CPlus℠

A Medicare Select Plan

with PMD

A Medicare Select Contract

Notice to Buyer: This policy may not cover all of your medical expenses.

PLAN B

CAD62-2409

NOTICE REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE INSURANCE

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244-2858

C Plus Medicare Select Plan B

SAVE YOUR COPY OF THIS NOTICE!
IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

This notice applies to you only if you intend to cancel existing Medicare supplement or Medicare Advantage insurance and replace it with this C Plus Medicare Select Plan B policy issued by Blue Cross and Blue Shield of Alabama. You have 30 days to decide whether you want to keep your new C Plus policy. If you do not want to keep it, we will refund any fees paid if you let us know within 30 days of your effective date.

You should review this new policy carefully. Compare it with all accident and sickness coverage you now have that may duplicate this policy. If you find that the purchase of this C Plus Medicare Select Plan B is a wise decision, you should terminate your present Medicare supplement policy or Medicare Advantage plan. Before you cancel an existing Medicare supplement policy or Medicare Advantage plan, you should determine whether there is a good reason to replace that coverage with this C Plus Medicare Select Plan B policy issued by Blue Cross and Blue Shield of Alabama. When making your decision consider whether this policy provides additional benefits, similar benefits but lower premiums, or fewer benefits but lower premiums.

If you determine that your existing Medicare supplement policy or Medicare Advantage plan is better for you and you decide to keep that coverage, you must notify us of your decision within 30 days because we may not sell you this C Plus Medicare Select Plan B policy if you have an existing Medicare supplement policy or participate in a Medicare Advantage plan.

If you are certain that you wish to terminate your present policy and replace it with new coverage, be certain that you have truthfully and completely answered all questions on the application. Failure to include all material information on an application may allow or require us to deny any future claims and to refund your premium as though the policy had never been in force. You should review your copy of the application you submitted carefully to be certain that all information in it is correct and accurate.

Do not cancel your present Medicare supplement policy or Medicare Advantage plan until you have received your new policy from us and are sure that you want to keep it.

C Plus Medicare Select Plan B

Welcome to C Plus

Thank you for choosing our C Plus Medicare Select Plan B as your Medicare supplement insurance. You can feel secure knowing your Medicare supplement coverage is from Blue Cross and Blue Shield of Alabama.

This C Plus Medicare Select Plan B coverage (which is standard Plan B in the Outline of Medicare Supplement Coverage) includes our network of Preferred Providers. Preferred Providers are identified in our Preferred Provider directories. You can get updated copies of these directories by calling our Rapid Response automated telephone system at 1-800-248-5123 (toll-free in Alabama) or 1-205-988-5401 (in Birmingham). You may also visit our website **www.bcbsalmedicare.com** for updated provider information.

With your C Plus Medicare Select Plan B, it is important that you use providers in our Preferred Provider network. To receive the full inpatient benefits of your Medicare Select Plan, you need to use a C Plus Preferred Hospital. For other types of medical providers, we encourage you to get the most benefit from your C Plus coverage by using a Preferred Provider. Our Preferred Provider network of doctors is called the Preferred Medical Doctor (or PMD) program.

We are glad you have chosen C Plus Medicare Select Plan B as your Medicare supplement insurance and we will do all we can to handle your health benefit needs. If you have any questions please call Customer Service at 1-205-733-7044 or 1-888-417-4775.

Sincerely,

Rebekah Elgin Council

Rebekah Elgin-Council
Vice President, Marketing

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C Plus Medicare Select Plan B Contract

Purpose of This Contract

Notice: This Contract may not cover all of your medical expenses. The purpose of this Contract is to supplement the amounts Medicare pays for some hospital, medical, and surgical services. C Plus is not designed to cover all the expenses which Medicare does not pay.

This Contract provides benefits which supplement Medicare Parts A and B as described in this Contract. This Contract does not provide any prescription drug benefits which supplement Medicare Part D. “Medicare” means the programs established by Title XVIII of the Social Security Act, as amended. You must be enrolled in Parts A and B of Medicare in order to receive any benefits under this Contract. This Contract does not supplement nor coordinate in any way with any Medicare Advantage plan.

We are Blue Cross and Blue Shield of Alabama, referred to in this Contract as “we” or “us”. “You” and “your” refer to the person eligible for Medicare who signed the application for coverage.

Open Enrollment Period

You must be a resident of the state of Alabama and be enrolled in Medicare Part A and Part B to be eligible for this Contract. You have a six-month open enrollment period that begins the month you turn 65 and enroll in Medicare Part B. You can apply for this Contract before this enrollment period, and your coverage will be effective the first day of the enrollment period. If you already have Medicare Part B when you turned 65, your open enrollment period to buy this Contract begins the month of your 65th birthday.

Other Enrollment Periods

If you miss your open enrollment period, you can also buy this Contract within 63 days of when you lose or end certain kinds of health coverage. This includes:

- If you had group health coverage that paid supplemental to Medicare and lost it through no fault of your own;
- If you joined a Medicare Advantage plan when you first became eligible for Medicare and disenrolled within 12 months; or,
- If your previous Medicare supplement plan, Medicare Select plan, Medicare Advantage plan, PACE program ends its coverage or commits fraud.

Renewal of This Contract is Guaranteed

We guarantee you can renew your Contract with us unless your fees are not paid on time or you indicate material misrepresentation on your application which would affect our decision whether to contract with you.

Important Notice

If you are not satisfied with the Contract, return it with your identification card within 30 days. We will refund any fees you have paid.

Important Information for Medicaid Recipients and Other Low-Income Individuals

Rules that Apply at the Time You Apply for this Contract

If you are covered by Medicaid or otherwise receive assistance from Medicaid to help pay for your medical expenses, federal law may prohibit us from selling this Contract to you. Specifically –

- You **may not** buy this Contract if you are covered by Medicaid or are classified under Medicaid as a Qualified Medicare Beneficiary (QMB).

- You **may** buy this Contract if Medicaid directly or indirectly pays the premiums for you or if you are classified under Medicaid as a Specified Low-Income Medicare Beneficiary (SLMB) or a QI-1 Qualifying Individual.

We must depend on you to accurately inform us of your status under Medicaid. If you are unsure of your status, please contact the State Medicaid Agency.

Rules that Apply After You Have Bought this Contract

If you become eligible for Medicaid after you buy this Contract, you will need to determine whether it is beneficial to keep, suspend, or terminate this Contract. There are several factors that you should consider when making this decision. For example, if you terminate or suspend this Contract and go to see a doctor who does not accept Medicaid, you will be required to pay applicable Medicare coinsurance amounts. Once you terminate (as opposed to suspend) this Contract, you cannot buy another Medicare supplement contract as long as you are eligible for Medicaid. In addition, if you do not participate in the Qualified Medicare Beneficiary (QMB) program, Medicaid benefits may be subject to limits. If you do not have a Medicare supplement contract, you would be required to pay any deductibles and coinsurance that Medicare does not pay if you exceed your Medicaid limits.

If you wish, you may suspend the benefits and premiums under this Contract during your entitlement to benefits under Medicaid for up to 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

We encourage you to contact the appropriate State Medicaid Agency for advice about whether it is beneficial for you to keep this Contract if you have become covered by Medicaid after you have purchased C Plus.

If you are under age 65 and eligible for Medicare benefits by reason of disability, you may also request a suspension of the benefits and premiums under this Contract if you become covered under a group health plan. For this purpose, a group health plan is a plan sponsored by an employer or employee organization to provide health care to employees, others associated with the employer in a business relationship, or their families. If you then lose your group health plan coverage, your policy will be reinstated if you give us notice within 90 days of the loss and pay the premium for the period beginning as of the date of your termination of enrollment in the group health plan.

Organization of this Contract

In the following pages, we begin by explaining how you obtain coverage under this Contract. Then we explain the types of coverage. Following these are conditions which all benefits must meet and exclusions or situations in which this Contract does not provide coverage.

General provisions relating to fees, the operation of the Contract, subrogation, claims procedures,

and definitions appear near the end of the Contract. For the most part, defined terms begin with initial capital letters. Please refer to the definitions in order to fully understand your benefits under the Contract.

Coverage

Beginning Coverage

You apply for coverage by filling out an application and sending it to us with the necessary fees. The application must be complete and truthful and must be signed or this Contract will not be effective.

Upon acceptance of your application, we will send you an identification card. If we do not accept the application, we will notify you. Paying fees when you apply will not begin any coverage for you, since only our acceptance will do that. If you pay fees and we do not accept your application, then our only obligation to you is to return the fees.

The date your coverage begins depends on when you apply and when we accept your application:

- If we accept your application during the last three months before, or the month in which, you first become eligible for Medicare, your coverage begins on the first day of the month in which you become eligible for Medicare.

- If we accept your application during the first six months after you first become eligible for Medicare, your coverage begins on the day shown on your identification card.

- If you do not apply when you first become eligible for Medicare, as described above, your coverage, if accepted, will begin on the day shown on your identification card.

- The day on which your coverage begins as shown on your identification card is the effective date of your contract.

If you are disenrolling from a Medicare Advantage plan and applying for coverage under this Contract to supplement your coverage under Medicare, your coverage under this Contract will not begin earlier than the effective date of your disenrollment from your Medicare Advantage plan.

Ending Coverage

There are two ways your Contract can end. In both ways it ends automatically without notice from us. The two ways are:

- If we do not receive your fees within 30 days after they are due, this Contract ends retroactively back to the date they were due.

- If you die, this Contract ends on the date of your death.

How Medicare and This Contract Work Together

Before we present the benefits, we would like to go into a little more detail about how Medicare and this Contract work together.

As a person enrolled under Part A and Part B of Medicare, you probably know that Medicare has provisions that require you to pay a deductible amount and some amounts of coinsurance.

The Medicare deductible is that amount of health care charges that you are required to pay before you begin to receive Medicare benefits. This Contract pays for the Medicare Part A deductible, subject to the limitations under “Hospital Coverage” below.

Coinsurance is that portion or percentage of your expenses, for certain medical services, that the law requires you to pay after benefits begin. This Contract pays for Medicare Part B coinsurance and the Part A coinsurance (except for skilled nursing facility care) that you would otherwise have to pay yourself for Medicare approved services, subject to the limitations under “Hospital Coverage” below.

Medicare deductible and coinsurance amounts change from time to time. When they do, our benefits under this Contract will automatically change with them. If an increase in Contract fees is needed as a result of a change in benefits or for other reasons, the increase will take effect only after we give you 30 days’ notice.

The Order in Which Benefits Are Paid

Your Medicare coverage always pays first. In order to collect these benefits, be sure to follow the instructions in “Medicare & You”, a free publication of the Centers for Medicare and Medicaid Services (CMS). Then, if you still have expenses left unpaid, your coverage under this Contract may pay them. Please see the instructions on how to file a claim that are printed near the end of this Contract. You can obtain a copy of “Medicare & You” on the Internet. Go to **www.medicare.gov** to download a copy or obtain information on ordering a copy. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

■ Benefits

HOSPITAL COVERAGE

This portion of the Contract provides coverage for certain inpatient and outpatient hospital services.

Inpatient Hospital Services

We will cover the Medicare Part A deductible amount and the Medicare Part A coinsurance amount for inpatient hospital services covered by Medicare for your hospital stay in a C Plus Preferred Hospital.

If you receive inpatient hospital services in a hospital that is not a C Plus Preferred Hospital, we will pay the deductible and coinsurance only if the services qualify as emergency hospital services.

Services qualify as emergency hospital services if:

1. They are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition, or,

2. It is not reasonable to obtain such services through a C Plus Preferred Hospital.

If you receive inpatient hospital services in a Non-participating Hospital, we will pay the deductible and coinsurance only if the services qualify as emergency hospital services covered under Medicare. See the definitions near the end of this Contract to understand the distinction that we and Medicare make between Participating and Non-participating Hospitals.

Additional Inpatient Hospital Services

It is possible that, during an extended hospital stay, your Medicare benefits may run out (including your lifetime reserve days as described in "Medicare & You"). If this happens to you, we will pay for the following inpatient hospital services and supplies: Part A Medicare eligible expense for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period; Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used; and, upon exhaustion of the Medicare hospital inpatient coverage (including the lifetime reserve days), an additional 365 days of inpatient hospital services and supplies, all subject to the following:

- If the hospital in which you are confined is a C Plus Preferred Hospital, we will pay for inpatient hospital services and supplies if they are medically necessary and would otherwise have been covered by Medicare.

- If the hospital in which you are confined is not a C Plus Preferred Hospital, we will provide additional inpatient hospital benefits to you only if inpatient hospital services qualify as emergency services under "Inpatient Hospital Services" above. Our payment will cover expenses that are reasonable and medically necessary. If services do not qualify as emergency services under "Inpatient Hospital Services" above, there are no additional inpatient hospital services benefits under the Contract.

- If you receive the inpatient hospital services in a Non-participating Hospital, we will provide additional inpatient hospital benefits only if services qualify as emergency hospital services under Medicare guidelines.

This Contract does not cover the Part A coinsurance amount for skilled nursing facility care covered by Medicare.

Inpatient and Outpatient Blood Deductible

We will pay any non-replacement fee charged by a hospital for the first three pints of whole blood or units of packed red blood cells in each year. Any blood deductible satisfied under Part B will reduce the blood deductible required by Part A. We will also pay 20% of the Medicare allowable charge for blood under Part B of Medicare above the Part B deductible amount.

Hospice Care Services

If you receive hospice and respite care services and supplies covered by Medicare Part A, we will pay the Part A coinsurance/copayment amounts not paid by Medicare but otherwise payable by you.

Outpatient Hospital Services

If you receive outpatient hospital services covered by Part B of Medicare in the outpatient department of a Participating Hospital (regardless of whether the hospital is C Plus Preferred Hospital), we will pay the hospital Part B coinsurance amounts not paid by Medicare but otherwise payable by you.

Outpatient services in a Non-participating Hospital are covered only if they are emergency services for which payment is made under Medicare.

MEDICAL AND SURGICAL COVERAGE

Covered Medical Expenses

"Covered Medical Expenses" mean the expenses of the kinds covered by Medicare Parts A and B

which are incurred by you and determined by Medicare to be reasonable and allowable for medically necessary services and supplies when performed or prescribed by a physician. The following are some examples of covered medical expenses:

- physicians' services for medical care and treatment and for surgical operations and procedures;
- radiation therapy and outpatient physical therapy services;
- x-ray and pathology services;
- prosthetic devices (other than dental) and orthopedic devices (except corrective shoes);
- medical supplies such as oxygen, splints, casts, trusses, catheters, ostomy bags and supplies, and surgical dressings;
- portable diagnostic X-ray services;
- durable medical equipment (not implantable);
- ambulance services;
- rural health clinic services; and,
- ambulatory surgical center services.

Covered medical services are considered to be "incurred" by you on the day the service is rendered or the supplies are furnished.

Medicare Part B Deductible

For any services covered by Medicare Part B, Medicare requires that you first pay an annual Part B deductible amount (regardless of hospital confinement), after which Medicare pays generally 80% of the Medicare approved amounts. We pay the remaining portion (generally 20%) of the Medicare approved amounts.

Many providers of medical services do not accept the Medicare allowed amount as payment in full. These providers are generally described as not "accepting assignment". With the exception of Preferred Providers (discussed below), a provider who does not accept assignment may bill you for charges above the Medicare allowed amount. Such excess charges will not be covered under this Contract, and you will be responsible for paying them.

A Preferred Provider has agreed with us to accept the combination of Medicare's payment and our payment (after you pay the Part B deductible) as payment in full. This means that, if you are treated by a Preferred Provider, you will not have any out of pocket costs arising from covered medical expenses other than the Part B deductible.

CASE MANAGEMENT COVERAGE

Unfortunately, some people suffer from catastrophic, long-term, and chronic illness or injury. If you have a catastrophic, long-term, or chronic illness or injury, a Blue Cross registered nurse may be able to assist you in accessing the most appropriate health care for your condition. The nurse case

manager will work with you, your physician, and other health care professionals to design a treatment plan to best meet your health care needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan.

Benefits provided to you through individual case management are subject to all Contract maximums and exclusions. In addition, case management benefits are limited to those benefits that we are permitted to offer under Medicare Select Plan B, which is described in the Outline of Medicare Supplement Coverage that you received with your application materials.

If you think that you may benefit from individual case management, please call Customer Service at the number shown on the "Welcome Page" of the Contract.

CONDITIONS FOR ALL BENEFITS

Contract In Effect

To qualify as benefits under this Contract, services, care, treatment or supplies must be provided while this Contract is in effect; that is, after its effective date and before it ends.

Supplemental to Medicare

Medicare benefits include all benefits available to you under Parts A and B of Medicare to which you are entitled and for which you make claim. Medicare benefits also include those for which you would have been eligible if you had enrolled and maintained your enrollment and filed a claim for benefits under Parts A and B of Medicare. Benefits provided under this Contract supplement Medicare benefits. Therefore, the benefits of this Contract are limited to the services and supplies of the same type covered by Medicare and to the charges for them allowed by Medicare.

Medical Necessity and Reasonableness

For any service or supplies as to which no determination of reasonableness or necessity is made by Medicare, any benefits under this Contract will be paid only if we determine that the charges for them are reasonable and the services and supplies are medically necessary. See the definition of medical necessity near the end of this Contract for more information about these determinations.

■ Exclusions

We will not provide benefits for the following, whether or not a physician recommends or prescribes them:

1. Services or expenses which are excluded by Medicare.

2. Services, care or treatment for which Medicare does not make a determination and which we determine not to have been medically necessary.

3. Services, care or treatment received by you during the 30-day grace period if we do not actually receive the required amount of your fees during the grace period.

4. Services, care or treatment you receive before the effective date or after the end of the Contract (except as otherwise provided below under Benefits After Termination of Coverage).

5. Services or expenses for cosmetic surgery not covered by Medicare. "Cosmetic surgery" includes any surgical procedure that primarily improves or changes appearance and does not primarily improve physical bodily functions or correct deformities resulting from disease, trauma, or congenital anomalies. Improvement of physical functions does not include

improvement of psychological effects caused by physical defects or conditions.

6. Services or expenses not covered by Medicare for the care, treatment, filling, extraction, removal, replacement or augmentation of teeth or structures directly supporting teeth. “Structures directly supporting the teeth” mean the periodontium, which includes the gingivae, dentogingivial junction, periodontal membrane, cementum, and aveolar process. Also excluded are periodontal care, prosthodontal care, endodontic care, orthodontic care, or any other dental care. Services or expenses for hydro-xylapatite or any material with a similar purpose are also excluded.

7. Services or expenses that are paid for directly or indirectly by a governmental entity, except as otherwise required by Section 411.8 of the Medicare regulations.

8. Services or expenses in cases covered in whole or in part by worker’s compensation or employers’ liability laws, state or federal. This applies regardless of whether you file a claim under that law. It applies regardless of whether the law is enforced against or assumed by the employer. It applies regardless of whether the law provides for hospital or medical services as such. Finally, it applies regardless of whether the employer has insurance coverage for benefits under the law.

9. Services or expenses furnished by a Federal provider of services or other Federal agency or furnished at public expense under Federal law or a Federal contract, except as otherwise required by Sections 411.6 and 411.7 of the Medicare regulations.

10. Services or expenses for routine physical examinations, convalescent care, rest cures, or sanatorium care.

11. Services or expenses for custodial care, meaning care primarily for providing room and board (with or without nursing care, training in personal hygiene or self care, or supervisory care by a physician) for a person physically or mentally disabled even if covered by Medicare.

12. Any medical or surgical treatment or procedures, any facilities, drugs, drug usage, equipment or supplies which are experimental or investigative (the meaning of which is explained near the end of this Contract).

13. Services or expenses for a claim not properly filed. You must file on proper forms all the information we need on or before December 31 of the year following the year services were received. Or, if you received services in the last three months of any calendar year, you must file by the end of the second year following the one in which services were rendered.

14. Hearing aids, eyeglasses, or contact lenses or for their examination or fittings. We will pay for eye glasses or contact lenses that replace the human lens function and are required by surgery in the eye or an eye injury defect. Our payment in these cases is limited to one pair of eyeglasses or contact lenses or one pair of each if both are medically necessary.

15. Travel, whether or not recommended by a physician.

16. Private duty nurses and their board.

17. Prescription drugs and medicines, except those drugs and medicines covered under Parts A and/or B of Medicare.

18. Services or expenses for home health (except for the 20% copayment for durable medical equipment).

19. Services or expenses of any kind covered under Part A of Medicare for a skilled nursing facility, nursing home, assisted living facility, or intermediate care facility (except for the Part A coinsurance/ copayment amounts for hospice and respite care covered by Part A of Medicare).

20. Services or expenses in a Non-participating or non-C Plus Preferred Hospital for inpatient or outpatient treatment, except as otherwise allowed under the benefit portions of this Contract.

21. Charges in excess of the reasonable and allowable amounts under Medicare.

22. Any difference (due to federal law, regulations, or both) in the amount of Medicare benefits paid and the Medicare approved amount except for deductible and co-payment amounts covered by this Contract.

Fees

Fees Payment

We must receive your fees for the first term before we begin your coverage. If someone else pays your fees, such as a family member, financial institution, employer, guardian, conservator or other legal representative, that person is your agent and acts as your, and not our, agent for the payment of your fees, and you (not we) have the responsibility for any failure by your agent to pay us the necessary fees when due, even if they have been paid by you to your agent. We do not accept payment of your fees from any provider who may be paid under this Contract with one exception. The exception is for a physician or other individual provider who pays fees of close relatives(s) or friend(s) and who does not provide services which are benefits of this Contract to that person as a patient.

Your fees should be mailed to:

Blue Cross and Blue Shield of Alabama
P.O. Box 11551
Birmingham, AL 35282-9722

You can also pay by Electronic Checking, Debit or Credit Card

You can have your monthly plan premium automatically withdrawn from your bank account, charged directly to your debit card or charged directly to your credit card. Deductions/charges will be made on our around the first of each month. If you would like to pay your premium by electronic checking, debit or credit card, you will need to fill out an Authorization Agreement. You can obtain this form from our website at www.BCBSALMedicare.com or you can contact Customer Service to request one. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Term

Beginning with the fees paid with your application, your fees are to be paid in advance for each term of the Contract. Each term, or benefit period, of your Contract is the period of time for which your fees should be, and are, paid in advance.

Refund

This Contract may end before the term ends. If it does, we will refund the fees paid for the rest of the term unless you have received during the term services or supplies covered by the Contract. Refund of fees in that case will be our only obligation under the Contract.

Grace Period

We give you or your agent, 30 days to pay your fees after they are due. If you, or your agent, do not pay your fees by the end of the 30 days, your Contract ends on the day your fees were due, not at the end of the 30 days. If your agent fails to pay us within the grace period, your coverage will end even though you have made timely payments to your agent. If the Contract ends, we will not pay for any services, care, treatment or expenses of any kind received by you during or after the 30-day grace period.

■ General Information

Contract Revisions

By giving 30 days written notice to you, or your agent, we may change the fees you pay for coverage under this Contract or any provision of this Contract. If you or your agent pays any fees after the notice, you thereby accept the new fees or changes in the Contract.

If we change the Contract, we will send you or your agent a written amendment signed by one of our officers. None of our officers, employees or agents can make any oral changes, such as by telephone. Nor may anyone waive or vary any provisions of this Contract except in writing, signed by one of our officers.

Notice

From us to you:

> We give you notice when we mail it to you at the last address we have for you in our records. If your fees are paid by an agent, any notice to you is given when we mail it to the agent's address. If your agent receives any notice or correspondence from us in connection with this Contract, we have no responsibility for the agent's failure to inform you of any such notice or correspondence.

From you to us:

> You give us notice when you mail it to:

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244-2858

Agent Responsibility

Any agent (that is, a family member, financial institution, employer, guardian, conservator or legal representative) who pays or undertakes to pay your fees or to receive notice under the Contract is your agent and not ours. This means that we are not responsible for any failures by the agent to pay your fees to us or to give you notices and correspondence from us, nor for any statements or representations made by the agent about your coverage under the Contract.

Multiple Contracts

If you are covered at the same time by a group and non-group contract issued by us, we will only pay under the one which provides the most coverage.

Federal law requires us to check for duplicate Medicare supplement or Medicare Advantage coverage at the time you enroll. We have issued this Contract based on information you supplied on your application. If you do have duplicate Medicare supplement or Medicare Advantage coverage after this Contract begins, and we are not notified of this fact, your Contract may be revoked by us back to the time of duplication when we are notified.

Reinstatement

We may decide, at our option, to reinstate your Contract after it ends. If we do, the reinstatement will be on whatever terms and conditions we decide to impose. The Contract will not be reinstated until you receive from us a written notice of reinstatement. Paying fees after the Contract ends will not reinstate it. If we decide not to reinstate the Contract, our liability is limited to refunding any fees you have sent to us.

Providers of Services

We are not responsible for any acts or omissions by any institution or individual provider in furnishing any service, care, treatment, or supplies to you. Nor are we responsible if any provider of service refuses to admit or treat you or provide services to you. This Contract does not require us to do anything to enable providers to furnish services or supplies to you.

Misrepresentation

Your misrepresentation of any material fact in applying for this Contract will make the Contract invalid, and in that case we will not be obligated to return any portion of any fees paid by you.

Benefit Payment Options

We, at our option, may pay any benefits under the Contract to you or to the hospital, physician or other provider who furnishes services or supplies. And our payment, either to you or to the provider, will fully perform our obligation under the Contract. But neither this nor any other provision in the Contract gives to any provider of services or any other person any right to recover any payment from us.

If you die or become incompetent, at our option we may pay your estate, your guardian or any relative we feel is equitably entitled to payment. Such payment will fulfill our obligations under the Contract, because this Contract is for your benefit alone and not for the benefit of any provider or any other person.

Release of Information

By signing and submitting to us your application for this Contract and without further consent or

notice, you agree that we may obtain from any person or institution that has treated, diagnosed, attended, or performed any health service for you all information and records we believe to be necessary or desirable to the processing of your claim, the performance of this Contract, or to perform any other function authorized or permitted by law. You also authorize the providers of health services, and any other person or organization having possession of such information to furnish us the requested information and records. Neither we nor the provider will be liable for gathering, using, and releasing such records and information in the manner considered by us to be appropriate for such purposes.

Responsibility for Filing Claims

Before we provide benefits under this Contract we must receive a claim for benefits under the Contract and, when applicable, a Medicare Explanation of Benefits. You must submit claims with all the information we need on the forms we require. We may ask you for more information. If we do, you must provide any information we request so we can decide whether services, care, treatment or supplies were medically necessary and otherwise covered and entitled to payment of benefits under the Contract.

Because Medicare is your primary insurance and C Plus is your Medicare supplement insurance, all claims must first be filed with Medicare before filing for benefits under C Plus. C Plus cannot return claims to you or send them to Medicare if they are first sent to C Plus by mistake.

Information from Providers of Services

Any hospital, physician, or other provider of services for which benefits under the Contract are claimed must furnish to us any requested information considered by us to be necessary or appropriate to the processing of your claim or to the performance of any provisions of this Contract. In addition, any provider furnishing services for which claim is made by or for you shall be deemed to be bound by provisions of the Contract.

Legal Options

No legal action may be brought against us unless, as a condition precedent, you and any provider furnishing services for which benefits under the Contract are claimed, both have fully complied with all the provisions of the Contract including the provision for Arbitration. **THE ONLY LEGAL ACTION THAT YOU MAY BRING AGAINST US IS TO ENFORCE OR SEEK REVIEW OF AN ARBITRATION AWARD UNDER THE FEDERAL ARBITRATION ACT, 9 U.S.C. § 1 ET SEQ.**

Quality Assurance

We use advice from providers and national organizations to develop our quality standards. We carefully screen applications for our Preferred Care Program. We audit providers to see if the care you get is up to our standards. Quality of care issues are reviewed by our Medical Director and/or other medical specialists. Problems are addressed through discipline, refunds and removal from Preferred Care when necessary. Periodically, Preferred Care providers go through a re-credentialing process. This ensures adequate malpractice insurance, and that there has been no discipline by facilities or governmental agencies.

If you have a question or concern about the quality of care of any provider write to:

Blue Cross and Blue Shield of Alabama
ATTENTION: Quality Management
P.O. Box 11043
Birmingham, Alabama 35282-8126

Governing Law
This Contract is governed by federal law, such as Title XVIII of the Social Security Act (Medicare) and the Federal Arbitration Act, and – to the extent that federal law is not applicable – state law, such as the provisions of Alabama Code §§ 27-19-52 through 27-19-59, regulating Medicare supplement (Medigap) policies.

Benefits After Termination of Coverage
Termination of this Contract shall be without prejudice to any continuous loss which commenced while the Contract was in force, but the extension of benefits beyond the period during which the Contract was in force is conditioned upon your continuous total disability, limited to the duration of the Contract benefit period or payment of the maximum benefits under the Contract. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

You will be considered totally disabled for this purpose if you have a condition caused by disease or injury that we determine has resulted in your inability to perform all of the substantial and material duties of your regular occupation or to perform the normal activities of a person of like age and sex. You cannot be engaged in any employment or occupation for wage or profit and be considered totally disabled. You must be under the regular care and attendance of a physician.

You must notify us in writing if you believe you are totally disabled. Once we receive your written notice, we will determine whether you qualify for extended coverage under the Contract and give you our determination.

Subrogation or Reimbursement

Right of Subrogation
If we pay or provide any benefits for you under this Contract, 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. That 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 Contract benefits. This means that you promise to repay us from any money you recover the amount we've paid or provided in Contract 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 Contract 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 our 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 attorneys' fees charged you by your attorney for obtaining the recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow our reimbursement and subrogation rights under this Contract 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 Contract.

How C Plus Medicare Select Plan B Claim Filing Works

How C Plus Works for Medical Services

Claim filing is easy when you are enrolled in C Plus and use a PMD doctor or other Preferred Provider. In most cases, the paperwork will be done by your Preferred Provider who will handle all claim filing procedures for you. All you have to do is show your C Plus identification card and your Medicare approved charges will be covered in full when you visit a Preferred Provider. All you are responsible for is the Medicare Part A coinsurance for skilled nursing care (when applicable), the Medicare Part B deductible and any difference (due to federal law, regulations, or both) between the amount Medicare approves and the amount paid.

All physicians are required by federal law to file Medicare claims, at no charge to you, for services usually approved by Medicare. Preferred Providers will also file your C Plus claims. Non-Preferred Providers may require you to file your own C Plus claim. You may also be required to file your own C Plus claim directly with Blue Cross and Blue Shield of Alabama if you receive Medicare services outside of Alabama. We will give you step-by-step instructions on how to file your own C Plus claims in the section below called "Filing Your Own C Plus Claims".

Follow these steps for medical services received in Alabama:

1. When you go to the doctor or hospital, show both your Medicare Health Insurance card and your C Plus identification card.

2. All claims must first be filed for processing with Medicare. If Medicare approves the service and your C Plus identification number is on the claim, the claim will generally be sent to Blue Cross and Blue Shield of Alabama automatically for processing. Because C Plus covers only Medicare approved services, claims that are not approved by Medicare will not be sent to Blue Cross and Blue Shield of Alabama for consideration.

   IMPORTANT: If you or a relative is filing a C Plus claim, please be sure to first file your claim with Medicare before filing with Blue Cross and Blue Shield of Alabama. We cannot return claims to you or send them to Medicare if they are sent in error to Blue Cross and

Blue Shield of Alabama before Medicare.

3. You are responsible for paying any personal charges in the hospital for telephone, TV, private room, and other personal items. You are also responsible for the Part B deductible, any difference (due to federal law, regulations, or both) between the amount Medicare pays and the approved amount, any Part A coinsurance amounts not covered by this Contract, and any charges in excess of the Medicare approved amount when you do not use a PMD doctor or Preferred Provider or your charges are not approved by Medicare.

Filing Your Own C Plus Claims

The three simple procedures listed below should explain how to file your own claim.

1. Make sure your claim is filed with Medicare and wait until you receive your MEDICARE SUMMARY NOTICE form, also called an "MSN".

2. Completely fill out a MEDICAL EXPENSE CLAIM form, number CL-438. You can obtain the form by calling Customer Service (telephone numbers are included on the back cover of this booklet). Be sure to write both the Medicare Health Insurance claim number from your Medicare card and your C Plus identification number on the claim form.

3. Attach a copy of your Medicare MSN to your completed claim form and mail both forms to this address:

   Blue Cross and Blue Shield of Alabama
   450 Riverchase Parkway East
   Birmingham, Alabama 35244-2858

We will send a C Plus Claims Report to you after your claim is processed.

Review and Dispute Procedures

You have the right to seek and obtain full and fair review by us of any determination by us. The review may include determinations of medical necessity, physician or other provider fee determinations, or any other questions on which a determination was based.

Requesting a Review

If you believe that we incorrectly denied all or part of your benefits or made an incorrect decision relating to anything else, and you want us to review our determination, you should follow the procedures below.

1. Submit a written request for review to this address.

   Blue Cross and Blue Shield of Alabama
   Attn: C Plus Request for Review
   450 Riverchase Parkway East
   Birmingham, Alabama 35244-2858

   Your request must state your full name and contract number. If your request relates to a claim, you must state the number of the claim that you want reviewed and include a copy of the C Plus Claim Report. Your envelope should be marked **"C Plus Request for Review".**

2. Your written request should contain the questions and comments that you have, and you should submit all additional information that you believe will support your request. If requested in writing, you also may review our records relating to claims at our main office

in Birmingham at a reasonable time determined by us. You may supplement your questions, comments, or information contained in your initial request for review.

3. On the basis of the comments, questions, and information received in your request for review, together with any other information available to us, we will review our prior determination and make a new determination. We will send you a copy with the reason for the new determination.

Your right of review is available in all cases except when your provider of services has a similar right of review or dispute resolution under his or its agreement with us and the provider pursues that right for services or supplies furnished to you. If your provider obtains such review with us, you will not seek separate or additional review either with us or in the courts and are bound by the determination made in those proceedings to the same extent that the physician or other provider is bound.

Dispute Resolution Procedure
If you have a complaint or dispute that has not been adequately addressed under the review procedures just described, you may submit an appeal to us. Your appeal must be submitted in writing within 30 days to:

Blue Cross and Blue Shield of Alabama
Attn: C Plus Dispute Resolution
450 Riverchase Parkway East
Birmingham, Alabama 35244-2858

Your envelope should be marked "**C Plus Dispute Resolution**". Upon receipt of your appeal, we will examine the facts fully and fairly. You will receive a written decision from us within 30 days.

Arbitration

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

- **ANY CLAIM THAT ARISES OUT OF OR RELATES TO THE CONTRACT;**
- **ANY CLAIM THAT INVOLVES ANY RELATIONSHIPS THAT RESULT FROM OR RELATE IN ANY WAY TO THE CONTRACT (INCLUDING CLAIMS INVOLVING PERSONS OR ORGANIZATIONS WHO ARE NOT PARTIES TO THE CONTRACT);**
- **ANY CLAIM THAT ALLEGES ANY CONDUCT BY YOU OR US, REGARDLESS OF WHETHER RELATED TO THE CONTRACT; OR,**
- **ANY CLAIM THAT CONCERNS THE VALIDITY, ENFORCEABILITY, SCOPE, OR ANY OTHER ASPECT OF THIS ARBITRATION PROVISION.**

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

THE ARBITRATOR SHALL APPLY GOVERNING FEDERAL LAW, SUCH AS TITLE XVIII OF THE SOCIAL SECURITY ACT (MEDICARE) AND THE FEDERAL ARBITRATION ACT, AND – TO THE EXTENT THAT FEDERAL LAW IS NOT APPLICABLE – STATE LAW, SUCH AS THE PROVISIONS OF ALABAMA CODE §§ 27-19-52 THROUGH 27-19-59, REGULATING

MEDICARE SUPPLEMENT (MEDIGAP) POLICIES.

THE ARBITRATION SHALL BE CONDUCTED IN ACCORDANCE WITH, AND WITHIN THE FIXED TIME LIMITS ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION'S ("AAA") DISPUTE RESOLUTION PROCEDURES FOR INSURANCE CLAIMS (A COPY OF WHICH MAY BE OBTAINED BY WRITTEN REQUEST TO US), EXCEPT AS MODIFIED IN THE CONTRACT. THE CLAIMANT IS RESPONSIBLE FOR STARTING THE ARBITRATION PROCEEDINGS.

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

THE ARBITRATION WILL BE CONDUCTED BEFORE A SINGLE ARBITRATOR IN THE COUNTY IN WHICH YOU RESIDE UNLESS YOU AND WE AGREE TO CONDUCT THE ARBITRATION IN SOME OTHER COUNTY. PRIOR TO THE ARBITRATION, IF ALL PARTIES CONSENT TO MEDIATE THE CLAIM, THE ARBITRATOR WILL REFER THE CLAIM TO A SEPARATE MEDIATOR, BUT ARBITRATION WILL FOLLOW IF NO SETTLEMENT IS REACHED. A CLAIMANT'S CLAIMS MUST BE ARBITRATED SEPARATELY FROM THE CLAIMS OF OTHERS, AND MAY NOT BE CONSOLIDATED WITH THE CLAIMS OF OTHERS OR ARBITRATED ON A CLASS-WIDE BASIS. THE ARBITRATOR SHALL APPLY ALL APPLICABLE SUBSTANTIVE LAW, INCLUDING SECTION XVIII OF THE SOCIAL SECURITY ACT, ANY STATUTES OF LIMITATIONS, AND ANY CLAIMS OF PRIVILEGE RECOGNIZED BY LAW. THE ARBITRATOR SHALL BE EMPOWERED TO GRANT WHATEVER RELIEF WOULD BE AVAILABLE IN COURT UNDER LAW OR EQUITY, EXCEPT AS EXPRESSLY LIMITED IN THE CONTRACT. THE ARBITRATOR'S DECISION SHALL BE SPECIFIC ABOUT THE BASIS FOR THE DECISION, AND THE TYPE OF ANY DAMAGES OR RELIEF AWARDED. THE ARBITRATOR'S DECISION MAY NOT BE REVIEWED IN COURT EXCEPT TO THE LIMITED EXTENT PERMITTED UNDER THE FEDERAL ARBITRATION ACT, 9 U.S.C. § 1 ET SEQ.

YOU UNDERSTAND AND AGREE THAT THIS ARBITRATION AGREEMENT IS MADE PURSUANT TO A TRANSACTION INVOLVING INTERSTATE COMMERCE, AND SHALL BE GOVERNED BY THE FEDERAL ARBITRATION ACT, 9 U.S.C. § 1 ET SEQ. IF ANY PORTION OF THIS ARBITRATION PROVISION IS DEEMED INVALID OR UNENFORCEABLE, THE REMAINING PORTIONS SHALL CONTINUE IN FULL FORCE AND EFFECT.

Definitions

Contract: The Contract consists of this booklet, your signed application, your identification card when issued, and any revisions to this Contract.

Experimental or Investigative: 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.

Hospital: A Participating or Non-participating Hospital. For ease of reference, we generally use the word "hospital" to refer to a Participating Hospital. When we mean to refer to a Non-participating hospital, we will be explicit. A hospital does not include a place primarily for convalescent care, for rest, homes for the aged, and does not include any school or college infirmary, sanatorium, nursing home or mental institution.

Medically Necessary (applies only when Medicare has not made an applicable medical necessity determination): To be "medically necessary," services or supplies must be determined by us to:

(a) be consistent with the diagnosis and treatment of your condition,

(b) be in accordance with standards of good medical practice,

(c) not be for the convenience of you or your physician,

(d) be performed in the least costly setting required by your condition, and,

(e) not be experimental or investigative (meaning that they are recognized by us as medically effective and, when required, have been approved by the Food and Drug Administration or any other governmental agency).

A "setting" would be your home, a physician's office, a hospital outpatient department, or a hospital when you are a bed patient. Only your medical condition (not your financial or family situation, the distance you live from a hospital, or any other non-medical factor) is considered in deciding which setting is required. As a patient's medical condition changes, the need for a particular setting may change.

"Medically necessary" is an especially important phrase because it is a basis on which benefits for services are provided or denied. Just because a service is prescribed for you does not automatically mean the service is "medically necessary" as described above. In an effort to make treatment convenient or to follow the wishes of the patient or the patient's family, a physician may suggest or permit a method of providing care that is not truly medically necessary. In all cases, if we determine that services you receive are not medically necessary, benefits for the services will be denied.

Non-participating Hospital: Any hospital not participating in Medicare that is recognized or approved as such by the American Hospital Association or the Joint Commission on Accreditation of Health Care Organizations.

Participating Hospital: A hospital that participates in Medicare under an agreement with the Department of Health and Human Services.

Physician: The term "physician" means one of the following who is licensed and acts within the scope of that license at the time and place you are treated: a Doctor of Medicine, a Doctor of Osteopathy, a Doctor of Dental Surgery, a Doctor of Medical Dentistry, a Doctor of Chiropractic, and a Doctor of Podiatry.

C Plus Preferred Hospital: A C Plus Preferred Hospital is a type of Preferred Provider. A hospital is a C Plus Preferred Hospital only if it is a Medicare Selective Contracting Facility that has a contract with us for furnishing those goods or services.

Preferred Provider: A supplier of medical goods or services that has a contract with us for the furnishing of those goods or services. Examples of Preferred Providers include C Plus Preferred Hospitals, PMD physicians, preferred durable medical equipment suppliers, and so forth.

Preferred Medical Doctor: A physician who participates in our Preferred Medical Doctor (PMD) program.

Disclosure Statement

"Subscriber hereby expressly acknowledges its understanding this constitutes a Contract solely between Subscriber and Blue Cross and Blue Shield of Alabama, which 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 "Association") permitting Blue Cross and Blue Shield of Alabama to use the Blue Cross and Blue Shield Service Marks in Alabama, and that Blue Cross and Blue Shield of Alabama is not Contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than Blue Cross and Blue Shield of Alabama and that no person, entity, or organization other than Blue Cross and Blue Shield of Alabama shall be held accountable or liable to Subscriber for any of Blue Cross and Blue Shield of Alabama's obligations to Subscriber created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Alabama other than those obligations created under other provisions of this agreement."

NOTES

For questions about your C Plus coverage, call Customer Service:

205-733-7044 (in Birmingham) or 1-888-417-4775

To order provider directories, call our automated response line:

205-988-5401 (in Birmingham) or 1-800-248-5123

You may also contact us online at

BCBSALMedicare.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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