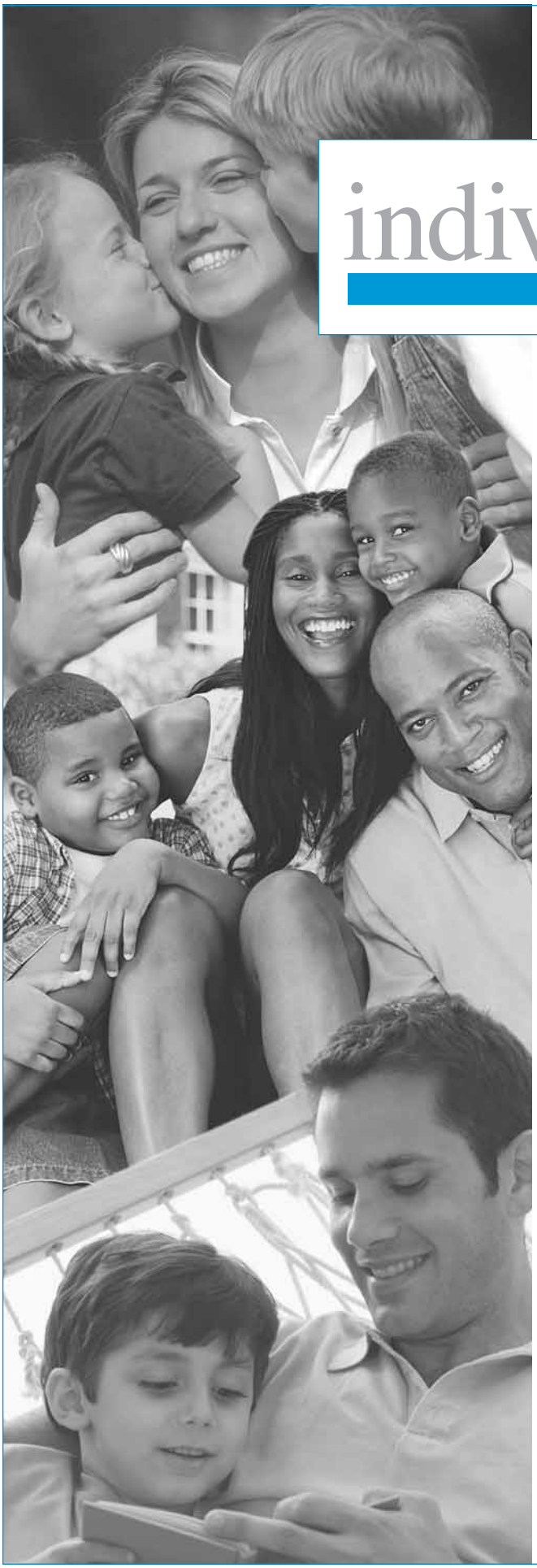

individualBlue℠

A Direct-Pay Health Plan

For Individuals and Families in Alabama

2500 PLAN CONTRACT BOOKLET

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

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OVERVIEW OF THE PLAN

This booklet contains a summary in English of your plan rights and benefits. If you have questions about your benefits please contact Customer Service at 1 888 258-1628. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor - Spanish
Este folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1 800 258-1628. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

Purpose of the Plan: The plan is intended to help you and your covered dependents pay for the cost of medical care. The plan does not pay for all of your medical care. You may be required to pay deductibles, copays, and coinsurance. These types of requirements, which are described throughout the remainder of this booklet, are meant to share the cost of medical care with you and help you to become a smarter consumer of health care benefits.

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.

Glossary of Terms: Near the end of this booklet you will find a Glossary of Terms, 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 glossary 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.

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.

Coverage of New Family Members: The section of the booklet called Eligibility will also tell you how to cover new family members that you acquire by marriage, birth, or adoption. Even if you have purchased a family contract, new dependents are not automatically added to the plan. You must submit an application for coverage. If you fail to submit an application, or in some cases, if you submit your application too late, you may not be able to obtain coverage for your new family members.

Limitations, Exclusions and Waiting Periods: In order to maintain the cost of the plan at an overall level that is reasonable for all plan participants, the plan contains a number of provisions that limit benefits or in some cases subject them to a waiting period. These waiting periods are not reduced by your prior coverage under any plan. Please see the section of this booklet called Waiting Periods. 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, waiting periods, and exclusions to determine if this plan will meet your health care needs.

Nature of Coverage: This plan is not group insurance or COBRA. If you recently lost group coverage or COBRA you may be eligible for coverage under the Alabama Health Insurance Program (AHIP). Qualifying individuals have a 63-day window in which they can enroll in AHIP. It may take us longer than 63 days to determine whether you satisfy our health underwriting guidelines. Generally AHIP does not impose pre-existing condition exclusion or other waiting periods. You can reach AHIP by calling the State Employees' Insurance Board in Montgomery, Alabama at 1 877 619-2447. If you become covered by this plan, you will no longer qualify for AHIP.

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 policies to aid us when we make such determinations. We publish many of these policies on the Internet at **www.bcbsal.com.** The definitions of medical necessity and investigational are found in the Glossary of Terms. In some cases, we must pre-certify the medical necessity of your care. The provisions later in this booklet will tell you when precertification is required, and how to obtain it. Please note that pre-certification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan.

In-Network Benefits: One way in which the plan tries to manage health care costs is through negotiated discounts with medical providers. In-network providers are hospitals, physicians, and other health care providers that contract with Blue Cross and/or Blue Shield Plans for furnishing health care services at a reduced price (examples: PMD, Preferred Care, BlueCard PPO). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or Preferred Care Services, Inc.

It is important for you to understand that these advantages apply only when the network provider is providing an in-network benefit to you. An "in-network benefit" means that the service or supply is covered under the plan as an in-network benefit and is also covered under the contract between us (or another Blue Cross and/or Blue Shield Plan, as applicable) and the provider. If a network provider furnishes a service or supply to you that is not covered under the provider's contract, benefits will not be processed as in-network benefits.

When you are outside our service area, in-network providers must also be designated by the local Blue Cross and/or Blue Shield Plan as BlueCard PPO providers. (See the definition of BlueCard PPO program in the Glossary of Terms). Please call 1 800 810-BLUE (2583) or access the web site at **www.bluecares.com** to find out if your provider is a BlueCard PPO member. You can also go to **www.bcbsal.com** to obtain the same information.

Claims and Appeals: When you receive services from a network provider, the provider will in most cases 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 and we will give the claim 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. When you submitted your application to us, you agreed to be bound by these arbitration provisions.

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.

ELIGIBILITY

Who Is Eligible For This Plan?

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

1. You are a resident of Alabama under the age of 65;

2. You are not eligible for, or entitled to, Medicare; and,

3. We have determined that you meet our health underwriting guidelines, and have accepted you 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.

May I Cover My Family Members When I Apply For the Plan?

When you first apply for the plan, you will be given the option to cover eligible family members.

Your spouse can be covered if he or she is of the opposite sex from you and:

1. Is a resident of the State of Alabama under the age of 65;

2. Is not eligible for, or entitled to, Medicare; and,

3. Has met our health underwriting guidelines and has been accepted by us for coverage.

If you and your spouse apply for coverage under the plan through two single contracts (that is, you each elect to obtain self-only coverage) you and your spouse will not be allowed to later combine your self-only coverage into family coverage. This means, for example, that if you have a child, one of you will be permitted to convert your self-only coverage to family coverage, and add the new child (within the time limit discussed below), but you will not be allowed to cover both of you on the same family contract.

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

1. Is a resident of Alabama;

2. Is not eligible for, or entitled to, Medicare; and,

3. Has been accepted by us for coverage under our health underwriting guidelines; and meets the following**:**

    a. Is unmarried and under the age of 19; or,

    b. Is unmarried and age 19 to 25 while a full-time student in a state accredited school, not working full-time, and chiefly depending on you for support.

In addition, the child must be a natural child; a stepchild residing in your household; a legally adopted child; a child placed for adoption; or any other unmarried child for whom you have permanent legal custody and who depends solely on you for support, and regularly and permanently resides with you in a parent/child relationship.

If a covered child becomes incapacitated, while covered, before the age of 19 (or 25 if a full-time student), the child may continue to be covered as a dependent for so long as he or she remains incapacitated. A

child is incapacitated if we determine that the child is not able to support himself or herself and if the child depends on you for support.

You may not cover your grandchild unless you adopt that child.

May I Add a Newly Acquired Spouse or Children After I Have Obtained Coverage Under the Plan?

Yes, but if you are covering yourself only under the plan, you will first have to convert your coverage to family coverage, pay any additional premiums, and follow the rules below.

If you have family coverage, you may add a spouse or child as follows:

1. If you marry after the effective date of your coverage under the plan, you may apply to add your new spouse and your spouse's eligible children. Your new spouse and your spouse's children will have to satisfy the eligibility standards outlined above for coverage of dependents, including satisfaction of our health underwriting guidelines.

2. If you or your covered spouse gives birth to or adopts a child, you may apply to add your new child as a covered dependent under the plan. If you submit this application to us within 30 days of the date of birth or date of placement for adoption, we will waive the application of our health underwriting guidelines. By contrast, if you apply after this 30-day window, coverage will be contingent upon satisfaction of our health underwriting guidelines.

When Does Coverage Begin?

Initial Enrollment:

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 pay your premiums at the time of application or in full within the 30-day grace period following your effective date. If you fail to pay your premiums in full either at the time of application or during the 30-day grace period, your coverage will be canceled as of the effective date.

Newly Acquired Dependents:

A newborn baby's effective date is its birth date if added within 30 days of birth. A dependent added by adoption is effective as of the date of placement for adoption if added within 30 days of the placement. A dependent added by marriage to an existing policy is effective on the date of the marriage if added within 30 days (assuming satisfaction of our health underwriting guidelines).

What Happens If Blue Cross Declines to Issue a Contract?

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

What Happens If I or One of My Covered Dependents Later Becomes Covered Under Medicare or Some Other Group or Individual Health Plan?

Medicare: If you become eligible for, or entitled to, Medicare (regardless of whether you actually obtain coverage under Medicare), you may continue to keep your coverage under the plan, but the only benefits payable under the plan will be for services that are not included in the coverage of Parts A or B of Medicare - such as for the purchase of authorized prescription drugs. In other words, once you reach age 65 or otherwise become eligible for Medicare, your current health coverage will not pay primary, secondary, or supplemental benefits to Medicare. Your coverage will not pay for any services included in the benefits provided by Medicare; nor will it pay for the copays and deductibles left by Medicare.

Other Health Plan Coverage: If you obtain coverage under some other group or individual health policy or plan, you should see the section later in the booklet called Coordination of Benefits for information about how coverage under this plan will coordinate with other health plan coverage.

When Does Coverage End?

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 subscriber's death unless proper documentation is received within 30 days from the date of death to allow coverage to continue (we will not notify the subscriber's dependents upon the date of death of his/her options to continue coverage);

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

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

9. 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.

Are There Any Continuation of Coverage Rights Under the Plan?

Yes, in some circumstances. Upon divorce, other termination of marriage, or death of one or more members, coverage may continue for all members who would otherwise lose coverage if we are properly notified within 30 days of the event. For example, upon divorce, if we receive proper notice within 30 days, we can establish separate contracts effective as of the date of divorce. We will not apply our usual health underwriting guidelines in this circumstance. We **will not** provide notice to members of these options to continue coverage. You and your dependents will be responsible for remembering that these continuation options are available.

This plan does not provide Continuation of Coverage rights under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

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. For example, if you have a child enrolled under the plan and we amend the plan to decrease the eligibility age for full-time students

from 25 to 23, that change would not apply to any of your currently covered children. But it would apply to any children you add to the plan after the effective date of the amendment.

WAITING PERIODS

For 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 or placement for adoption. 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.

Exclusion Period for Some Surgical Procedures

For the first 365 days you are covered by this plan there are no plan benefits for removal of tonsils and adenoids, a hysterectomy, to put tubes in the ears, to replace any joint such as a knee, or to treat a birth defect. This applies to any related surgery, such as removing the ovaries with a hysterectomy. This does not apply to eligible children properly enrolled in a family plan within 30 days of birth or placement for adoption.

Exclusion Period for Maternity Care Benefits

Each female subscriber or wife of a male subscriber must serve a waiting period of 365 consecutive days before benefits for maternity care are available to her under this booklet. There are no maternity care benefits for dependents other than a spouse of a male subscriber. The entire 365-day waiting period must be served before any maternity benefits are available under the plan.

Limitation on Effect of Certain Amendments

Except as otherwise required by law, no amendment or change to this section of the booklet (Waiting Periods) will result in an extension of the waiting period, an extension of the exclusion period for surgical procedures listed above, an expansion of the list of procedures subject to the waiting period, or an extension of the exclusion period for maternity care benefits for any member covered under the plan and currently serving a waiting period or exclusion period as of the effective date of the amendment. For example, if you are serving your 365 day waiting period for pre-existing conditions and we amend the plan to increase the waiting period from 365 days to 724 days (2 years), that change would not apply to you or any other member of your family currently serving the waiting period. But it would apply to any members of your family added to the plan after the effective date of the amendment.

COST SHARING

CALENDAR YEAR DEDUCTIBLE	$2,500 individual per year; $7,500 family maximum per year.

Calendar Year Deductible: The calendar year deductible is the amount you must pay for medical expenses covered by the plan before your health care benefits begin. The calendar year deductible is applied on a per person per calendar 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 calendar 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.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM	$7,500 individual per year

Calendar Year Out-of-Pocket Maximum: The calendar year out-of-pocket maximum applies on a per person per calendar year basis, and does not include the calendar year deductible. The out-of-pocket maximum applies to expenses you incur in connection with the following:

- Coinsurance to in-network providers (except coinsurance for mental health or substance abuse treatment or prescription drugs). As explained below under the Section called Cost Sharing Provisions, coinsurance is the amount that you must pay as a percent of the allowed amount for services or supplies.

Once the out-of-pocket maximum has been reached, you will no longer be required to pay the expenses listed above for the remainder of the calendar year; however, all other cost sharing requirements under the plan, such as outpatient hospital copayments (that is, fixed dollar amounts that you must pay upon receipt of care), will continue to apply.

Non-covered expenses and copays or coinsurance for out-of-network providers do not count toward the calendar year out-of-pocket maximum.

LIFETIME MAXIMUM	$1,000,000 per individual

Lifetime Maximum: The lifetime maximum benefit for each covered member under the plan is shown above. Unless otherwise noted in other portions of this booklet, the lifetime maximum applies to the following benefits:

- Other Covered Services (other than in-network hospice care);
- Out-of-network services and supplies (other than facility charges for inpatient hospital admissions);
- Outpatient facility services for mental and nervous conditions and substance abuse; and,
- Physician services for mental and nervous conditions and substance abuse.

Individual Case Management Benefits may also, in some cases, count towards the lifetime maximum

The lifetime maximum does not begin again if you lose coverage and then reapply and obtain a new contract.

OTHER COST SHARING PROVISIONS	See below

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. *Copays.* A copay is a fixed dollar amount you must pay on receipt of care. The most common example is a copay that must be paid 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. A common example is the 20% of the allowed amount that you must pay when you receive Other Covered Services.
4. *Amounts in excess of the allowed amount.* As a general rule, and as explained in more detail in the Glossary of Terms, the allowed amount may be less than the provider's actual charges. When you receive benefits from an out-of-network provider, for example, you may be responsible for paying the provider's charges in excess of the allowed amount.

BENEFITS

This portion of the booklet tells you what benefits are available under the plan once you have met any applicable waiting periods. It is organized for the most part by the type of service or supply being provided. For example, if you go to the emergency room of a hospital for treatment of an illness or injury, we might receive claims from the hospital, claims from an emergency room physician, and claims from a radiologist who looked at your x-rays. These claims will be separately processed according to the portions of this booklet that apply to them, depending in part on the manner in which the providers file the claims, even though they all arise out of a single episode of care.

The benefit tables below will tell you the benefit percentage for the type of service and supply involved depending upon whether you are receiving services and supplies in-network or out-of-network. It is important for you to note three things about these tables. First, the benefit percentages are stated in reference to the allowed amount. Allowed amount is defined in the Glossary of Terms. Second, the benefit percentages represent the amount that the plan will pay. If the percentage is less than 100% (for example, 80%), you will be responsible for the remaining 20%. Third, for out-of-network services and supplies or services and supplies where no network exists, you will be responsible for charges in excess of the allowed amount.

It is important for you to read this portion of the booklet, in addition to the exclusions, in its entirety so that you will understand how your benefits under the plan relate to one another. For example, in most cases, outpatient hospital benefits are processed according to the section below called Outpatient Hospital Benefits. But in some cases outpatient hospital benefits are processed as Other Covered Services.

All benefits for mental and nervous disorders and substance abuse are set forth in a separate section of the booklet called Mental Health and Substance Abuse Benefits. This means that the only benefits available under the plan for mental and nervous conditions and substance abuse are set forth in that section of the booklet. There is one exception to this: the section below called Prescription Drug Benefits applies regardless of whether your underlying medical condition is attributable to a mental and nervous condition or substance abuse.

Inpatient Hospital Benefits

NOTE: **Preadmission Certification** is required for all hospital admissions except maternity admissions.

For emergency hospital admissions, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. This means that you will be required to obtain preadmission certification for the newborn's hospitalization.

Preadmission certification does not mean that your admission is covered. It only means that we have approved the medical necessity of the admission. For example, your admission may relate to a pre-existing condition for which benefits are not yet available to you under the plan.

In many cases your provider will initiate the preadmission certification process for you. You should be sure to check with your admitting physician or the hospital admitting office to confirm whether preadmission certification has been obtained.

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

A $250.00 per admission penalty will apply if no preadmission certification is received for a covered admission.

INPATIENT HOSPITAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Services Up to 365 days of care during each confinement.	Covered at 100% after $200 per day copay for days 1-5 for each admission.	Covered at 50% subject $2,000 per admission deductible Note: In Alabama available only for accidental injury; covered at 75% of hospital's charge for ancillary services and supplies plus $10 a day for room, board and nursing

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.

Inpatient hospital benefits do not include services and expenses provided to a hospital patient that could have been provided on an outpatient basis given the patient's condition and the services provided. Benefits for those services will apply as though the services were provided on an outpatient basis. Examples are hospitals stays primarily for diagnosis, diagnostic study, medical observation, rehabilitation, physical therapy, and hydrotherapy.

If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward your 365-day maximum. Inpatient hospital days are limited to a combined in-network and out-of-network maximum of 365 days for each confinement.

Outpatient Hospital Benefits

OUTPATIENT HOSPITAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% after $300 hospital copay	Covered at 50% subject to calendar year deductible
Emergency Room-Medical Emergency	Covered at 100% after $300 hospital copay	Covered at 50% subject to calendar year deductible
Emergency Room-Accident	Covered at 100% after $300 hospital copay	Covered at 50% subject to calendar year deductible
Outpatient Diagnostic Lab, X-ray and Pathology	Covered at 100% after $300 hospital copay	Covered at 50% subject to calendar year deductible
Outpatient Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%	Covered at 50% subject to calendar year deductible

Outpatient hospital services will be processed as Other Covered Services (subject to the calendar year deductible and applicable coinsurance) rather than as Outpatient Hospital Benefits, if (1) the facility bills for an emergency room visit but the patient's condition does not meet the definition of a medical emergency, (this includes any lab and x-ray exams and other diagnostic tests associated with the emergency room fee) or (2) the services or supplies you receive are not listed in the table above.

If you receive outpatient hospital services in an out-of-network hospital in Alabama, no benefits are payable under this or any other section of the booklet unless services are to treat an accidental injury.

Physician Benefits

PHYSICIAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Office Visits & Consultations	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Emergency Room Physician	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Surgery, Second Surgical Opinions & Anesthesia	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Maternity Care	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Inpatient Visits and Inpatient Consultations	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Diagnostic Lab, X-rays and Pathology	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Chemotherapy and Radiation Therapy	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible.
Allergy Testing and Treatment	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible.

The following terms and conditions apply to Physician Benefits:

1. Surgical care includes preoperative and postoperative care, reduction of fractures, and endoscopic procedures, maternity deliveries, and heart catheterization. The allowed amount for surgical care follows these rules:

    a. If two or more related surgical procedures are done in the same sessions, we allow for only the procedure with the greater allowed amount. If the procedures are not related but done during the same session, we allow the full allowed amount for the procedure with the largest allowance and one-half of the allowed amounts for each of the others.

    b. For delivery of twins, triplets, etc., benefits will be based upon the allowed amount for the delivery of one baby.

    c. When two different specialists assist each other to operate in the same field as co-surgeons, we allow each 75% of the allowed amount for the surgery. We will not allow them more for assisting in surgery, as they assisted each other.

2. Physician Benefits include obstetrical care for childbirth, pregnancy, and the usual care before and after those services.

3. Inpatient hospital visits are covered; but if you are admitted to a hospital for surgery, obstetrical care, or radiation therapy these visits are covered only if the visits are for an unrelated condition.

4. Inpatient consultations by a specialty provider are limited to one for each hospital stay.

5. Emergency room physician services are covered unless they constitute surgery or maternity services.

Physician Preventive Benefits

PHYSICIAN PREVENTIVE BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Routine Newborn Exam (In Hospital)	Covered at 80%; no copay or deductible	Not covered
Routine Well Child Care Exams Nine visits during first 24 months of life and one visit each year thereafter through age six	Covered at 80%; no copay or deductible	Not covered
Routine Immunizations Age limitations apply to certain immunizations (see below)	Covered at 80%; no copay or deductible	Not covered
Routine Office Visits One office visit per year for members eligible for routine pap smear, routine mammogram, or routine PSA	Covered at 80%; no copay or deductible	Not covered
Routine Pap Smear One per year	Covered at 80%; no copay or deductible	Not covered
Routine/Screening Mammogram One exam for females ages 35-39 and one exam per year for females ages 40 and over See Additional Benefit Information, Mastectomy and Mammograms (later in this booklet), for additional information	Covered at 80%; no copay or deductible	Not covered
Routine PSA (Prostate Specific Antigen) One exam each year for males age 40 and over	Covered at 80%; no copay or deductible	Not covered

Colorectal Cancer Screening-Ages 50 and Over • Fecal occult blood test (FOBT) once per year; • Flexible sigmoidoscopy once every three years; • Double-contrast barium enema once every five years; • Colonoscopy once every 10 years See Additional Benefit Information, Colorectal Cancer Screenings (later in this booklet), for additional information	Covered at 80%; no copay or deductible NOTE: Claims for facility charges will be processed under your Outpatient Hospital Benefits and subject to any applicable outpatient copayments	Not covered

The plan provides Physician Preventive Benefits only when the physician is an in-network physician. If you receive physician preventive services from an out-of-network physician, the services will not be covered under this or any other portion of the plan.

Routine immunizations are covered if:

- Administered to prevent diphtheria, tetanus, pertussis, polio, rubella, mumps, measles, HIB (meningitis, epiglottitis and joint infections), hepatitis B, and chicken pox; or,
- Administered during the first 24 months of life to prevent invasive pneumococcal disease; or,
- Administered during 6 through 23 months of life to prevent influenza.

Mental Health and Substance Abuse Benefits

You have two options for the receipt of mental health and substance abuse benefits. The first option is called Expanded Psychiatric Services (EPS). Benefits under this option are available only if your care is coordinated by a provider who is a member of the EPS network. The second option is to receive limited benefits if your care is not coordinated by an EPS provider.

Benefits for Members Whose Care is Coordinated by an EPS Provider:

Expanded Psychiatric Services (EPS)	Covered at 100%; no deductible Inpatient: up to 30 days each year; includes facility, physician and therapy expenses Outpatient: includes office visits, therapy, counseling and testing

EPS providers participate in a program called Expanded Psychiatric Service (EPS). The EPS program provides members with a broad range of services for treatment of mental and nervous disorders and substance abuse without any deductible or copays when your care is coordinated by an EPS provider. In some cases, EPS providers will furnish care directly to you. In other cases, EPS providers will contract with other providers or facilities to furnish care to you. The plan pays a fixed, per member, fee to the EPS network in exchange for the network's coordination and management of your care.

Providers who participate in the EPS network are available throughout Alabama and in a few locations in states bordering Alabama. A list of EPS providers can be found in the Expanded Psychiatric Services Network directory. To find an EPS provider call Customer Service or search the online provider finder on our web site at **www.bcbsal.com.**

The following treatment, services, or supplies are covered under the EPS program:

1. 30 days of inpatient care a year for mental and nervous disorders, chemical detoxification and rehabilitation;

2. Outpatient visits;
3. Individual, group and family therapy or counseling;
4. Psychological tests;
5. Lab tests; and,
6. Services by professional staff members such as psychologists and social workers trained in mental health and chemical dependency.

The following treatment, services, or supplies are not covered under the EPS program:

1. Speech therapy;
2. Diagnosis or treatment of mental retardation;
3. Rehabilitation of a temporary or permanent disability or for hearing or vision impairment;
4. Treatment for chronic pain or solely for obesity;
5. Services related to narcotic maintenance therapy such as methadone maintenance therapy;
6. Services related to nicotine addiction;
7. Sex therapy programs or treatment for sex offenders;
8. Prescription drugs; and,
9. Residential psychiatric facilities.

Benefits for Members Whose Care is not Coordinated by an EPS Provider

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Up to 15 days of inpatient treatment during any 12 consecutive months; no coverage after 15 days	Covered at 100% after $200 daily facility copay for days 1– 5 for each admission	Covered at 50% after $2,000 per admission deductible Note: In Alabama**,** not covered
Inpatient Physician Up to 15 days of inpatient treatment during any 12 consecutive months; no coverage after 15 days	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Outpatient Facility and Physician Up to 20 visits per calendar year	Covered at 50% subject to calendar year deductible	Covered at 50% subject to calendar year deductible

Other Covered Services

	IN-NETWORK	OUT-OF-NETWORK
Chiropractic Services Limited to $600 per calendar year	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible.

Chiropractic services must be provided by a licensed chiropractor.

	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (DME) and Supplies	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible

Durable medical equipment and supplies consist of the following:

- Artificial arms and other prosthetics, leg braces, and other orthopedic devices; and,
- Medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints.

Benefits for durable medical equipment will be based on the lesser of the rental or purchase price.

	IN-NETWORK	OUT-OF-NETWORK
Home Health and Hospice Precertification required for services rendered outside Alabama; for precertification call 1 800 821-7231	80% subject to calendar year deductible.	Covered at 50% subject to calendar year deductible **Note:** In Alabama**,** not covered

In-network home health care benefits consist of home IV therapy, intermittent home nursing visits by an R.N. or L.P.N. and home phototherapy for newborns. These services must be ordered by your attending physician and provided by an in-network home health care provider. When these services are provided outside of Alabama, benefits are paid **only** if precertification is obtained by calling 1 800 821-7231.

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. An in-network hospice must furnish the services and supplies to a member certified by his physician to have less than six months to live. When these services are provided outside of Alabama, benefits are paid **only** if precertification is obtained by calling 1 800 821-7231.

	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Services and Supplies for the days of an admission extending beyond the 365 day benefit maximum	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible.

As previously noted, this benefit does not apply to mental health and substance abuse admissions.

	IN-NETWORK	OUT-OF-NETWORK
Occupational, Physical and Speech Therapy Occupational, physical and speech therapy are limited to a combined maximum of 30 visits per calendar year	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible

Occupational, speech and/or physical therapy services must be medically necessary and performed by a licensed occupational, speech and/or physical therapist.

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Hospital Services and Supplies (Including Lab and X-ray Exams and Other Diagnostic Tests)	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible.

Outpatient hospital services and supplies are payable as Other Covered Services if (1) the hospital bills for an emergency room visit but the patient's condition does not meet the definition of a medical emergency, (this includes any lab and x-ray exams and other diagnostic tests associated with the emergency room fee) or (2) services or supplies received are not listed in the table called Outpatient Hospital Benefits (earlier in this booklet).

As previously noted, this benefit does not apply to outpatient hospital services and supplies for mental and nervous conditions and substance abuse.

Additional Other Covered Services	IN-NETWORK	OUT-OF-NETWORK
Ambulance services	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Accident related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if service is received within 90 days of the injury	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Dialysis services at a renal dialysis facility	Covered at 80% subject to calendar year deductible	Covered at 50% subject to calendar year deductible **Note:** In Alabama, not covered

Prescription Drug Benefits

PRESCRIPTION DRUG BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs	**Generic drugs:** You pay 20% or $15 per prescription copay (whichever is greater) **Preferred brand drugs:** You pay 20% or $30 per prescription copay (whichever is greater) **Other brand name drugs:** You pay 20% or $50 per prescription copay (whichever is greater) **Brand name drugs for which a generic equivalent is available:** Not covered	Not covered

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

1. To be eligible for benefits, drugs must be 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.” Compound drugs may be covered if at least one of the drugs in the compound is a legend drug.
2. You must satisfy in-network copays with respect to each prescription.
3. Drugs can be dispensed up to a maximum 90-day supply. You must satisfy the copay requirement for each 30-day supply. Refills of prescriptions are allowed only after 60% of the previous prescription has been used (e.g., 18 days into a 30-day supply).
4. In some cases, drugs may require prior authorization. Your in-network pharmacist will advise you if prior authorization is required.
5. Insulin, needles, and syringes purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. Blood glucose strips and lancets purchased on the same day in the same quantity will have one copay. Otherwise, each has a separate copay. Glucose monitors always have a separate copay. These are the only diabetic supplies available as prescription drug benefits under the plan.

Health Management Benefits

HEALTH MANAGEMENT BENEFITS	
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury
Care Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease

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 assist you in accessing the most appropriate health care benefits for your condition. The nurse case manager will work with you, your physician, and other health care professionals to design a benefit 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. The program is voluntary to 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 benefit contract maximums. If you think that you may benefit from Individual Case Management, please call the Health Management division at (205) 733-7067 or 1 800 821-7231.

If you suffer from certain long-term, chronic, diseases or conditions you may qualify to participate in the Care Management Program. Care Management is designed for individuals whose long-term medical needs require disciplined compliance with a variety of medical and lifestyle requirements. If the manager of the Care Management Program determines from your claims data that you are a good candidate for Care Management, the manager will contact you and ask if you would like to participate. Participation in the program is completely voluntary. If you would like to obtain more information about the program, call Customer Service at the number on the back cover.

Additional Benefit Information

Organ, Tissue, and Bone Marrow/Cell Transplants

The organs and tissue for which there are transplant benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas; (5) kidney; (6) heart-valve; (7) skin; (8) cornea; and (9) small bowel. Bone marrow transplants, which include stem cells and tissue to restore or make stronger the bone marrow function, are also included. The transplant 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. Donor organ costs are limited to search, removal, storage and transporting of the organ and removal team.

There are no transplant benefits for: (1) any 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) recipient or donor room, food, or transportation costs we did not approve in writing; (7) a condition or disease for which a transplant is considered investigational; (8) transplants performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

Mastectomy and Mammograms

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.

Treatment decisions are made by the attending physician and patient. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Benefits for Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim.

- If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.

- If you are at high risk of developing breast cancer or you have a family history of breast cancer - within the meaning of our medical guidelines - and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.

- In all other cases the claim will be subject to the routine mammogram benefit provisions and limits described elsewhere in this booklet.

Benefits for Colorectal Cancer Screening

Benefits for colorectal cancer screening vary depending upon the reason the procedure is performed and the way in which the provider files the claim.

- If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.

- If you are at high risk of developing colon cancer or you have a family history of colon cancer - within the meaning of our medical guidelines - and if the provider properly files the claim with this information, we will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.

- In all other cases the claim will be subject to the routine colorectal cancer screening benefit provisions with the age and frequency limitations described elsewhere in this booklet.

BlueCard Copay and Coinsurance

When you obtain health care services through the BlueCard Program outside the geographic area we serve, the amount you pay for covered services is calculated on the **lower** of:

- The billed charges for your covered services, or
- The negotiated price that the local Blue Cross and/or Blue Shield Plan (Host Plan) passes on to us.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the

actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your payment for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate payment calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Health Benefit Exclusions

We **will not** provide benefits under any portion of this booklet for the following:

A

Services 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.

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

Anesthesia services or supplies or both by local infiltration.

Services, care, treatment or supplies furnished by a provider that is not recognized by us as an **approved provider** for the type of service or supply being furnished. For example, we reserve the right not to pay for some or all services or supplies furnished by certain persons who are not medical doctors (M.D.s), even if the services or supplies are within the scope of the provider's license. Call Customer Service if you have any question as to whether your provider is recognized as an approved provider for the services or supplies that you intend to receive.

C

Services or expenses of a hospital stay, except one for an emergency, unless we **certify** it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 48 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.

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 24 months** after services were rendered or expenses incurred.

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, Mastectomy and Mammograms 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.

a. You may 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 fields 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.

b. 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** 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.

Services for or related to a **dependent pregnancy**, including the six-week period after delivery. A dependent pregnancy means the pregnancy of any dependent other than the subscriber’s wife.

Drugs or medicines dispensed from a pharmacy that is not a Participating Pharmacy or for brand name drugs for which there is a generic equivalent available.

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.

Eyeglasses or contact lenses or related examination or fittings. One pair of eyeglasses, contact lenses or one pair of each will be considered under Other Covered Services if they replace the lens of the eye after eye surgery or injury or defect.

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.

F

Services or expenses in any **federal hospital or facility** except as provided 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

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. This applies even if the law does not cover all your expenses.

H

Hearing aids or examinations or fittings for them.

Services and expenses provided to a **hospital patient** at a covered facility, which could have been provided on an outpatient basis, given the patient's condition and the services provided. Other Covered Service benefits for those services will apply as though the services were provided on an outpatient basis. Examples are hospital stays primarily for diagnosis, diagnostic study, medical observation, rehabilitation, physical therapy and hydrotherapy

I

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

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.

L

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.

M

Treatment for **mental and nervous** disorders or disease (including alcoholism and drug addiction) is not covered under Other Covered Services after the basic hospital days have been used. However, benefits may be available with Expanded Psychiatric Service (EPS).

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.

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 a Participating Pharmacy.

Services or expenses of any kind provided by a **Non-Participating Hospital** located in Alabama for any benefits under this plan, except for inpatient and outpatient hospital benefits in case of accidental injury.

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.

P

Services or expenses of **private duty nurses** unless previously stated as a covered service. Private duty nursing services consist of nursing care by a licensed professional nurse (R.N.) or a licensed practical nurse (L.P.N.) provided specifically to the patient and arranged by the patient or his/her family.

Services provided by **Psychiatric Specialty Hospitals** which do not participate with nor are considered members of any Blue Cross and/or Blue Shield Plan.

Services or expenses for **physical therapy** which do not require a licensed physical therapist, 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.

R

Services or expenses for **recreational** or educational therapy.

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

Hospital admissions in whole or in part when the patient primarily receives **rehabilitation** services such as physical therapy, speech therapy, or occupational therapy.

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. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed physical therapist.

Services provided by a Non-Participating **Renal Dialysis Facility** in Alabama.

Routine well child care and routine immunizations except for the limited services described in the "Preventive Benefits" section.

Routine physical examinations except for the limited services described in the "Physician Preventive Benefits" section.

S

Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease or which are related to surgical sex transformations.

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

Services provided by **Substance Abuse Facilities** including Substance Abuse Residential Facilities**.**

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, to those services by a

physician to treat or replace natural teeth which are harmed by accidental injury covered under Other Covered Services.

Services provided through **teleconsultation.**

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.

Travel, even if prescribed by your physician.

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

W

Services or expenses in cases covered in whole or in part by **workers' compensation** or employers' liability laws, state or federal. This applies even if you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for hospital or medical services as such. Finally, it applies whether or not your employer has insurance coverage for benefits under the law.

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

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.

COORDINATION OF BENEFITS

We coordinate the benefits under this plan with other group and non-group health 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, it 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, subscriber, or eligible dependent of any of the forgoing.

3. Non-Group Health Plan: If the other plan is a non-group health plan not issued by us, the following rules apply:

    a. The benefits of the plan which covers the person as an applicant or subscriber (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, 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. If both plans don't use this "birthday rule" the other plan's rule will be used.

    c. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:

        1. First, the plan of the parent with custody;
        2. Then, the plan of the spouse of the parent with custody;
        3. Last, the plan of the parent without custody.

        If the divorced or separated parents have joint custody, benefits are determined as if the parents are not separated or divorced (see paragraph b. above).

        If there is a court order that specifically states that one parent must provide the child's health expenses, that parent's plan is primary.

    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.

If this plan is secondary, according to the above rules, it will not pay more than if it would have paid if primary. We will compare primary liability to secondary liability and select the most cost-effective payment on a claim-by-claim basis. This means that we will first calculate our primary liability as if no other insurance coverage had been involved. We will then calculate secondary liability by subtracting the amount payable by the other insurance coverage from the covered charge. We will compare the primary liability to the secondary liability and pay the lesser amount.

If you are covered both by this plan and by another non-group health plan we issue, you will be entitled to benefits only under the plan that provides the most coverage to you.

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.

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 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 attorney's 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 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.

In General

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.

Who Gets Paid: Some of the contracts we have with providers of services, such as hospitals, require us to pay benefits directly to the providers. With other claims we may choose whether to pay you or the provider. If you or the provider owes us money we may deduct the amount owed from the benefit paid. When we pay or deduct the amount owed from you or the provider, this completes our obligation to you under the plan. We need not honor an assignment of your claim to anyone. 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.

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 (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 not require you to file a pre-service claim so long as you provide 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: (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 Internet web site at **www.bcbsal.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 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 (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 – 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 (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 SUBSCRIBER 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 35242

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 SPECIFIY 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 the Individual Blue 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

1. 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 Individual Blue policyholders who have purchased the same type contract as you.

2. 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.

3. 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 make any material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to your effective date. We need not even refund any payment for your coverage.

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 health care 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.

Additionally, we may use or disclose your personal health information for treatment, payment, or health care 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 contact office:

Blue Cross and Blue Shield of Alabama
Privacy Office
P. O. Box 2643
Birmingham, Alabama 35202-2643

Telephone: 1 800 292-8868

GLOSSARY OF TERMS

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 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 copays, 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. See BlueCard Copay and Coinsurance, earlier in this booklet, for a thorough description of the contracting arrangements that exist outside the state of Alabama.

2. **Out-of-Network Providers:** The allowed amount for care for out-of-network providers is normally determined by the Blue Cross and/or Blue Shield Plan where services are rendered. This amount may be based on the negotiated rate payable to in-network providers or may be based on the average charge for the care in the area. For out-of-network services or supplies in Alabama, 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 for the same or a similar service;
   - The relative complexity of the service;
   - The in-network allowance in Alabama for the same or a similar service;
   - Applicable state health care factors;
   - The rate of inflation using a recognized measure; and,
   - Other reasonable limits, as required with respect to outpatient prescription drug costs.

   In this situation 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.

Application: The subscriber's original application form and any written supplemental application we accept.

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.

Blue Cross: Blue Cross and Blue Shield of Alabama.

BlueCard PPO Program: A national program that links Blue Cross and/or Blue Shield plans together through a single electronic network for claims processing and reimbursement. The BlueCard PPO program enables Blue Cross and Blue Shield of Alabama members obtaining health care services outside

the Alabama service area to receive in-network benefits, provided that the local Blue Cross and/or Blue Shield plan has designated the provider as a BlueCard PPO provider and provided further that the service or supply furnished is covered under the plan as an in-network benefit.

Coinsurance: Coinsurance is the amount that you must pay as a percent of the allowed amount. A common example is the 20% of the allowed amount that you must pay when you receive Other Covered Services.

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.

Copays: A copay is a fixed dollar amount you must pay on receipt of care. The most common example is a copay that must be paid when you go to a doctor’s office.

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 "Exclusions" section.

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.

Effective Date: The date on which the coverage of each individual subscriber/dependent begins as listed in Blue Cross’s records.

Family Coverage, Family Plan or Family Contract: A plan or contract that covers the subscriber and properly added dependents.

Generic Drugs: Any drug which does not have a brand name or trademark.

Home Health Care 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 health care 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.

Hospital: Any hospital that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those that are classified or could be classified under standards of the American Hospital Association as "specialty" hospitals. Examples of these "specialty" hospitals are those classified for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

In-Network Provider: A provider is considered to be an in-network provider if, and only to the extent that, the provider is furnishing a service or supply that is specified as an in-network benefit under the terms of the contract between the provider and the Blue Cross and/or Blue Shield Plan. Examples include BlueCard PPO providers, Preferred Medical Doctors (PMD physician), and Participating Pharmacies. When receiving services or supplies outside the Alabama service area, a provider will be considered an in-network provider only if the local Blue Cross and/or Blue Shield plan designates the provider as a BlueCard PPO provider for the service or supply being furnished.

Inpatient: A registered bed patient in a hospital.

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: A subscriber or eligible dependent who has coverage under the plan.

Mental and Nervous Disorders: These are mental disorders, mental illness, psychiatric illness, mental conditions and psychiatric conditions. These disorders, illnesses and conditions are considered mental and nervous disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental and nervous disorders however they are caused, based or brought on. Mental and nervous 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 intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those that are classified or could be classified under standards of the American Hospital Association as "special" hospitals. Examples of these "special" hospitals are those classified for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

Non-Preferred Brand: Any brand name drug that is not a Preferred Brand.

Out-of-Network Provider: A provider is an out-of-network provider when there is no in-network contract covering the services or supplies rendered.

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.

Participating Pharmacy: Any pharmacy with which Blue Cross and Blue Shield of Alabama or its subsidiary, Preferred Care Services, Inc., has a contract for dispensing prescription drugs.

Participating Renal Dialysis Facility: Any freestanding hemodialysis facility with which Blue Cross and Blue Shield of Alabama has a contract for furnishing health care services.

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.), and Psychologist (Ph.D., Psy.D. or Ed.d.), as defined in Section 27-1-18 of the Alabama Code.

Plan: The plan consists of our 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.

Preferred Brand Drugs: Prescription drugs that are cost effective and have been approved therapeutically safe and effective by a panel of physicians and pharmacists on Blue Cross and Blue Shield of Alabama’s Pharmacy and Therapeutics Committee.

Preferred Medical Doctor: A physician who has an agreement with Blue Cross and Blue Shield of Alabama to provide surgical and medical services to members entitled to benefits under the PMD program.

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.

Self-Only Coverage, Self-Only Plan, or Self-Only Contract: A plan or contract that covers the subscriber only.

Subscriber: The person whose application for coverage under the contract is made and accepted by Blue Cross.

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider.

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

You, Your: The subscriber or member as shown by context.

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Preadmission Certification:

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BlueCross BlueShield of Alabama

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HEALTH PLAN