- Preferred Home Infusion Network
- Preferred Occupational Therapists
- Preferred Physical Therapists
- Preferred Speech Therapists
- Blue Achievement - Knees and Hips Network
- Participating CRNA
- Participating Ground Ambulance
- Participating Licensed Registered Dietitian Network
- Pharmacy Vaccine Network
- Pharmacy Select Network
- ValueONE Network

To locate Alabama in-network providers, go to AlabamaBlue.com/FindADoctor.

1. Enter a search location by using the zip code or city and state for the area you would like to search.
2. In the search box, you can select the category you would like to search (doctor, hospital, dentist, pharmacy, etc.) or keep on "All Categories" to search all. Type in provider's name to search or leave blank to see all results.
3. In the "Network or Plan" section, use the drop down menu to select a specific provider network (as noted above).

Search tip: If your search returns zero results, try expanding the number in the "Distance" drop down.

In-Network Benefits Outside the State of Alabama

The plan provides in-network benefits outside the State of Alabama only for the following:

- Services, expenses and drugs for medical emergencies and accidental injuries in the an in-network hospital;
- Prescription drugs from an in-network pharmacy;
- Routine immunizations from an in-network pharmacy; and
- Ambulance services from an in-network ambulance.

If you receive services outside our Alabama service area for the above listed services or expenses a special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit AlabamaBlue.com/FindADoctor and log into your *my*BlueCross. PPO providers will file claims on your behalf with the local Blue Cross and/or Blue Shield plan where services are rendered. The local Blue Cross and/or Blue Shield plan will then forward the claims to us for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the plan or is not covered under the contract between the provider and Blue Cross and Blue Shield of Alabama or the local Blue Cross and/or Blue Shield plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the plan, such as Other Covered Services.

Relationship Between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

Claims and Appeals

When you receive services from an in-network provider, your provider will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with us for reimbursement under the terms of the plan. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review. The provisions of the plan dealing with claims and appeals are found later on in this booklet.

Arbitration

In order to provide for an efficient and fair resolution of disputes, the plan contains arbitration provisions. These provisions are explained in the section of this booklet called General Information.

Changes in the Plan

From time to time it may be necessary for us to change the terms of the plan. When this occurs we will give you written notice. The rules we follow for changing the terms of the plan are described later in the section called Health Plan Changes.

Termination of Coverage

The section called Eligibility tells you when coverage will terminate under the plan. If coverage terminates, no benefits will be provided thereafter, even if for a condition or course of treatment that began before termination.

Respecting Your Privacy

To administer this plan we need your personal health information from physicians, hospitals and others. To decide if your claim should be paid or denied or whether other parties are legally responsible for some or all of your expenses, we need records from healthcare providers, other insurance companies, and other plan administrators. By applying for coverage and participating in this plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer this plan or to perform any function authorized or permitted by law. You further direct all other persons to release all records to us about you and your minor dependents that we need to administer this plan. If you or any provider refuses to provide records, information or evidence we request within reason, we may deny your benefit payments. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law. Additionally, we may use or disclose your personal health information for treatment, payment, or healthcare operations, or as permitted or authorized by law, pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have prepared a privacy notice that explains our obligations and your rights under the HIPAA privacy regulations. To request a copy of our notice or to receive more information about our privacy practices or your rights, please contact us at the following:

Blue Cross and Blue Shield of Alabama
Privacy Office
P. O. Box 2643
Birmingham, Alabama 35202-2643
Telephone: 1-800-292-8868

You may also go to AlabamaBlue.com for a copy of our privacy notice.

Your Rights

As a member of the plan, you have the right to:

- Receive information about us, our services, in-network providers and your rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the plan provides.
- Make recommendations regarding our member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service Department number on the back of your ID card.

Your Responsibilities

As a member of the plan, you have the responsibility to:

- Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ELIGIBILITY

Eligibility for the Plan

You are eligible for this plan if all of the following requirements are satisfied:

- You are a resident of Alabama;
- You are not enrolled in Medicare, Medicaid or another short term limited duration policy; and
- You have met our health underwriting guidelines and have been accepted by us for coverage.

If the applicant is under the age of 19, a parent or legal guardian must submit an application for coverage on the child's behalf and assume responsibility for payment of all premiums.

Dependent Coverage

Your spouse can be covered if he or she:

- Is a resident of the State of Alabama;
- Is not enrolled in Medicare, Medicaid or another short term limited duration policy; and,
- Has met our health underwriting guidelines and has been accepted by us for coverage.

Your married or unmarried child may likewise be covered, if, at the time of your application, he or she:

- Is a resident of the State of Alabama;
- Is not enrolled in Medicare, Medicaid or another short term limited duration policy; and,
- Has met our health underwriting guidelines and has been accepted by us for coverage.

In addition, the child must be your natural child; stepchild; legally adopted child; child placed for adoption; or, child placed as an eligible foster child. An eligible foster child is a child that is placed with you by an authorized placement agency or court order.

You may cover your grandchild only if you are eligible to claim your grandchild as a dependent on your federal income tax return.

Beginning of Coverage

If we accept your application, we will send you an identification card. Your coverage begins on the effective date shown on your identification card provided that you timely pay your premiums at the time of the application in full on or before the effective date of coverage. If you apply for coverage between the first and the 14th day of the month, coverage will be effective no later than the first day of the following calendar month (assuming you timely pay your premiums in full). If you apply for coverage between the 15th day and the last day of the month, coverage will be effective no later than the 15th day of the following month (assuming you timely pay your premiums in full). If you fail to pay your premiums in full on or before the effective date of coverage, your coverage will be canceled as of the effective date.

If we decline to issue a contract, all the law requires us to do is refund any fees paid with respect to the application.

Spouses and Dependents Added After Your Initial Enrollment

If we accept your application for dependent coverage after your initial application, dependent coverage will also begin on the effective date shown on the identification that we send you thereafter. If you apply for dependent coverage within 30 days of the following events, the effective date of coverage will be as follows:

- For a newborn baby, the date of birth;
- For a dependent added by adoption, the effective date of placement for adoption;
- For a dependent added by placement as an eligible foster child, the effective date of placement as an eligible foster child;

- For a spouse or dependent added by marriage, the date of the marriage; and,
- For a spouse or dependent added as a result of losing other coverage, the first day of the month following the date of our acceptance of the application to add such spouse or dependent.

Termination of Coverage

Plan coverage ends for you and your dependents when the first of the following happens:

1. You fail to pay all applicable fees for coverage within the first 30 days following the effective date of your coverage, in which case coverage for you and your dependents will be cancelled as of the effective date of coverage;

2. You fail to pay subsequent fees for coverage within the 30 day grace period;

3. You are no longer a resident of the State of Alabama;

4. For spouses, the first day of the month following divorce or other termination of marriage;

5. For children, the first day of the month following the date a child ceases to be a dependent;

6. For all covered dependents, the first day of the month following the date of a contract holder's death;

7. For any member, the date of his or her death;

8. For any member, the date he or she becomes enrolled in Medicare, Medicaid and/or a short term limited duration plan;

9. Upon completion of 36 months of coverage;

10. Upon discovery of fraud or intentional misrepresentation or omission of a material fact; or

11. Upon termination of the plan as explained later in this booklet in the section called General Information.

In all cases the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

In some cases, termination may be retroactive. For example, if we determine that an employer improperly endorsed or sponsored the plan, we reserve our right to terminate the plan retroactively to the date as of which the employer's endorsement or sponsorship began or to the effective date of coverage.

Attention: Because this plan is not a group insurance plan, it does not provide benefits under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986).

Limitation on Effect of Certain Amendments

Except as otherwise required by law, no amendment or change to this section of the booklet (Eligibility) will result in the disenrollment, loss of eligibility, or early termination of eligibility of a member properly enrolled under the terms of the plan as of the effective date of the amendment.

PRE-EXISTING CONDITIONS

For the first 365 days you are covered under this plan there are no benefits for "pre-existing conditions." This does not apply to children properly enrolled in a family plan within 30 days of birth, placement for adoption or placement as an eligible foster child. There are no benefits for "pre-existing conditions." A pre-existing condition is any condition, no matter how caused, for which you received medical advice, a diagnosis, care, or for which treatment was recommended or received during the two-year period preceding your effective date. Even if your condition is not diagnosed until after your effective date, we will treat your condition as pre-existing if treatment was recommended or received during the two-year period preceding your effective date for symptoms that are consistent with the presence of your condition. This exclusion for pre-existing conditions is not reduced by any prior coverage under any other plan or policy you may have had prior to the effective date of your coverage under this plan.

Please refer to the Health Benefit Exclusions section of your benefit booklet for more exclusions that apply to the plan.

COST SHARING

Plan Year Deductible	$1,500 individual per year; $3,000 family maximum per plan year
Plan Year Out-of-Pocket Maximum	$10,000 per individual per plan year; $20,000 family maximum per plan year
Plan Year Prescription Drug Contract Maximum	$3,000 per individual per plan year
Contract Maximum	$2,000,000 per individual

Plan Year Deductible

The plan year deductible is specified in the table above. The plan year deductible is the amount you must pay for medical expenses covered by the plan before your healthcare benefits begin. The plan year deductible is applied on a per member per plan year basis, subject to the family maximum. The deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received. Other portions of this booklet will tell you when your receipt of benefits is subject to the plan year deductible.

All amounts applied to individual deductibles will count toward the family deductible. Therefore, it is

not necessary for any one family member to completely satisfy his or her individual deductible in order for the family deductible to be met. Only one deductible is required when two or more family members have expenses resulting from injuries received in one accident.

No amounts paid under any prior plan contracts will count towards the plan year deductible. If you lose coverage and then purchase a new contract, the amounts you paid under the plan year deductible will not count toward your new contract's plan year deductible. In other words, your plan year deductible starts over.

Plan Year Out-of-Pocket Maximum

The plan year out-of-pocket maximum is specified in the table above. All cost sharing amounts (deductibles, copayments and coinsurance) for covered in-network services that you or your family are required to pay under the plan apply to the plan year out-of-pocket maximum. Once the maximum has been reached, you will no longer be subject to cost sharing for covered expenses of the type that count toward the plan year out-of-pocket maximum for the remainder of the plan year.

There may be many expenses you are required to pay under the plan that **do not** count toward the plan year out-of-pocket maximum and that you must continue to pay even after you have met the plan year out-of-pocket maximum. The following are some examples:

- All cost sharing amounts (deductibles, copayments, and coinsurance) paid for any out-of-network services or supplies that may be covered under the plan);
- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges);
- Amounts paid for services or supplies in excess of any plan limits or maximums (for example, a limit on the number of covered visits for a particular type of provider); and,
- Amounts paid as a penalty (for example, failure to precertify).

The plan year out-of-pocket maximum applies on a per member per plan year basis, subject to the family plan year out-of-pocket maximum amount. Once a member meets its individual plan year out-of-pocket maximum, affected benefits for that member will pay at 100% of the allowed amount for the remainder of the plan year.

The family plan year out-of-pocket maximum is an aggregate dollar amount. This means that all amounts that count toward the individual plan year out-of-pocket maximum will count toward the family plan year out-of-pocket maximum amount. Once the family plan year out-of-pocket maximum is met, affected benefits for all covered family members will pay at 100% of the allowed amount for the remainder of the plan year.

No amounts applied to the plan year out-of-pocket maximum under any prior plan contracts will count towards the plan year out-of-pocket maximum under this plan. If you lose coverage and then purchase a new contract, the amounts applied under the plan year out-of-pocket maximum will not count toward your new contract's plan year out-of-pocket maximum. In other words, your plan year out-of-pocket maximum starts over.

Plan Year Prescription Drug Contract Maximum

The plan year prescription drug contract maximum under the plan is specified in the table above. The plan year prescription drug maximum applies on a per member per plan year basis and applies to all prescription drug benefits each member receives under the plan per plan year. Once a member reaches his or her prescription drug maximum, no benefits for that member for prescription drugs will be payable under the plan for the remainder of the plan year. If you lose coverage and then purchase a new contract, the prescription drug contract maximum for all members will begin again under the new contract.

Contract Maximum

The contract maximum under the plan is specified in the table above. The contract maximum applies on a per member basis and applies to all benefits each member receives under the plan. Once a member reaches the contract maximum, no further benefits for that member will be payable under the plan for the remainder of the plan contract. If you lose coverage and then purchase a new contract, the contract maximum for all members will begin again under the new contract.

Other Cost Sharing Provisions

The plan may also impose other types of cost sharing requirements, such as the following:

1. Per admission deductibles. A per admission deductible is an amount that must be paid upon your admission as a hospital inpatient.
2. Copayments. A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor's office.
3. Coinsurance. Coinsurance is the amount that you must pay as a percent of the allowed amount.
4. Amounts in excess of the allowed amount. As a general rule, and as explained in more detail in Definitions, the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with us or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount or the plan may not cover the out-of-network service at all.

Out-of-Area Services

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield /Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of providers.

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, we may process your claims for covered healthcare services through Negotiated Arrangements for National Accounts.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to us by the Host Blue.

C. Nonparticipating Providers Outside the Blue Cross and Blue Shield of Alabama Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue’s nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, we may use other payment methods, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph.

D. Blue Cross Blue Shield Global® Core

If you are outside the United States (hereinafter “BlueCard service area”), you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered healthcare services. Blue Cross Blue Shield Global® Core is not served by a Host Blue.
If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global® Core Claim**

When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the service center or online at bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

MEDICAL NECESSITY AND PRECERTIFICATION

The plan will only pay for care that is medically necessary and not investigational, as determined by us. The definitions of medical necessity and investigational are found in the Definitions section of this booklet.

In some cases described below, the plan requires that you or your treating provider precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered.

In some cases, your provider will initiate the precertification process for you. You should be sure to check with your provider to confirm whether precertification has been obtained. It is your responsibility to ensure that you or your provider obtains precertification.

Inpatient Hospital Benefits

Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) including notification within 48 hours or next business day after an admission for a medical emergency or accidental injury.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

For precertification call 1-800-248-2342 (toll-free)

Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

There is only one exception to this for services rendered in an in-network hospital for medical emergencies and accidental injury: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the plan.

Outpatient Hospital Benefits, Physician Benefits and Other Covered Services

Precertification is required for the following outpatient hospital benefits, physician benefits and other covered services. You can find more information about the specific services that require precertification at AlabamaBlue.com/Precert. This list will be updated no more than twice a calendar year. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services.

The general categories or descriptions of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the printing of this booklet include:

- Certain advanced imaging (such as, for example, MRA, MRI, CT, CTA and PET);
  For precertification, call 1-866-803-8002 (toll free).

- Intensive outpatient services and partial hospitalization.
  For precertification, call 1-800-548-9859 (toll free).

- Certain select procedures (such as, for example, implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, and surgery for obstructive sleep apnea);
  For precertification, call 1-800-248-2342 (toll free).

- Certain reconstructive procedures (such as, for example, reduction mammoplasty, rhinoplasty, and surgery for varicose veins);
  For precertification, call 1-800-248-2342 (toll free).

- Certain durable medical equipment (such as, for example, motorized/power wheelchair)
  For precertification, call 1-800-248-2342 (toll free).

- Home health and hospice when services are rendered outside the state of Alabama
  For precertification, call 1-800-821-7231 (toll free).

- Certain radiation therapy management services (such as, for example, proton beam therapy, cyberknife and stereotactic radiosurgery); and
  For precertification, call 1-866-803-8002 (toll free).

- Certain genetic laboratory testing (such as, for example, breast cancer (BRCA) testing and genetic carrier screening).

  For precertification, call 1-866-803-8002 (toll free).

- ABA therapy services.

For precertification, call 1-877-563-9347 (toll free)

If precertification is not obtained, no benefits will be payable for these services.

Provider-Administered Drugs

Precertification (also sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find a list of the provider-administered drugs that require precertification at AlabamaBlue.com/ProviderAdministeredSpecialtyDrugList. This list will be updated monthly.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office or home healthcare setting. Provider-administered drugs also include gene therapy and cellular immunotherapy. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

For precertification, call the Customer Service Department number on the back of your ID card.
If precertification is not obtained, no benefits will be payable under the plan for the provider-administered drugs.

Prescription Drug Benefits

Precertification (also sometimes referred to as prior authorization) is required for certain prescription drugs. You can find a list of the prescription drugs that require precertification at AlabamaBlue.com/SourceRx1DrugList6T. This list will be updated quarterly.

For precertification, call the Customer Service Department number on the back of your ID card.

If precertification is not obtained, no benefits will be payable under the plan for the prescription drug.

BENEFITS

Attention: Benefit levels for most mental health disorders and substance abuse are not separately stated. Please refer to the appropriate subsections below that relate to the services or supplies you receive, such as **Inpatient Hospital Benefits**, **Outpatient Hospital Benefits**, **etc.**

Inpatient Hospital Benefits

Attention: Precertification is required for all hospital admissions(including within 48 hours or next business day after the admission in the case of a medical emergency or accidental injury admission). You can find more information about this in the Medical Necessity and Precertification section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Inpatient First 365 days of care during each confinement in a general hospital or psychiatric specialty hospital (combined in-network and out-of-network)	100% of the allowed amount, after a $500 per day copayment for days 1-5 for each admission	50% of the allowed amount, subject to a $3,000 per admission deductible **Note:** Available for accidental injury and medical emergency only
Inpatient Days of confinement in a general hospital or psychiatric specialty hospital extending beyond the 365-day benefit maximum	80% of the allowed amount, subject to the plan year deductible	50% of the allowed amount, subject to the plan year deductible **Note:** Available for accidental injury and medical emergency only

Attention: The only in-network inpatient benefits available outside the Alabama service area are medical emergency and accidental injury services in an in-network hospital.

The per admission inpatient deductible is due for each admission or readmission; however, only one deductible is due per pregnancy, during transfers from one hospital to another, or when two or more family members are admitted as inpatient as a result of injuries received in one accident.

Inpatient hospital benefits consist of the following if provided during a hospital stay:

1. Bed and board and general nursing care in a semiprivate room;
2. Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them;
3. Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
4. Administration of anesthetics by hospital employees and all necessary equipment and supplies;
5. Casts, splints, surgical dressings, treatment and dressing trays;
6. Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and x-rays;
7. Physical therapy, hydrotherapy, radiation therapy and chemotherapy;
8. Oxygen and equipment to administer it;
9. All drugs and medicines used by you if administered in the hospital;
10. Regular nursery care and diaper service for a newborn baby while its mother has coverage; and,
11. Blood transfusions administered by a hospital employee.

If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward any applicable maximum number of inpatient days.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the setting in which they were rendered. This means that we may, at times, reclassify an inpatient hospital admission as outpatient services. There may also be times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

Generally we will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, this does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, we will not require that you or a provider obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Outpatient Hospital Benefits

Attention: Precertification is required for certain outpatient hospital benefits. You can find more information about this in the **Medical Necessity and Precertification** section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Outpatient surgery (including ambulatory surgical centers)	100% of the allowed amount, after a $500 hospital copayment	Not covered
Emergency room-medical emergency and accidental injury	100% of the allowed amount, after a $500 hospital copayment Mental health and substance abuse: 50% of the allowed amount, subject to the plan year deductible	50% of the allowed amount, subject to the plan year deductible
Outpatient diagnostic lab, X-ray and pathology	100% of the allowed amount, after a $500 hospital copayment	Not covered
Outpatient dialysis, IV therapy, chemotherapy and radiation therapy	100% of the allowed amount, after a $500 hospital copayment	Not covered
Intensive outpatient services and partial hospitalization for mental health disorders and substance abuse	100% of the allowed amount, subject to a $50 copayment	Not covered
Services billed by the facility for an emergency room visit when the patient's condition does not meet the definition of a medical emergency (including any lab and X-ray exams and other diagnostic tests associated with the emergency room fee)	80% of the allowed amount, subject to the plan year deductible	Not covered
Outpatient hospital services or supplies not listed above and not listed in the section of the booklet called Other Covered Services	80% of the allowed amount, subject to the plan year deductible	Not covered

Attention: The only in-network outpatient hospital benefits available outside the Alabama service area are medical emergency and accidental injury services in an in-network hospital.

Outpatient hospital benefits include provider-administered drugs. You can find more information about provider-administered drugs in the Medical Necessity and Precertification section of this booklet.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the setting in which they were rendered. This means that we may, at times, reclassify an outpatient hospital service as an inpatient admission. There may also be times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

Physician Benefits

Attention: Precertification is required for certain physician benefits. You can find more information about this in the **Medical Necessity and Precertification** section of this booklet.

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

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Office visits, consultations, and psychotherapy	100% of the allowed amount, after a $50 copayment	Not covered
Telephone and online video consultations program To enroll in the telephone and online video consultations program, go to Teladoc.com/Alabama or call 1-855-477-4549. Telephone and online video consultations are available through **Teladoc** to diagnose, treat and prescribe medication (when necessary) for certain medical issues. Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations (where available) are offered 7 days a week, 7 a.m. to 9 p.m.	100% of the allowed amount, subject to a $45 copayment per consultation	Not covered
Emergency room physician	100% of the allowed amount, after a $125 copayment	50% of the allowed amount, subject to the plan year deductible **Note:** Available for accidental injury and medical emergency only
Surgery and anesthesia for a covered service	80% of the allowed amount, subject to the plan year deductible	Not covered
Maternity care	80% of the allowed amount, subject to the plan year deductible	Not covered
Inpatient visits	80% of the allowed amount, subject to the plan year deductible	Not covered

Inpatient consultations by a specialty provider (limited to one consult per specialist per stay)	80% of the allowed amount, subject to the plan year deductible	Not covered
Diagnostic lab, X-rays and pathology	100% of the allowed amount, subject to the plan year deductible	Not covered
Chemotherapy and radiation therapy	80% of the allowed amount, subject to the plan year deductible	Not covered
Psychological testing	50% of the allowed amount, subject to the plan year deductible	Not covered
Allergy testing and treatment	80% of the allowed amount, subject to the plan year deductible	Not covered

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, and heart catheterization.
- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.
- Physician benefits include provider-administered drugs. You can find more information about provider-administered drugs in the Medical Necessity and Precertification section of this booklet.

Attention: The only in-network physician benefits available outside the Alabama service area are medical emergency and accidental injury services in an in-network hospital.

Physician Preventive Benefits

Attention: The only in-network physician preventive benefits available outside the Alabama service area are routine immunizations received from Pharmacy Vaccine Network.

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

Some immunizations may be covered in-network not only when provided in an in-network physician's office, but also when provided by an in-network pharmacy that participates in the **Pharmacy Vaccine Network**. Pharmacy Vaccine Network pharmacies have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to provide and administer certain immunizations.

To find a pharmacy that participates in the Pharmacy Vaccine Network:

1. Go to AlabamaBlue.com/ValueONEVaccinePharmacyLocator.
2. Enter a search location by using the zip code or city and state for the area you would like to search.
3. Click the Search button to find a pharmacy in the Vaccine Network for ValueONE Network.

A list of the eligible vaccines these pharmacies may provide can be found at: AlabamaBlue.com/VaccineNetworkDrugList.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Routine newborn exam (in hospital) One per benefit period	80% of the allowed amount, no deductible or copayment	Not covered
Routine well child care exams: First 24 months – 9 visits Age 2 – 1 visit Age 3 – 1 visit Age 4 – 1 visit Age 5 – 1 visit Age 6 – 1 visit	80% of the allowed amount, no deductible or copayment	Not covered

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Routine Immunizations To find a pharmacy that participates in the Pharmacy Vaccine Network: 1. Go to AlabamaBlue.com/ValueONEVaccinePharmacyLocator 2. Enter a search location by using the zip code or city and state for the area you would like to search 3. Click the Search button to find a pharmacy in the Vaccine Network for ValueONE Network. A list of the eligible vaccines these pharmacies may provide can be found at AlabamaBlue.com/VaccineNetworkDrugList	100% of the allowed amount, no deductible or copayment	Not covered
Routine pap smear: One per benefit period	80% of the allowed amount, no deductible or copayment	Not covered
Routine screening mammogram: One exam for females ages 35-39 and one exam per calendar year for females ages 40 and over (See the Women's Health and Cancer Rights Act section for additional information)	80% of the allowed amount, no deductible or copayment	Not covered
Routine PSA/Routine DRE (prostate specific antigen and digital rectal exam) One per benefit period for males age 40 and over	80% of the allowed amount, no deductible or copayment	Not covered
Routine Human Papilloma Virus (HPV) Testing One per benefit period for females age 30 and over	80% of the allowed amount, no deductible or copayment	Not covered
Routine Developmental Screening One per benefit period between the ages of 9 months and 30 months	80% of the allowed amount, no deductible or copayment	Not covered

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Routine Chlamydia Screening One per benefit period for females ages 15-24	80% of the allowed amount, no deductible or copayment	Not covered
Routine office visits: One per benefit period for ages 7 and over	80% of the allowed amount, no deductible or copayment	Not covered
Colorectal cancer screening – ages 50 and over: Fecal occult blood test (FOBT) once per calendar year Flexible sigmoidoscopy once per benefit period Double-contrast barium enema once per benefit period Colonoscopy once per benefit period	80% of the allowed amount, no deductible or copayment	Not covered

Other Covered Services

Attention: Precertification is required for certain other covered services. You can find more information about this in the **Medical Necessity and Precertification** section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Accident-related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury	80% of the allowed amount, subject to the plan year deductible	Not covered
Ambulance services	80% of the allowed amount, subject to the plan year deductible	50% of the allowed amount, subject to the plan year deductible
Chiropractic services	80% of the allowed amount, subject to the plan year deductible	Not covered
Dialysis services at a renal dialysis facility	80% of the allowed amount, subject to the plan year deductible	Not covered
DME: Durable medical equipment and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints **Note:** For DME the allowed amount will generally be the lesser of the rental or purchase price	80% of the allowed amount, subject to the plan year deductible	Not covered
Home health and hospice care In-network home healthcare benefits consist of intermittent home nursing visits and home phototherapy for newborns ordered by your attending physician In-network hospice benefits consist of physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management provided to a member certified by his physician to have less than six months to live	80% of the allowed amount, subject to the plan year deductible	Not covered

Home infusion Home infusion benefits include coverage of certain provider-administered drugs ordered by your attending physician and administered by a home infusion service provider in the home or in an infusion suite associated with the home infusion service provider. In-network benefits include coverage of the provider-administered drug and drug infusion related administration services. See **Provider-Administered Drugs** paragraph under the **Medical Necessity and Precertification** section of this booklet for precertification requirement of these drugs.	100% of the allowed amount, subject to a $250 copayment	Not covered
Occupational, physical and speech therapy Limited to a combined maximum of 30 visits per member per calendar year (combined in-network and out-of-network)	80% of the allowed amount, subject to the plan year deductible	Not covered
Occupational, speech and physical therapy, ages 0-18, for autism spectrum disorders	80% of the allowed amount, subject to the plan year deductible	Not covered
ABA therapy, ages 0-18, for autism spectrum disorders	80% of the allowed amount, subject to the plan year deductible	Not covered

Attention: The only in-network other covered services benefits available outside the Alabama service area are ambulance services.

Prescription Drug Benefits

Attention: Precertification (sometimes referred to as prior authorization) is required for certain prescription drugs. You can find more information about this in the **Medical Necessity and Precertification** section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Prescription Drug The pharmacy network for the plan is the **ValueONE Network** • Locate a ValueONE Network Pharmacy at AlabamaBlue.com/ValueONEPharmacyLocator Prescription drugs (other than maintenance prescription drugs) can be dispensed for up to a 30-day supply • View the **SourceRx 1.0 Drug** list that applies to the plan at AlabamaBlue.com/SourceRx1DrugList6T Maintenance prescription drugs can be dispensed for up to a 90-day supply but the copayment is applicable for each 30-day supply • View the Maintenance Drug List that applies to the plan at AlabamaBlue.com/MaintenanceDrugList The only in-network pharmacy for some Tiers 5 and 6 (specialty) drugs is the **Pharmacy Select Network** • View the Specialty Drug List that applies to the plan at AlabamaBlue.com/SelfAdministeredSpecialtyDrugList Some immunizations may be received from an in-network pharmacy that participates in the **Pharmacy Vaccine Network.** A list of eligible vaccines these pharmacies may provide can be found at: AlabamaBlue.com/VaccineNetworkDrugList	100% of the allowed amount, subject to the following: **Tier 1 drugs:** $15 per prescription copayment **Tier 2 drugs:** $30 per prescription copayment **Tier 3 drugs:** $60 per prescription copayment **Tier 4 drugs:** 0% of the allowed amount **Tier 5 (preferred specialty) drugs:** $250 per prescription copayment **Tier 6 (non-preferred specialty) drugs:** 0% of the allowed amount **Fertility drugs:** Not covered Covered Insulin Products: $99 maximum cost share per 30-day supply	Not covered

Prescription drug benefits are subject to the following terms and conditions:

- To be eligible for benefits, drugs must be FDA approved legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal law prohibits dispensing without a prescription."

- Drugs are classified in tiers generally by their cost to the plan with Tier 1 drugs having the lowest cost to the plan and Tier 6 (non-preferred specialty) having the highest cost to the plan. To determine the Tier in which a drug is classified by your plan, log into *my*BlueCross at AlabamaBlue.com. Once there, you can search for your drug by clicking the "Find Drug Pricing" link located in the Manage My Prescriptions section of our website. The Tier drug classifications are updated periodically.

- Prescription drug coverage is subject to Drug Coverage Guidelines developed and modified over time based upon daily or monthly limits as recommended by the Food and Drug Administration, the manufacturer of the drug, and/or peer-reviewed medical literature. These guidelines can be found in the pharmacy section of our website. Even though your physician has written a prescription for a drug, the drug may not be covered under the plan or clinical edit(s) may apply (i.e. prior authorization, step therapy, quantity limitation) in accordance with the guidelines. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. You may call the Customer Service Department number on the back of your ID card for more information.

- Prescription drug benefits are provided only if dispensed by an in-network pharmacy. Except for certain Tier 5 (preferred specialty) drugs and Tier 6 (non-preferred specialty) drugs, in-network pharmacies are pharmacies that have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense prescription drugs under the plan. For certain Tier 5 (preferred specialty) drugs and Tier 6 (non-preferred specialty) drugs, in-network pharmacies must have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense Tier 5 (preferred specialty) drugs and Tier 6 (non-preferred specialty) drugs.

- Tier 5 (preferred specialty) drugs and Tier 6 (non-preferred specialty) drugs are high-cost drugs that may be used to treat certain complex and rare medical conditions and are often self-injected or self-administered. Specialty drugs often grow out of biotech research and may require refrigeration or special handling.

- Compounded drugs are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded drugs may be subject to additional coverage criteria and utilization management edits. Compounds are covered only when medically necessary. Compound drugs are always classified as Tier 4 drugs.

> **Attention:** Just because a drug is classified as Tier 1 or any other classification on our website does not mean the drug is safe or effective for you. Only you and your prescribing physician can make that determination.

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

- Insulin, needles, and syringes purchased on the same day will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day will have one copayment. Otherwise, each has a separate copayment. Glucose monitors always have a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan.

Provider-Administered Drug Benefits

> Attention: Precertification (sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find more information about this in the Medical Necessity and Precertification section of this booklet.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office or home healthcare setting. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

Provider-administered drugs also include gene therapy and cellular immunotherapy. Gene therapy is generally a therapy designed to introduce genetic material into cells to compensate for abnormal genes or to make a beneficial protein. Cellular immunotherapy is generally the artificial stimulation of the immune system to treat cancer, such as cytokines, cancer vaccines oncolytic virus therapy, T-Cell therapy and some monoclonal antibodies.

Provider-administered drug coverage is subject to Drug Coverage Guidelines and medical necessity policies found in the pharmacy section of our website. A drug may not be covered under the plan because, for example, there are safety and/or efficacy concerns. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. The guidelines in some instances also require the drug administered by a provider and/or facility approved by the drug manufacturer.

ADDITIONAL BENEFIT INFORMATION

Individual Case Management

Unfortunately, some people suffer from catastrophic, long-term or chronic illness or injury. If you suffer due to one of these conditions, a Blue Cross Registered Nurse may work with you, your physician, and other healthcare professionals to design a benefit plan to best meet your healthcare needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to Blue Cross, you, and your physician. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through individual case management are subject to your plan benefit maximums. If you think you may benefit from individual case management, please call our Health Management Department at 1-205-733-7067 or 1-800-821-7231 (toll-free).

Chronic Condition Management

You may also qualify to participate in the chronic condition management program. The chronic condition management program is available for members with heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD), asthma and other specialized conditions. This program offers personalized care designed to meet your lifestyle and health concerns. Our staff of healthcare professionals will help you cope with your illness and serve as a source of information and education. Participation in the program is completely voluntary. If you would like to enroll in the program or obtain more information, call 1-888-841-5741 (Monday – Friday, 8 a.m. to 4:45 p.m. CST), or e-mail membermanagement@bcbsal.org.

Baby Yourself Program

Baby Yourself offers individual care by a registered nurse. Please call our nurses at 1-800-222-4379 (or 1-205-733-7065 in Birmingham) or visit AlabamaBlue.com/BabyYourself as soon as you find out

you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant.

If you fall into one of the following risk categories, please tell your doctor and your Baby Yourself nurse: age 35 or older; high blood pressure; diabetes; history of previous premature births; multiple births (twins, triplets, etc.).

Organ and Bone Marrow Transplants

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

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

Transplant benefits for living donor expenses are limited to:

- solid organs: testing for related and unrelated donors as pre-approved by us
- bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrow registry
- prediagnostic testing expenses of the actual donor for the approved transplant
- hospital and surgical expenses for removal of the donor organ, and all such services provided to the donor during the admission
- transportation of the donated organ
- post-operative hospital, medical, laboratory and other services for the donor related to the organ transplant limited to up to 90 days of follow-up care after date of donation

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copayments, coinsurance and other plan limitations. For example, if the member's coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

The only in-network transplant benefits described above outside the state of Alabama are for transplants rendered in an in-network hospital that arises out of a medical emergency or accidental injury.

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

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

Air Medical Transportation

If a member is hospitalized more than 150 miles from home (calculated as a straight-line distance, not road miles) air ambulance transportation is available to transport the member to a hospital of their choice. Ground ambulance transportation is provided from the hospital to the aircraft and then from the aircraft to the receiving hospital.

Air ambulance transportation is also available in some cases when a member needs specialized hospital services in a hospital located more than 150 miles from their primary residence so long as the hospital is located within the country of residence (United States or Canada only), the member is unable to travel by commercial means without a medical escort, and the transport is approved by us. This includes transport of transplant recipients.

There are no deductibles, copayments or coinsurance applicable and there are no claim forms to file for this service. Members call a toll free hotline 1-877-872-8624 (available 24 hours a day, 7 days a week) to request air transport services. There are no restrictions on the number of travel days within the United States but services are not available to members travelling outside the United States for more than 90 consecutive days. Services are also not available for (1) any location where the US State Department has issued travel restrictions or declared to be high risk areas; (2) any member with tuberculosis or other chronic airborne pathogens; (3) in most instances a member beyond the second trimester of pregnancy; (4) members with simple injuries or mild illnesses which do not require hospitalization.

Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema. Benefits for this treatment will be subject to the same calendar year deductible and coinsurance provisions that apply for other medical and surgical benefits.

HEALTH BENEFIT EXCLUSIONS

In addition to other exclusions set forth in this booklet, we **will not** provide benefits under any portion of this booklet for the following:

A

Services or expenses for or related to **abortions** (except in cases of rape or incest, or when the life of

the woman would be endangered).

Services or expenses for **acupuncture**, biofeedback, behavioral modification and other forms of self-care or self-help training.

Anesthesia services or supplies or both by local infiltration.

Services, drugs or expenses for or related to the treatment of infertility and/or **Assisted Reproductive Technology (ART)**. ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

B

Services and expenses related to **Blepharoplasty**

C

Services or expenses for which a **claim** is not properly submitted to Blue Cross.

Services or expenses for a **claim we have not received within 12 months** after services were rendered or expenses incurred.

Services or expenses for or related to **cochlear implants.**

Services or expenses for personal hygiene, **comfort or convenience,** items such as: air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.

Services or expenses for sanitarium care, **convalescent care**, or rest care.

Services or expenses for cosmetic surgery. **Cosmetic surgery** is any surgery done primarily to improve or change the way one appears. “Reconstructive surgery” is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. (See the section, Women's Health and Cancer Rights Act for exceptions.) Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

- You must contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.

- Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have

septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.

Services or expenses for treatment of injury sustained in the commission of a **crime** (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.

Services or expenses for **custodial care**. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

D

Dental implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.

Dental services or expenses of any kind except for the limited circumstances set forth in the section of this booklet called Other Covered Services.

Replacement or upgrade of existing properly functioning **durable medical equipment** (including prosthetics), even if the warranty has expired.

E

Services, care, or treatment you receive after the **ending date of your coverage**. This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.

Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.

Eyeglasses or contact lenses or related examination or fittings.

F

Services or expenses in any **federal hospital or facility** except as required by federal law.

Services or expenses for routine **foot care** such as removal of corns or calluses or the trimming of nails (except mycotic nails).

G

Unless otherwise required by applicable law, services or expenses covered in whole or in part under the

laws of the United States, any state, county, city, town or other **governmental** agency that provides or pays for care, through insurance or any other means.

H

Hearing aids or examinations or fittings for them.

I

Implantable devices (and services, supplies, equipment and accessories ancillary to implantation of same), unless provided by an in-network provider or in-network third party vendor and covered by the terms of the applicable in-network contract.

Services or expenses for or related to the treatment of **impotence** or erectile dysfunction, including prescription medications and surgery to implant or remove a penile prosthesis.

Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including services that are part of a clinical trial.

J

Services or expenses for or related to **joint replacement** (unless the joint replacement occurs as a result of a medical emergency or accidental injury).

L

Learning or vocational rehabilitation except for the limited circumstances set forth in the section of this benefit booklet called Other Covered Services.

Services or expenses which you are not **legally obligated to pay**, or for which no charge would be made if you had no health coverage.

Services or expenses for treatment which does not require a **licensed provider**, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency, or duration.

M

Services or expenses we determine are not **medically necessary**.

Services or supplies to the extent that a member is, or would be, entitled to reimbursement under **Medicare**, regardless of whether the member properly and timely applied for, or submitted claims to, Medicare, except as otherwise required by federal law.

Services or expenses for or related to the diagnosis or treatment of **mental retardation**.

N

Services or expenses of any kind for **nicotine addiction** such as smoking cessation treatment. The only exception to this exclusion is expenses for nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist from an in-network pharmacy.

Services, care or treatment you receive during any period of time with respect to which we have **not been paid for your coverage** and that **nonpayment** results in termination.

O

Unless otherwise expressly covered under the Physician Preventive Benefits section of this booklet, services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion includes bariatric surgery and gastric restrictive procedures and any complications arising from bariatric surgery and gastric restrictive procedures. (This exclusion does not apply to cardiac or pulmonary rehabilitation, diabetes self-management programs or plan-approved programs for pediatric obesity.)

Oral prescription drugs specifically prescribed for sexual dysfunction.

P

Hot and cold **packs**, including circulating devices and pumps.

Services or expenses for **"pre-existing condition**." A pre-existing condition is any condition, no matter how caused or which you received medical advice, a diagnosis, care, or for which treatment was recommended or received during the two –year period preceding your effective date. Even if your condition is not diagnosed until after your effective date, we will treat your condition as pre-existing if treatment was recommended or received during the two-year period preceding your effective date for symptoms that are consistent with the presence of your condition

Private duty nursing.

R

Services or expenses for **recreational** or educational therapy (except for plan-approved ABA therapy, diabetic self-management programs, pulmonary rehabilitation programs, or Phase 1 or 2 cardiac rehabilitation programs).

Services and related expenses for or related to **reduction mammoplasty**

Hospital admissions in whole or in part when the patient primarily receives services to **rehabilitate** services such as physical therapy, speech therapy, or occupational therapy unless the admission is determined to be medically necessary for acute inpatient rehabilitation.

Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household.

Replacement or upgrade of existing properly functioning durable medical equipment (including prosthetics), even if the warranty has expired.

Residential treatment

Services or supplies furnished by a facility that is solely classified as a **residential treatment center**.

Services or expenses for or related to **reverse sterilization**.

Services and expenses related to **rhinoplasty.**

Room and board for hospital admissions in whole or in part when the patient primarily receives services that could have been provided on an outpatient basis based upon the patient's condition and the services provided.

Routine well child care and routine immunizations (except for Physician Preventive Benefits).

Routine physical examinations except for (Physician Preventive Benefits).

S

Services or expenses for, or related to **sex therapy** programs or treatment for **sex offenders**.

Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition).

Services or supplies furnished by a **skilled nursing facility**.

Services or expenses for testing or treatment of **sleep disorders**.

Sleep studies performed outside of a healthcare facility, such as home sleep studies, whether or not supervised or attended.

Services, **supplies,** equipment, accessories or other items which can be purchased at retail establishments or otherwise over-the-counter without a doctor's prescription that are not otherwise covered services under another section of this booklet, including but not limited to:

- Hot and cold packs;
- Standard batteries used to power medical or durable medical equipment;
- Solutions used to clean or prepare skin or minor wounds including alcohol solution or wipes, povidone-iodine solution or wipes, hydrogen peroxide, and adhesive remover;
- Standard dressing supplies and bandages used to protect minor wounds such as band aids, 4 x 4 gauze pads, tape, compression bandages, eye patches;
- Elimination and incontinence supplies such as urinals, diapers, and bed pans; and
- Blood pressure cuffs, sphygmometers, stethoscopes and thermometers.

T

Services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded.

It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. For example, braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw or because of injury of natural teeth. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under Other Covered Services.

Treatment for or related to **temporomandibular joint (TMJ) disorders**. This includes Phase I and Phase II Treatment, therapy or exams, according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.

Services, supplies, implantable devices, equipment and accessories billed by any out-of-network **third party vendor** that are used in surgery or any operative setting. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.

Transcutaneous Electrical Nerve Stimulation (TENS) equipment and all related supplies including TENS units, Conductive Garments, application of electrodes, leads, electrodes, batteries and skin preparation solutions.

Services or expenses for or related to organ, tissue or cell **transplants** except specifically as allowed by this plan.

Travel, even if prescribed by your physician (not including ambulance services otherwise covered under the plan).

Services or expenses for or related to the removal of **tonsils** and /or adenoids.

Services or expenses for or related to the placement of **tubes** in the ear (i.e. tympanostomy and myringotomy)

W

Services or expenses for an accident or illness resulting from active participation in **war**, or any act of war, declared or undeclared, or from active participation in riot or civil commotion.

Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation is available in whole or in part under the provisions of any **workers' compensation** or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the group. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your group has insurance coverage for benefits under the law.

COORDINATION OF BENEFITS

We coordinate the benefits under this plan with other group and non-group health plans. For purposes

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

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

For purposes of these coordination of benefits rules, the term “closed panel plan” is a plan that provides healthcare benefits to covered persons in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

When a person is covered by two or more plans, the determination of which plan is primary is decided by the first rule below that applies:

1. If the other plan has no COB provision or a COB provision that is inconsistent in substance with the COB provisions of this plan, the other plan is primary.

2. **Group Health Plan:** If the other plan is a group health plan (for example, a plan sponsored by an employer for its employees and their eligible dependents), the benefits of the other plan are determined before the benefits of this plan. This rule applies regardless of whether the other plan covers the patient as an employee, retiree, COBRA beneficiary, contract holder, or eligible dependent of any of the forgoing.

3. **Non-Group Health Plan:** If the other plan is a non-group health plan, the following rules apply:

    a. The benefits of the plan which covers the person as an applicant, contract holder, or policyholder (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

    b. Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. The term “birthday” refers only to month and day in a calendar year and does not include the year in which the individual is born.

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

        If there is no court decree allocating responsibility for the child’s healthcare expenses or healthcare coverage, the order of benefits for the child are determined as follows:

            1. First, the plan of the custodial parent;
            2. Second, the plan of the spouse of the custodial parent;
            3. Third, the plan of the non-custodial parent; and

4. Last, the plan of the spouse of the non-custodial parent.

The term “custodial parent” means a parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

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

If a court decree states that both parents are responsible for the dependent child’s healthcare expenses or healthcare coverage, benefits are determined as if the parents are not separated or divorced (see paragraph 3.b. above).

If the court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, benefits are determined as if the parents are not separated or divorced (see paragraph 3.b. above).

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined under paragraph 3.b. or 3.c. above, as applicable, as if those individuals were the parents of the child.

d. Longer/Shorter Length of Coverage: If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

e. Equal Division: If none of the above rules determine the order of payment, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

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

For purposes of these coordination of benefits rules, except as set forth below or where a statute requires a different definition, the term “allowable expense” means any healthcare expenses, including coinsurance, co-payments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

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

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.

- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for dental services and supplies, vision care or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit.

For separate rules concerning coordination of plan benefits with Medicare, see the section under Eligibility that discusses Medicare.

Except as otherwise required by law, no amendment or change to this section of the booklet (Coordination of Benefits) will apply to claims incurred before the effective date of the amendment.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payment under this plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

SUBROGATION

Right of Subrogation

If we provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we

have paid or provided. This means that we may use your right to recover money from that other person or organization.

Right of Reimbursement

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

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

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce this plan's rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged to you by your attorney for obtaining the recovery. If you do not give us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

Except as otherwise required by law, no amendment or change to this section of the booklet (Subrogation) will apply to claims incurred before the effective date of the amendment.

CLAIMS AND APPEALS

The following explains the rules under the plan for filing claims and appeals.

Remember that you may always call our Customer Service Department for help if you have a question or problem that you would like us to handle without an appeal. The phone number to reach our Customer Service Department is on the back of this booklet.

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of your

booklet explains how we process these different types of claims and how you can appeal the denial of a claim.

Post-Service Claims

Filing a Claim: For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), we must receive a properly completed and filed claim from you or your provider.

Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. When you receive the form, complete it, attach an itemized bill, and send it to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

Processing of Claims: Even if we have received all of the information that we need in order to treat a submission as a claim, we might need additional information to determine whether the claim is payable. The most common example of this is medical records. If we need additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. However, you will remain responsible for getting us the information on time.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim is filed. If it is necessary for us to ask for additional information, we will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. In order to file a pre-service claim you or your provider must call our Health Management Department at 1-205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do require you to file a notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission.

Urgent Pre-Service Claims: We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information,

we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing within three days. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing the information to us.

Non-Urgent Pre-Service Claims: If your claim is not urgent, we will notify you of our decision within 15 days. If we need more information, we will let you know before the 15-day period expires. We will tell you what further information we need. You will then have 90 days to provide this information to us. In order to expedite our receipt of the information, we may request it directly from your provider. However, you will remain responsible for seeing that we get the information on time. We will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

Courtesy Pre-Determinations: For some procedures we encourage, but do not require, you to contact us before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask us to determine beforehand whether the procedure is cosmetic or reconstructive. We call this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, we will do our best to provide you with a timely response. Courtesy pre-determinations are not pre-service claims under the plan. When we process requests for courtesy pre-determinations, we are not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call our Customer Service Department.

Concurrent Care Determinations

Determinations by us to Limit or Reduce Previously Approved Care: If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you written notice. We will also give you an opportunity to appeal our decision.

Requests by You to Extend Previously Approved Care: If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows: 1-205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).

Appeals

In General: The rules in this section of the booklet allow you or your authorized representative to appeal any denial of a claim. Please note that if you call or write us without following the rules for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

In preparing for an appeal, you may ask us to send you copies of documents that we used in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

In all cases other than determinations by us to limit or reduce previously approved care, you have 180 days following our claim determination within which to submit an appeal.

How to Appeal Post-Service Claim Determinations: If you wish to file an appeal of a post-service claim determination, we recommend that you use a form that we have developed for this purpose. The

form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our Customer Service Department. You may also go to our website at AlabamaBlue.com. Once there, you may ask us to send a copy of the form to you.

If you choose not to use our appeal form, you may send us a letter. Your letter must contain at least the following information:

1. The patient's name;

2. The patient's contract number;

3. Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number, if available (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,

4. A statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross Blue Shield of Alabama
Attention: Customer Service Department – Appeals
P. O. Box 12185
Birmingham, Alabama 35202-2185

How to Appeal Pre-Service Adverse Benefit Determinations: You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call 1-205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free). If in writing, you should send your letter to:

Blue Cross and Blue Shield of Alabama
Attention: Health Management Department – Appeals
P. O. Box 2504
Birmingham, Alabama 35201-2504

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Time Limits For Our Consideration Of Your Appeal: If your appeal arises from our denial of a post-service claim, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a pre-service claim, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. If your pre-service claim is not urgent, we will give you a response within 30 days.

If your appeal arises out of a determination by us to limit or reduce a hospital stay or course of treatment that we previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), we will make a decision on your appeal as soon as possible. If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), we will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us

additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you have filed an appeal and are dissatisfied with our response, you may do one or more of the following:

1. You may ask our Customer Service Department for further help;
2. You may file a voluntary appeal (discussed below); or,
3. You may file a claim for arbitration, as explained under the section of this booklet dealing with arbitration.

Voluntary Appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service claim determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal, and state that you are filing a voluntary appeal.

Department of Insurance: If you have general insurance questions or if you are dissatisfied with an appeal decision from Blue Cross and Blue Shield of Alabama, you have the right to contact the Alabama Department of Insurance. For health insurance questions, contact the DOI by phone at 1-334-241-4141. The mailing address is P.O. Box 303351, Montgomery, Alabama 36130-3351. The web address is www.aldoi.gov.

Limitation on Effect of Certain Amendments: Except as otherwise required by law, no amendment or change to this section of the booklet (Claims and Appeals) will apply to claims incurred before the effective date of the amendment.

GENERAL INFORMATION

Discretionary Authority to Blue Cross

We have the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with the administration of the plan. Whenever we make reasonable decisions that are neither arbitrary nor capricious, our decisions will be determinative, subject only to your right of review under the plan and thereafter to arbitration to determine whether our decision was arbitrary or capricious.

Arbitration

IN CONSIDERATION OF COVERAGE UNDER THE PLAN AND PAYMENT OF PREMIUMS, YOU (AND WE) AGREE THAT ANY ONE OR MORE OF THE FOLLOWING CLAIMS SHALL BE RESOLVED BY FINAL AND BINDING ARBITRATION:

- **ANY CLAIM THAT ARISES OUT OF OR RELATES TO THE PLAN;**
- **ANY CLAIM THAT INVOLVES ANY RELATIONSHIPS THAT RESULT FROM OR RELATE IN ANY WAY TO THE PLAN (INCLUDING CLAIMS INVOLVING PERSONS OR ORGANIZATIONS WHO ARE NOT PARTIES TO THE PLAN);**

- **ANY CLAIM THAT ALLEGES ANY CONDUCT BY YOU OR US, REGARDLESS OF WHETHER RELATED TO THE PLAN; OR**

- **ANY CLAIM THAT CONCERNS THE VALIDITY, ENFORCEABILITY, SCOPE, OR ANY OTHER ASPECT OF THIS ARBITRATION PROVISION.**

THIS ARBITRATION AGREEMENT IS INTENDED TO HAVE THE BROADEST SCOPE PERMISSIBLE BY LAW, AND INCLUDES ANY AND ALL CLAIMS, WHETHER IN PLAN, TORT, OR OTHERWISE, WHETHER ARISING BEFORE, ON, OR AFTER THE DATE OF COVERAGE UNDER THE PLAN, AND INCLUDING WITHOUT LIMITATION ANY STATUTORY, COMMON LAW, INTENTIONAL TORT, OR EQUITABLE CLAIMS.

THE ARBITRATOR SHALL APPLY GOVERNING FEDERAL LAW, SUCH AS THE FEDERAL ARBITRATION ACT (FAA) AND, TO THE EXTENT FEDERAL LAW IS NOT APPLICABLE, STATE LAW. THE ARBITRATOR SHALL APPLY ALL APPLICABLE STATUTES OF LIMITATIONS AND ANY CLAIMS OF PRIVILEGE RECOGNIZED BY LAW.

THE CLAIMANT IS RESPONSIBLE FOR STARTING THE ARBITRATION PROCEEDINGS BY NOTIFYING THE OTHER PARTY IN WRITING OF THE ARBITRATION DEMAND. IF THE CONTRACT HOLDER OR MEMBER IS THE CLAIMANT, THE WRITTEN ARBITRATION DEMAND SHOULD BE SENT TO THE FOLLOWING ADDRESS:

BLUE CROSS AND BLUE SHIELD OF ALABAMA
LEGAL DEPARTMENT
450 RIVERCHASE PARKWAY EAST
BIRMINGHAM, AL 35244

THE ARBITRATION SHALL BE CONDUCTED BEFORE A SINGLE ARBITRATOR WHO SHALL BE CHOSEN BY THE JOINT AGREEMENT OF THE PARTIES, WITH THE SELECTION TO OCCUR ORDINARILY WITHIN ONE MONTH FROM THE RECEIPT OF THE DEMAND FOR ARBITRATION. IF THE PARTIES CANNOT AGREE ON AN ARBITRATOR, THEY SHALL OBTAIN A LIST OF SEVEN ARBITRATORS FROM THE AMERICAN ARBITRATION ASSOCIATION. THE LIST SHALL BE REDUCED TO ONE ARBITRATOR BY ALTERNATIVE STRIKES, WITH THE CLAIMANT STRIKING FIRST. ALL PARTIES SHALL BE ENTITLED PRIOR TO THE ARBITRATION HEARING TO THE PRODUCTION OF DOCUMENTS RELEVANT TO THE CLAIMANT'S INDIVIDUAL CLAIM AND DEFENSES AND TO THE DEPOSITIONS OF THE KEY WITNESSES. THE ARBITRATION HEARING SHALL ORDINARILY COMMENCE WITHIN FOUR MONTHS OF THE SELECTION OF THE ARBITRATOR UNLESS THE PARTIES AGREE OTHERWISE. ALL DISPUTES CONCERNING ARBITRATION PROCEDURES SHALL BE RESOLVED BY THE ARBITRATOR.

WE WILL BEAR ALL COSTS OF ARBITRATION OTHER THAN YOUR COSTS OF REPRESENTATION. BUT IF YOU INITIATE THE ARBITRATION, AND IF THE ARBITRATOR FINDS THAT THE DISPUTE IS WITHOUT SUBSTANTIAL JUSTIFICATION, THE ARBITRATOR HAS THE AUTHORITY TO ORDER THAT THE COST OF THE ARBITRATION PROCEEDINGS BE BORNE BY YOU.

THE ARBITRATION WILL OCCUR IN THE COUNTY IN WHICH YOU RESIDE UNLESS THE PARTIES AGREE TO A DIFFERENT LOCATION. PRIOR TO THE ARBITRATION, IF ALL PARTIES CONSENT TO MEDIATE THE CLAIM, THE CLAIM WILL BE REFERRED TO A SEPARATE MEDIATOR, BUT ARBITRATION WILL FOLLOW IF NO SETTLEMENT IS REACHED.

THE ARBITRATOR SHALL BE EMPOWERED TO GRANT WHATEVER RELIEF WOULD BE AVAILABLE IN COURT UNDER LAW OR EQUITY, EXCEPT AS EXPRESSLY LIMITED BY THE

CONTRACT. THE ARBITRATOR'S DECISION SHALL BE IN WRITING, SHALL CONTAIN FINDINGS OF FACT AND CONCLUSIONS OF LAW, AND SHALL SPECIFY THE TYPE OF ANY DAMAGES OR RELIEF AWARDED.

IN ALL CASES, THE ARBITRATOR'S DECISION SHALL BE FINAL AND BINDING, EXCEPT THAT IT MAY BE REVIEWED IN COURT TO THE LIMITED EXTENT PERMITTED BY THE FAA AND THIS PARAGRAPH. MOREOVER, IF THE AMOUNT IN CONTROVERSY EXCEEDS $50,000, ON APPEAL BY EITHER PARTY, THE COURT SHALL ALSO REVIEW THE ARBITRATOR'S DECISION USING THE STANDARD OF APPELLATE REVIEW APPLICABLE WHENEVER A COURT REVIEWS THE DECISION OF A TRIAL COURT SITTING WITHOUT A JURY. THE FOLLOWING RULES SHALL APPLY WHEN DETERMINING THE AMOUNT IN CONTROVERSY: (1) ALL CLAIMS OF ALL CLAIMANTS IN THE PROCEEDING SHALL BE AGGREGATED, AND (2), CLAIMS FOR UNSPECIFIED AMOUNTS, SUCH AS EMOTIONAL DISTRESS AND PUNITIVE DAMAGES, SHALL BE DEEMED TO EXCEED $50,000.

THIS PLAN IS MADE PURSUANT TO A TRANSACTION INVOLVING INTERSTATE COMMERCE, AND IS BE GOVERNED BY THE FAA. IF ANY PORTION OF THIS ARBITRATION PROVISION IS DEEMED INVALID OR UNENFORCEABLE, THE REMAINING PORTIONS SHALL CONTINUE IN FULL FORCE AND EFFECT.

EXCEPT AS OTHERWISE REQUIRED BY LAW, NO AMENDMENT OR CHANGE TO THE ARBITRATION PROVISIONS ABOVE WILL APPLY TO CLAIMS INCURRED BEFORE THE EFFECTIVE DATE OF THE AMENDMENT.

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us.

If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will show in your Claim Report.

Health Plan Termination

We may terminate the plan under the following two circumstances:

1. If we decide to discontinue offering this product, we may elect to terminate your plan (which will terminate your coverage and the coverage and all of your dependents) by giving you at least 90 days prior written notice. If we do this, and if we offer other health products in the individual market, we will give you the option to purchase any of these other products without regard to your health status or the health status of your dependents.

2. If we decide to discontinue offering all coverage in the individual health insurance market, we may elect to terminate your plan (which will terminate your coverage under the plan and all dependents) by giving you at least 180 days prior written notice.

Health Plan Changes

Except as other portions of this booklet expressly limit our right to amend the plan, we may change, add to, or remove any term of the plan or alter coverage under the plan. We will give you written notice of any such changes at least 30 days before the effective date of the changes. The changes will apply to all benefits for services you receive on or after the effective date of the changes (except as expressly limited by other portions of this booklet). If you submit payment for coverage to us after the effective date of the changes, your payment will be considered your acceptance of the benefit plan changes. Any

changes we make will apply on a uniform basis to all policyholders who have purchased the same type contract as you.

The written notice of changes referred to above must be signed by one of our officers in order to be effective. None of our representatives, officers, employees, or agents can make any plan changes orally, as by telephone, or in any other way except in a signed writing as described in this paragraph.

By giving 30 days' notice in writing to you, we may change the amount of your premium. Your payment of the new premium will be considered acceptance by you of the new premium.

Responsibility for Providers

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we cannot be responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you commit fraud or make an intentional material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to your effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage.

No Assignment

As discussed in more detail in the Claims and Appeals section of this benefit booklet, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in- network provider (as required by our contract with your in-network provider) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the provider – even if you have assigned payment of your claim to someone else. When we pay you or your provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

Alabama Insurance Fraud Investigation Unit and Criminal Prevention Act

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

DEFINITIONS

ABA Therapy: ABA therapy is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Accidental Injury: A traumatic injury to you caused solely by an accident.

Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that we recognize for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by us to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

1. **In-Network Providers:** Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered care. The negotiated price applies only to services that are covered under the plan and also covered under the contract that has been signed with the in-network provider.
   Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2), which subset of those providers will be considered BlueCard PPO providers, and (3), the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.

   See Out-of-Area Services, earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Alabama.

2. **Out-of-Network Providers:** In accordance with Blue Cross and Blue Shield of Alabama's applicable provider payment policies in effect at the time the service is rendered, the allowed amount for care rendered by out-of-network providers may be based on the negotiated rate payable to in-network providers for the care in the area, may be based on the average charge for the care in the area, or may be based on a percentage of what Medicare would typically pay for the care in the area (or, if no Medicare rates are available, an approximation of what Medicare would pay for care using various sources). In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

   - The charge or average charge for the same or a similar service;
   - Pricing data from the local Blue Cross and/or Blue Shield plan where services are rendered;
   - The relative complexity of the service;
   - The in-network allowance in Alabama for the same or a similar service;
   - Applicable state healthcare factors;
   - The rate of inflation using a recognized measure; and,
   - Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

   For services provided by an out-of-network provider, the provider may bill the member for charges in excess of the allowed amount. The allowed amount will not exceed the amount of the provider's charge.

Ambulatory Surgical Center: A facility that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care, hospital bed. In order to be considered an ambulatory surgical facility under the plan, the facility must meet the conditions for participation in Medicare.

Assisted Reproductive Technology (ART): Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body)

to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

Bariatrics: Services, conditions, or expenses which are based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction, or dietary control. This includes bariatric surgery and gastric restrictive procedures and complications arising from bariatric surgery and gastric restrictive procedures.

Blue Cross: Blue Cross and Blue Shield of Alabama, except where the context designates otherwise.

BlueCard® Program: An arrangement among Blue Cross Plans by which a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur. The BlueCard program is explained in more detail in other sections of this booklet, such as In-Network Benefits and Out-of-Area Services. The BlueCard Program is available only for ambulance services and services rendered in an in-network hospital for medical emergencies and accidental injuries.

Contract: The contract consists of your application for coverage (once accepted by us), this booklet, and any amendments or changes to this booklet. The terms “contract” and “plan” are used interchangeably unless the context requires otherwise.

Cosmetic Surgery: Any surgery done primarily to improve or change the way one appears, cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma or birth defect. For important information on cosmetic surgery, see the exclusion under Health Benefit Exclusions for cosmetic surgery.

Custodial Care: Care primarily to provide room and board for a person who is mentally or physically disabled.

Diagnostic: Services performed in response to signs or symptoms of illness, condition or disease or in some cases where there is family history of illness, condition or disease.

Durable Medical Equipment (DME): Equipment we approve as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

General Hospital: Any institution that is classified by us as a “general” hospital using, as we deem applicable, generally available sources of information.

Home Infusion Service Provider: A home infusion service provider is a state-licensed pharmacy that specializes in provision of infusion therapies to patients in their home or other alternate sites associated with the home infusion provider such as a home infusion suite.

Home Healthcare Agency: An organization that provides care at home for homebound patients who need skilled nursing or skilled therapy. In order to be considered a home healthcare agency under the terms of the plan, the organization must meet the conditions for participation in Medicare.

Hospice: An organization whose primary purpose is the provision of palliative care. Palliative care means the care of patients whose disease is not responsive to curative treatments or interventions. Palliative care consists of relief of pain and nausea and psychological, social, and spiritual support services. In order for an organization to be considered a hospice under this plan it must meet the conditions for participation in Medicare.

Implantables: An implantable device is a biocompatible mechanical device, biomedical material, or therapeutic agent that is implanted in whole or in part and serves to support or replace a biological structure, support and/or enhance the command and control of a biological process, or provide a therapeutic effect. Examples include, but are not limited to, cochlear implants, neurostimulators, indwelling orthopedic devices, cultured tissues, tissue markers, radioactive seeds, and infusion pumps.

In-Network Providers: See the In-Network Benefits subsection of the Overview of the Plan section of the booklet.

Inpatient: A registered bed patient in a hospital; provided that we reserve the right in appropriate cases to reclassify inpatient stays as outpatient services, as explained above in Inpatient Hospital Benefits and Outpatient Hospital Benefits.

Intensive Outpatient: Mental health disorder and substance abuse services provided in a licensed facility by a licensed provider for a minimum of three hours per day at least three days per week with active psychosocial treatment and medication management as needed.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when we make determinations about the investigational nature of a service or supply we are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Medical Emergency: A medical condition that occurs suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention to prevent permanent damage to the health, other serious medical results, serious impairment to bodily function, or serious and permanent lack of function of any bodily organ or part.

Medically Necessary or Medical Necessity: We use these terms to help us determine whether a particular service or supply will be covered. When possible, we develop written criteria (called medical criteria) that we use to determine medical necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is not medically necessary according to one of our published medical criteria policies, we will not pay for it.

If a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be medically necessary only if we determine that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not “investigational”; and,
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when we make medical necessity determinations, we are making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Member: You or your eligible dependent who has coverage under the plan.

Mental Health Disorders: These are mental disorders, mental illness, psychiatric illness, mental conditions and psychiatric conditions. These disorders, illnesses and conditions are considered mental health disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders regardless of how they are caused, based, or brought on. Mental health disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are generally intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Out-of-Network Provider: A provider who is not an in-network provider.

Outpatient: A patient who is not a registered bed patient of a hospital. For example, a patient receiving services in the outpatient department of a hospital or in a physician’s office is an outpatient; provided that we reserve the right in appropriate cases to reclassify outpatient services as inpatient stays, as explained above in Inpatient Hospital Benefits and Outpatient Hospital Benefits.

Partial Hospitalization: Mental health disorder and substance abuse services provided in a licensed facility by a licensed provider for a minimum of six hours per day, five days per week with active psychosocial treatment and medication management as needed.

Physician: One of the following when licensed and acting within the scope of that license at the time and place you are treated or receive services: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic (D.C.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.).

With respect to the following non-physicians, we will treat professional services as though they have been provided by a physician, subject to the terms of any applicable contracts with providers:

- Psychologists who are licensed by the state in which they practice (Ph.D., Psy.D. or Ed.D.), as defined in Section 27-1-18 of the Alabama Code or other applicable state law.

- In-network Certified Registered Nurse Practitioners who are practicing within the scope of their license and in collaboration with an in-network M.D. or D.O.

- In-network Certified Nurse Midwives who are practicing within the scope of their license and in collaboration with an in-network M.D. or D.O.

- In-network Physician Assistants (P.A.s) (including P.A.s who assist in surgery) when the P.A. is acting within the scope of his or her license and is in compliance with the rules, regulations, and parameters applicable under local law to the P.A. and when the services of the P.A. would have been covered if provided directly by the M.D. or D.O.

- Anesthesiologist Assistants and Certified Registered Nurse Anesthetists.

Plan: The plan consists of your application for coverage (once accepted by us), this booklet, and any amendments or changes to this booklet. The terms “plan” and “contract” are used interchangeably unless the context requires otherwise.

Preadmission Certification: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or within 48 hours or the next business day after the admission in the case of an emergency admission or accidental injury, based upon medically recognized criteria.

Precertification: The procedures used to determine the medial necessity of the treatment prior to the service, or within 48 hours or the next business day after the service in the case of a medical emergency.

Pre-existing condition: Any condition, no matter how caused, for which you received medical advice, a diagnosis, care, or for which treatment was recommended or received during the two-year period preceding your effective date. Even if your condition is not diagnosed until after your effective date, we will treat your condition as pre-existing if treatment was recommended or received during the two-year period preceding your effective date for symptoms that are consistent with the presence of your condition.

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

Preventive or Routine: Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

Private Duty Nursing: A session of four or more hours during which continuous skilled nursing care is furnished to you alone.

Psychiatric Specialty Hospital: An institution that is classified as a psychiatric specialty facility by such relevant credentialing organizations as we or any Blue Cross and/or Blue Shield plan (or its affiliates) determines. A psychiatric specialty hospital does not include a substance abuse facility.

Residential treatment: Continuous 24 hour per day care provided at a live-in facility for mental health or substance abuse disorders.

Substance Abuse: The uncontrollable or excessive abuse of addictive substances, such as (but

not limited to) alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use.

Substance Abuse Facility: Any institution that is classified as a substance abuse facility by such relevant credentialing organizations as we or any Blue Cross and/or /Blue Shield plan (or its affiliates) determine and that provides outpatient substance abuse services.

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider. Teleconsultations include consultations by e-mail or other electronic means.

We, Us, Our: Blue Cross and Blue Shield of Alabama.

You, Your: The contract holder or member as shown by the context.

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STP-C22-2104

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