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 F

CAD63-2409

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.

Skilled Nursing Facility Care

If you receive inpatient care in a skilled nursing facility (not custodial or long-term care) covered by Medicare Part A, we will pay the Medicare Part A coinsurance amounts not paid by Medicare but otherwise payable by you for days 21 through 100 in such skilled nursing facility.

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 a C Plus Preferred Hospital), we will pay the hospital Part B deductible and 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, we pay the Part B deductible amount (regardless of hospital confinement). After the Part B deductible amount is met, Medicare pays generally 80% of the Medicare approved amounts. We pay the remaining portion (generally 20%) of the Medicare approved amounts.

Medicare Part B Excess Charges

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." A provider who does not accept assignment may bill you for charges above the Medicare allowed amount up to 15% of the Medicare allowed amount (also known as Medicare Part B excess charges). We will pay these Medicare Part B excess charges.

Emergency Foreign Travel Coverage - Not Covered by Medicare

If you are traveling outside the United States, we will pay 80% of the medically necessary emergency medical care expenses you incur during the first 60 days of each trip outside of the United States up to a lifetime benefit maximum of $50,000.00, after you first pay a $250 calendar year deductible.

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 is 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.

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

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.”