

Blue Secure Silver



**BlueCross BlueShield
of Alabama**

AlabamaBlue.com

We cover what matters.

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OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits please contact Customer Service at 1-855-350-7441. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor - Spanish

Las siguientes disposiciones de este folleto contiene un resumen en Inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con Servicio al Cliente al 1-855-350-7441.

Purpose of the Plan

The plan is intended to help you and your covered dependents pay for the cost of healthcare. The plan does not pay for all of your healthcare. You may also be required to pay deductibles, copayments, and coinsurance.

Using [myBlueCross](http://www.bcbsal.com) to Get More Information Over the Internet

Blue Cross and Blue Shield of Alabama's home page on the Internet is www.bcbsal.com. If you go there, you will see a section of our home page called *myBlueCross*. Registering for *myBlueCross* is easy and secure; and once you have registered you will have access to information and forms that will help you take maximum advantage of your benefits under the plan.

Nature of Coverage

The plan is not a Medicare supplement policy. If you are enrolled in Medicare, this means that this plan **will not** pay primary, secondary or supplemental benefits to Medicare. This means that you will have minimal or no benefits under the plan, without reduction in premiums. You (meaning any member covered under the plan) must notify us when you become enrolled in Medicare.

If you are enrolled in Medicare, we strongly suggest that you consider buying a Medicare supplement plan, a Medicare Part D prescription drug plan and/or a Medicare Advantage plan.

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

Free Review Period

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

Policy Year

The policy year of the plan is January 1 through December 31 of each year.

Definitions

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

Receipt of Medical Care

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

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 Family Members

The section of the booklet called [Eligibility](#) will also tell you how to cover family members. For example, that section of the booklet tells you how to cover family members that you acquire after the effective date of your coverage.

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 family members until the next annual open enrollment under the plan.

Limitations and Exclusions

In order to maintain the cost of the plan at an overall level that is reasonable for all plan members, the plan contains a number of provisions that limit benefits. There are also exclusions that you need to pay particular attention to as well. These provisions are found throughout the remainder of this booklet. You need to be aware of the limits and exclusions to determine if the plan will meet your healthcare needs.

Medical Necessity and Precertification

The plan will only pay for care that is medically necessary and not investigational, as determined by us. We develop medical necessity standards to aid us when we make medical necessity determinations. We publish many of these standards on the Internet at www.bcbsal.com.

The definitions of medical necessity and investigational are found in the [Definitions](#) section of this booklet. In some cases, the plan requires that you or your treating provider precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered.

In-Network Benefits

One way in which the plan tries to manage your costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments,

and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. Additionally, out-of-network providers have not contracted with us or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the plan.

Examples of the plan's Alabama in-network providers are Participating Hospitals, Preferred Outpatient Facilities, Participating Ambulatory Surgical Centers, Participating Renal Dialysis Providers, Preferred Medical Doctors (PMD), Blue Choice Behavioral Network, Participating Chiropractors, Participating Nurse Practitioners, Participating Physician Assistants, Preferred Occupational Therapists, Preferred Physical Therapists, Preferred Speech Therapists, Vaccine Pharmacy Network, Limited Retail Network, Specialty Pharmacy Network, and Preferred Dentist. To locate Alabama in-network providers, go to www.bcbsal.com.

1. Click "Find a Doctor."
2. Select a healthcare provider type: doctor, hospital, dentist, pharmacy, other healthcare provider, or other facility or supplier.
3. Enter a search location by using the zip code for the area you would like to search or by selecting a state.

Sometimes a network provider may furnish a service to you that is not covered under the contract between the provider and Blue Cross and Blue Shield of Alabama. When this happens, benefits may be denied or reduced.

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder website at www.bcbs.com/healthtravel/finder.html. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross plan where services are rendered. The local Blue Cross plan will then forward the claims to us for verification of eligibility and determination of benefits. Sometimes a network provider may furnish a service to you that is either not covered under the plan or is not covered under the contract between the provider and the local Blue Cross plan where services are rendered. When this happens, benefits may be denied or reduced.

Hospital Tiered Network in Alabama

Blue Cross and Blue Shield of Alabama has developed a Hospital Tiered Network within the state of Alabama. Hospitals are categorized into one of three "tiers", based on their performance in, for example, fiscal, quality and patient safety awareness. Tier 1 hospitals are recognized as having attained the highest level of compliance across those areas. Tier 1 hospitals also include certain specialty hospitals and ambulatory surgical centers within the state of Alabama that do not participate in the Hospital Tiered Network. Tier 1 hospitals also include some in-network hospitals

outside the state of Alabama. Tier 2 and Tier 3 hospitals are those facilities in Alabama that are not

Tier 1.

Copayment and deductible amounts for inpatient and outpatient services will vary between tiers as indicated later in this benefit booklet, with Tier 1 having the lowest copayment and deductible amounts.

To determine the tier level of a particular hospital, please visit our website at www.bcbsal.com. The tier level will be indicated next to the name of the hospital for those who participate in the Hospital Tiered Network. If you have any questions, please contact our Customer Service Department at 1-855-350-7437.

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

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

Claims and Appeals

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

Arbitration

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

Changes in the Plan

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

Termination of Coverage

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

Respecting Your Privacy

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

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

You may also go to our website at www.bcbsal.com for a copy of our privacy notice.

ELIGIBILITY

Your Eligibility for the Plan

You are eligible for the plan if you are a resident of the state of Alabama. When you first apply for the plan, you will be given the opportunity to cover your eligible family members.

You may apply for the plan only during the initial open enrollment period, each annual open enrollment period or a special open enrollment period as described in [Beginning of Coverage](#) below.

Your Eligible Dependents

Your spouse can be covered under the plan if he or she is of the opposite sex from you and is a resident of the state of Alabama.

Your married or unmarried child may likewise be covered if, at the time of your application, he or she is under the age of 26 and is a resident of the state of Alabama. In addition, the child must be your natural child; stepchild; legally adopted child; child placed for adoption; or eligible foster child. An eligible foster child is a child that is placed with you by an authorized placement agency or by court order.

You may not cover your grandchild unless your grandchild is your adopted child, a child placed for adoption or your eligible foster child.

Timely Payment of Premiums

Initial Payment of Premiums

Your first initial payment of premiums must be made no later than the last day before your scheduled effective date of coverage. If we do not receive your initial payment of premiums on time, your scheduled effective date of coverage under the plan will be cancelled and you will have no coverage under the plan.

Subsequent Monthly Payment of Premiums

After you make your first initial payment for plan coverage, you must make timely periodic payments for each subsequent month.

Each of your monthly periodic payments is due in advance on the 20th day of the month before that monthly coverage period. There is a grace period of 10 days for all monthly premium payments after the first initial premium payment. If you fail to pay in full a monthly payment before the end of the grace period for that coverage period, your coverage under the plan will be cancelled as of the last day of the month before that monthly coverage period. Failure to timely pay premium payments is not a special open enrollment event for later coverage under the plan.

Beginning of Coverage

Initial Open Enrollment Period

You may apply for the plan during the initial open enrollment period that begins October 1, 2013 and extends through March 31, 2014. If you apply for the plan during the initial open enrollment on or before December 15, 2013, your coverage will begin on January 1, 2014 (assuming you timely pay your premiums in full). If you apply between the first and fifteenth of any subsequent month during the initial open enrollment, your coverage will begin on the first day of the following month (assuming you timely pay your premiums in full). If you apply between the sixteenth and the last day of the month between December 2013 and March 31, 2014, your coverage will begin on the first day of the second following month (assuming you timely pay your premiums in full).

Annual Open Enrollment Period

If you do not enroll during the initial open enrollment period (or a special open enrollment period described below), you may enroll only during the plan's annual open enrollment period that begins October 15 and extends through December 7 of each year. If you apply for the plan during an annual open enrollment period, your coverage will begin on the following January 1 (assuming you timely pay your premiums in full).

Special Enrollment Period for Individuals Losing Other Minimum Essential Coverage

An eligible individual or dependent (1) who does not enroll during the initial open enrollment or an annual open enrollment because the eligible individual or dependent has other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or minimum essential coverage by other health plans which ended due to "loss of eligibility" (as described below), and (3) who requests enrollment within 60 days of the exhaustion or termination of coverage, may enroll in the plan. Coverage will be effective no later than the first day of the first month beginning after the date the request for special enrollment is received (assuming you timely pay your premiums in full).

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment, failure of your employer to offer minimum essential coverage to you and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage

for fraud or material misrepresentation of a material fact.

Special Enrollment Period for Newly Acquired Dependents

If you have a new dependent as a result of marriage, birth, placement for adoption, or adoption, you may enroll yourself and/or your spouse and your new dependent as special enrollees provided that you request enrollment within 60 days of the event. The effective date of coverage will be the date of birth, placement for adoption, or adoption (assuming you timely pay your premiums in full). In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first month beginning after the date the request for special enrollment is received (assuming you timely pay your premiums in full).

Special Enrollment Period related to Advance Payments of Premium Tax Credit and Cost-Sharing Reductions

An individual who is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions under the Affordable Care Act, regardless of whether such individual is already enrolled in a qualified health plan, may enroll in the plan provided the request for special enrollment is received within 60 days of the event. If the request for special enrollment is received between the first and the fifteenth day of the month, coverage will be effective no later than the first day of the following calendar month (assuming you timely pay your premiums in full). If the request for special enrollment is received between the sixteenth and the last day of the month, coverage will be effective no later than the first day of the second following month (assuming you timely pay your premiums in full).

Other Special Enrollment Periods

An eligible individual who is an Indian (as defined by section 4 of the Indian Healthcare Improvement Act) may enroll in the plan at any time (but no more than once per calendar month). If the request for special enrollment is received between the first and the fifteenth day of the month, coverage will be effective no later than the first day of the following calendar month (assuming you timely pay your premiums in full). If the request for special enrollment is received between the sixteenth and the last day of the month, coverage will be effective no later than the first day of the second following month (assuming you timely pay your premiums in full).

An eligible individual who becomes eligible for the plan because of a permanent move may enroll in the plan provided that the individual requests special enrollment within 60 days. If the request for special enrollment is received between the first and the fifteenth day of the month, coverage will be effective no later than the first day of the following calendar month (assuming you timely pay your premiums in full). If the request for special enrollment is received between the sixteenth and the last day of the month, coverage will be effective no later than the first day of the second following month (assuming you timely pay your premiums in full).

An eligible individual who was not previously a citizen, national, or lawfully present individual gains such status may enroll in the plan provided that the individual requests special enrollment within 60 days. If the request for special enrollment is received between the first and the fifteenth day of the month, coverage will be effective no later than the first day of the following calendar month (assuming you timely pay your premiums in full). If the request for special enrollment is received between the sixteenth and the last day of the month, coverage will be effective no later than the first day of the second following month (assuming you timely pay your premiums in full).

An individual who the Health Insurance Marketplace determines is eligible for a special enrollment period because of (1) unintentional, inadvertent or erroneous enrollment in another plan; (2) another plan under which the employee or dependent was enrolled that substantially violated a material provision of that plan; or (3) other exceptional circumstances may also enroll in the plan provided that the individual requests special enrollment within 60 days. If the request for special enrollment is

received between the first and the fifteenth day of the month, coverage will be effective no later than the first day of the following calendar month (assuming you timely pay your premiums in full). If the request for special enrollment is received between the sixteenth and the last day of the month, coverage will be effective no later than the first day of the second following month (assuming you timely pay your premiums in full).

Termination of Coverage

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

1. You fail to pay all applicable fees for coverage before 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 your applicable day grace period as explained above in this booklet in the subsection called [Timely Payment of Premiums](#);
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 the contract holder's death;
7. For any member, the date of his or her death;
8. Upon discovery of fraud or intentional misrepresentation of a material fact; or,
9. Upon termination of the plan as explained later in this booklet in the section called [General Information](#).

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.

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.

COST SHARING

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	\$2,000 individual;	\$2,000 individual;
The in-network and out-of-network calendar year deductibles are separate and do not apply to each other	(\$4,000 family)	(\$4,000 family)
Calendar Year Out-of-Pocket Maximum (including the in-network calendar year deductible)	\$6,350 individual; (\$12,700 family)	There is no out-of-pocket maximum

Calendar Year Deductible

The calendar year deductible is specified in the table above. Other portions of this booklet will tell you when your receipt of benefits is subject to the calendar year deductible. The calendar year deductible is the amount you or your family must pay for medical expenses covered by the plan before your healthcare benefits begin.

- The individual calendar year deductible must be satisfied on a per person per calendar year basis, subject to the family calendar year deductible maximum.
- The family calendar year deductible is an aggregate dollar amount. This means that all amounts applied toward the individual calendar year deductible will count toward the family deductible amount. Once the family deductible is met, no further family members must satisfy the individual calendar year deductible.

The calendar year deductibles for in-network and out-of-network providers apply independently of one another. This means that amounts applied towards the in-network calendar year deductible do not count towards your out-of-network calendar year deductible; nor do amounts applied towards your out-of-network calendar year deductible count towards your in-network calendar year deductible. Thus, if you receive care, services, or supplies during the course of the calendar year from both in-network and out-of-network providers, it may be necessary for you to satisfy both the in-network and out-of-network calendar year deductibles.

In all cases, the deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

Calendar Year Out-of-Pocket Maximum

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

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

- All cost-sharing amounts (deductibles, copayments, coinsurance and amounts in excess of the allowed amount) paid for any out-of-network services or supplies that may be covered under the plan;
- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies in excess of any plan limits (for example, a limit on the number of covered services for a particular type of service); and,
- Amounts paid as a penalty (for example, failure to precertify).

The calendar year out-of-pocket maximum applies on a per person per calendar year basis, subject to the family calendar year out-of-pocket maximum.

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

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 an inpatient in an out-of-network hospital.
2. **Copayments.** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is a copayment 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.
4. **Amounts in excess of the allowed amount.** As a general rule, the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with us or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount. As one example, out-of-network facility claims may often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the plan. This means you will be responsible for these charges if you use an out-of-network provider.

Out-of-Area Services

Blue Cross and Blue Shield of Alabama has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard® Program.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Our payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

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

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

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

taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Non-Participating Healthcare Providers Outside Our Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

2. Exceptions

In some exception cases, we may pay such claims based on the payment we would make if we were paying a non-participating provider inside of our service area, as described elsewhere in this benefit booklet, where the Host Blue's corresponding payment would be more than our in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In other exception cases, we may use other payment bases, such as billed covered charges, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

HEALTH BENEFITS

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

Inpatient Hospital Benefits

Attention: Preadmission certification is required for all hospital admissions except for medical emergency and 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. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,

- The baby is discharged and then readmitted.

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 surgery which is determined to be cosmetic and therefore non-covered 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. It is your responsibility to ensure that you or your provider obtains preadmission certification.

For preadmission certification call 1-800-248-2342 (toll-free).

If preadmission certification is not obtained but we later determine that the admission was medically necessary, you will be required to pay a **\$250 per admission penalty**. You will be required to pay the billed charges for the inpatient admission if we later determine that it was not medically necessary.

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Inpatient First 365 days of care during each confinement in a General Hospital or Psychiatric Specialty Hospital (combined in-network and out-of-network)	Tier 1: 100% of the allowed amount, subject to a \$300 daily inpatient facility copayment beginning with the 1 st day through the 5 th day Tier 2 & Tier 3: 100% of the allowed amount, subject to a \$600 daily inpatient facility copayment beginning with the 1 st through the 5 th day	50% of the allowed amount, subject to a \$1,200 inpatient admission deductible
Inpatient Days of confinement extending beyond the 365-day benefit maximum (available in a General Hospital only)	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible

Attention: If you receive inpatient hospital services in an out-of-network hospital in the Alabama service area, no benefits are payable under the plan unless services are to treat an accidental injury or medical emergency.

The per admission 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;
11. Blood transfusions administered by a hospital employee.

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

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

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

Outpatient Hospital Benefits

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Outpatient surgery (including ambulatory surgical centers)	<p>Tier 1: 100% of the allowed amount, subject to a \$300 outpatient facility copayment</p> <p>Tier 2 & 3: 100% of the allowed amount, subject to a \$600 outpatient facility copay</p>	<p>50% of the allowed amount, subject to the calendar year deductible</p> <p>Note: In Alabama, Not Covered</p>
Emergency room – medical emergency	100% of the allowed amount, subject to a \$300 outpatient facility copayment	<p>100% of the allowed amount, subject to a \$300 outpatient facility copayment and subject to the calendar year deductible</p> <p>Mental Health and Substance Abuse: 100% of the allowed amount, subject to a \$300 outpatient facility copayment</p>

Emergency room – accident	100% of the allowed amount subject to a \$300 outpatient facility copayment	100% of the allowed amount, subject to a \$300 outpatient facility copayment and subject to the calendar year deductible when services are rendered within 72 hours of the accident; 50% of the allowed amount, subject to the calendar year deductible when services are rendered after 72 hours of the accident
Outpatient diagnostic lab, X-ray, and pathology	Tier 1: 100% of the allowed amount, subject to a \$300 outpatient facility copayment Tier 2 & 3: 100% of the allowed amount, subject to a \$600 outpatient facility copayment Note: In Alabama, precertification is required for certain services. Go to www.bcbsal.com for more information about this. If precertification is not obtained, no benefits will be payable under the plan.	50% of the allowed amount, subject to the calendar year deductible Note: In Alabama, Not Covered
Outpatient dialysis, IV therapy, chemotherapy, and radiation therapy	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible Note: In Alabama, Not Covered
Services billed by the facility for an emergency room visit when the patient's condition does not meet the definition of a medical emergency (including any lab and X-ray exams and other diagnostic tests associated with the emergency room fee)	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible Note: In Alabama, Not Covered
Covered outpatient hospital services or supplies not listed above and not listed in the section of the booklet called Other Covered Services	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible Note: In Alabama, Not Covered

Attention: If you receive outpatient hospital services in an out-of-network hospital in the Alabama service area, no benefits are payable under the plan unless services are to treat an accidental injury or medical emergency.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the

setting in which they were rendered. This means that we may, at times, reclassify an outpatient hospital service as an inpatient admission. There may also be times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

Physician Benefits

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
<p>Office visits, consultations, and psychotherapy</p> <p>Primary Physicians include the following providers: General Practice, Family Practice, Internal Medicine, Pediatrics, Geriatrics, OB/GYN, Nurse Practitioner, Physician Assistant (including physician assistants who assist with surgery), and Midwife</p>	100% of the allowed amount, subject to a \$40 primary physician visit copayment or a \$60 specialist physician visit copayment	50% of the allowed amount, subject to the calendar year deductible
Second surgical opinions	100% of the allowed amount, subject to a \$60 specialist physician visit copayment	50% of the allowed amount, subject to the calendar year deductible
Emergency room physician	100% of the allowed amount, subject to a \$60 physician visit copayment	100% of the allowed amount, subject to a \$60 physician visit copayment and subject to the calendar year deductible Mental Health and Substance Abuse; 100% of the allowed amount, subject to a \$60 physician visit copayment
<p>Surgery and anesthesia for a covered service</p> <p>(See Special Diagnostic Procedures below for exceptions)</p>	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Maternity care	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Inpatient visits and inpatient consultations	100% of the allowed amount, subject to the calendar year deductible Mental Health and Substance Abuse: 100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible Mental Health and Substance Abuse: 50% of the allowed amount, no deductible or copayment
<p>Diagnostic X-rays</p> <p>(See Special Diagnostic Procedures below for exceptions)</p>	100% of the allowed amount, subject to a \$10 copayment per procedure Note: In Alabama, precertification is required for certain services. Go to www.bcbsal.com for more information about this. If precertification is not obtained, no benefits will be payable under the plan.	50% of the allowed amount, subject to the calendar year deductible

Diagnostic lab and pathology, dialysis, IV therapy, chemotherapy, radiation therapy (See Special Diagnostic Procedures below for exceptions)	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible
Special diagnostic procedures performed in the physician's office or free-standing diagnostic center: CAT Scan; MRI; PET/SPECT; ERCP; angiography/arteriography; cardiac cath/arteriography; UGI endoscopy; muga-gated cardiac scan; colonoscopy	100% of the allowed amount, subject to a \$300 copayment per procedure Note: In Alabama, precertification is required for certain services. Go to www.bcbsal.com for more information about this. If precertification is not obtained, no benefits will be payable under the plan.	50% of the allowed amount, subject to the calendar year deductible
Allergy testing and treatment Treatment is limited to 6 visits per member each calendar year (combined in-network and out-of-network)	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, and heart catheterization.
- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.
- If you receive out-of-network physician benefits (such as out-of-network laboratory services) for a medical emergency in the emergency room of a hospital, those services will also be paid at the applicable in-network coinsurance amounts for such physician benefits described in the matrix above, but subject to the out-of-network calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the applicable requirements of the Affordable Care Act.

Physician Preventive Benefits

Attention: In some cases, routine immunizations and routine preventive services may be billed separately from your office visit or other facility visit. In that case, the applicable office visit or outpatient facility cost-sharing amounts under your physician benefits or outpatient hospital benefits may apply. In any case, applicable office visit or facility cost-sharing amounts may still apply when the primary purpose for your visit is not routine preventive services and/or routine immunizations.

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

certain immunizations.

For a complete listing of Pharmacy Vaccine Network pharmacies and the eligible immunizations that a particular Pharmacy Vaccine Network pharmacy may provide in-network to you, see www.bcbsal.com/pharmacy.

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Routine preventive services and immunizations See www.bcbsal.com/preventiveservices for a listing of the specific immunizations and preventive services	100% of the allowed amount, no deductible or copayment	Not covered

Routine Vision Benefits

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Pediatric eye exam Limited to one exam per member up to age 19 each calendar year. Includes dilation if medically necessary	80% of the allowed amount, subject to the calendar year deductible	Not covered
Pediatric glasses or contact lenses Limited to one pair of prescription glasses (lenses and frames) or contact lenses per member up to age 19 each calendar year	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible

Other Covered Services

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Accident-related dental services , which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Ambulance services	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Chiropractic services Limited to 15 visits per member each calendar year (combined in-network and out-of-network)	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible Note: In Alabama, not covered

Dialysis services at a renal dialysis facility	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible Note: In Alabama, not covered
DME: Durable medical equipment and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints (For DME the allowed amount will generally be the smaller of the rental or purchase price)	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Home health and hospice care within the state of Alabama	100% of the allowed amount, subject to the calendar year deductible	Not covered
Home health and hospice care outside the state of Alabama Note: Precertification is required; call 1-800-821-7231. If precertification is not obtained, no benefits are payable under the plan	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Eyeglasses or contact lenses One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Occupational, physical, and speech therapy Limited to a combined occupational, physical and speech therapy maximum of 30 visits per person, per calendar year (combined in-network and out- of-network)	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible

In-network home healthcare benefits consist of home IV therapy, intermittent home nursing visits and home phototherapy for newborns. These services must be ordered by your attending physician and provided by an in-network home healthcare provider. When these services are provided outside of Alabama, benefits are paid **only** if precertification is obtained.

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.

Pediatric Dental Benefits

Attention: The plan provides dental benefits only for members up to age 19. No benefits are payable thereafter even if treatment for the member began before this time period.

The plan's in-network dental network is the Preferred Dentist. There are no in-network dentists outside of the Alabama service area.

The plan does not provide benefits for replacement of any appliances (such as dentures or orthodontia) that have been lost, misplaced or stolen; or for repair of damaged orthodontic appliances.

When there are two ways to treat you and both would otherwise be plan benefits, we'll pay toward the less expensive one. If you change dentists while being treated, or if two or more dentists do one procedure, we will pay no more than if one dentist did all the work.

Pediatric Diagnostic and Preventive Dental Services

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Diagnostic and preventive services (Limited to members up to age 19)	100% of the allowed amount, no copayment or deductible	Not covered

Pediatric diagnostic and preventive dental services consist of the following:

- Dental exams, up to twice per calendar year.
- Dental X-ray.
 - Full mouth X-rays, one set during any 60 months in a row.
 - Bitewing X-rays, up to twice per calendar year.
 - Intraoral complete series X-rays, once per 60 months.
 - Panoramic film, once per 60 months.
 - Other dental X-rays, used to diagnose a specific condition.
- Tooth sealants on unrestored permanent molars, limited to one application per tooth each 36 months.
- Fluoride treatment, twice per calendar year.
- Topical fluoride varnish, once per 36 months.
- Routine cleanings, twice per calendar year.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth.
- Diagnostic models, twice per calendar year.

Pediatric Basic Dental Services

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Basic services (Limited to members up to age 19)	80% of the allowed amount, subject to the calendar year deductible	Not covered

Pediatric basic dental services consist of the following:

- Fillings made of silver amalgam and tooth color materials.
- Simple tooth extractions.
- Direct pulp capping, removal of pulp, and root canal treatment (excluding surgical treatment and/or removal of the root tip of the tooth).
- Pulpal therapy for posterior primary teeth, once per tooth per lifetime.
- Repairs to crowns, inlays, onlays, veneers, fixed partial dentures and removable dentures.
- Prefabricated post and core (excluding crown), once per tooth per 60 months.
- Resin infiltration/smooth surface, once per tooth per 36 months.
- Emergency treatment for pain.

Pediatric Major Dental Services

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Major services (Limited to members up to age 19)	50% of the allowed amount, subject to the calendar year deductible	Not covered

Pediatric major dental services consist of the following:

- Oral surgery, i.e., to diagnose and treat mouth cysts and abscesses and for tooth extractions and impacted teeth.
- General anesthesia when given for oral or dental surgery. This means drugs injected or inhaled to relax you or lessen the pain, or make you unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.
- Surgical treatment and/or removal of the root tip of the tooth.
- Inlays.
- Crowns, onlays, core buildup (including pins) post and core (in addition to crowns), once per tooth per 60 months.
- Dentures, implants, and bridges, once per 60 months.
- Rebase and reline of dentures, once per 36 months, beginning 6 months after initial placement.
- Periodontic exams, twice each 12 months.
- Periodontic scaling, once per 24 months.
- Periodontic maintenance, four per 12 months.
- Removal of diseased gum tissue and reconstructing gums, once per 36 months.
- Removal of diseased bone.
- Reconstruction of gums and mucous membranes by surgery.
- Removing plaque and calculus below the gum line for periodontal disease.

Pediatric Orthodontic Services

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
<p>Dentally necessary orthodontic services (Limited to members up to age 19)</p> <p>Note: No benefits are available until the member has been covered under the plan for a continuous 24 month waiting period</p>	50% of the allowed amount, subject to the calendar year deductible	Not covered

Prescription Drug Benefits

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
<p>Prescription drugs</p> <p>The pharmacy network for the plan is the Limited Retail Network</p> <p>Some drugs require precertification (sometimes referred to as prior authorization). Go to www.bcbsal.com for more information. If precertification is not obtained, no benefits will be payable under the plan</p> <p>Prescription drugs (other than Specialty drugs) can be dispensed for up to a 90-day supply but the copayment is applicable for each 30-day supply</p> <p>Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Specialty drugs is the Specialty Pharmacy. Go to www.bcbsal.com for a list of these Specialty drugs</p> <p>View the PrimeChoice™ Essential Prescription Drug list that applies to the plan at www.bcbsal.com</p>	<p>100% of the allowed amount, subject to the following copayments for a 30-day supply for each prescription:</p> <p>Generic drugs (mandatory when available) \$20</p> <p>Preferred brand name drugs \$60</p> <p>Preferred brand name drugs for which a generic equivalent is available: Not covered</p> <p>Other brand name drugs \$100</p> <p>Other brand name drugs for which a generic equivalent is available: Not covered</p> <p>Specialty drugs: The lesser of 50% of the allowed amount or \$395 copayment</p>	Not covered

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

- To be eligible for benefits, drugs must be FDA approved legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal law prohibits dispensing without a prescription."
- Prescription drug coverage is subject to Drug Coverage Guidelines developed and modified over time based upon daily or monthly limits as recommended by the Food and Drug Administration, the manufacturer of the drug, and/or peer-reviewed medical literature. These guidelines can be found in the *myBlueCross* section of our website. Even though your physician has written a prescription for a drug, the drug may not be covered under the plan or

a clinical edit(s) may apply (i.e. prior authorization, step therapy, quantity limitation) in accordance with the guidelines. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. You may call the customer service number on your card for more information.

- Prescription drug benefits are provided only if dispensed by an in-network pharmacy. Except for certain specialty drugs, in-network pharmacies are pharmacies that have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense prescription drugs under the plan. For certain specialty drugs, in-network pharmacies must have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense certain specialty drugs.
- Compound drugs are covered only if determined to be medically necessary by us. Drug compounding for the purpose of convenience is not considered medically necessary. Compound drugs are always classified as **other brand name drugs**.
- To determine whether a drug is classified by your plan as a generic drug, Preferred Brand drug, or specialty drug, log into *myBlueCross* at www.bcbsal.com. Once there, you can search for your drug by clicking the “find drugs and pricing” link located in the Manage My Prescriptions section of our website. The Preferred Brand, generic and specialty drug classifications are updated periodically.
- A generic drug is one that the FDA has approved under an Abbreviated New Drug Application (ANDA) and no New Drug Application (NDA) is on file. A generic drug is also one that is manufactured by more than one manufacturer and is designated as a multi-source product by the major drug database providers, Medispan and First DataBank.
- Brand drugs classified as Preferred Brand drugs by the plan are brand-name drugs that are generally believed within the industry to be cost effective and have been approved for inclusion as a Preferred Brand drug by a panel of physicians and pharmacists on the plan’s Pharmacy and Therapeutics Committee.
- Brand-name drug that are not classified as a Preferred Brand are considered Other Brand name drugs.
- Specialty drugs are high-cost drugs that may be used to treat certain complex and rare medical conditions and are often self-injected or self-administered. Specialty drugs often grow out of biotech research and may require refrigeration or special handling.
- Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used, (e.g., 23 days into a 30 day supply).
- Insulin, needles, and syringes purchased on the same day will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day will have one copayment. Otherwise, each has a separate copayment. Glucose monitors always have a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan.
- If your drug is not covered and you think it should be, you may ask us to make an exception to the drug coverage rules. Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception.

Mail Order Prescription Drug Benefits

<p>Mail order prescription drugs program</p> <p>To enroll in the Mail Order Prescription Drugs Program, go to www.bcbsal.com</p> <p>Prescription drugs purchased through the Mail Order Prescription Drugs Program can be dispensed up to a 90-day supply with one per prescription copayment</p> <p>If you have less than a 90-day prescription, you will still have to pay the same copayment as a 90-day supply when using this Mail Order Program</p> <p>Specialty drugs are not available through this program</p>	<p>100% of the allowed amount, subject to the following copayments for up to a 90-day supply for each prescription:</p> <p>Generic drugs (mandatory when available) \$50</p> <p>Preferred brand name drugs \$150</p> <p>Other brand name drugs \$250</p> <p>Specialty drugs: Not covered</p>	<p>Not covered</p>
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ADDITIONAL BENEFIT INFORMATION

Individual Case Management

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

Disease Management

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

Tobacco Cessation Program

If you or your covered family members are smokers and want to quit, we can help. We offer a quit guide, quitting aids (one round of nicotine replacement therapy) and a quit coach for instruction, support and encouragement 24 hours a day. This allows you to create a plan that allows you to quit at your own pace while learning the skills needed to conquer your urges so that you can live the rest of your life without tobacco. Call 1-888-768-7848 to join the program and get started today.

Baby Yourself Program

Baby Yourself offers individual care by a registered nurse. Please call our nurses at 1-800-222-4379 (or 205-733-7065 in Birmingham) as soon as you find out you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant.

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

Organ and Bone Marrow Transplants

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

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

Transplant benefits for living donor expenses are limited to:

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

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copayments, coinsurance and other plan limitations. For example, if the member's coverage terminates,

transplant benefits also will not be available for any donor expenses after the effective date of termination.

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

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

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. Benefits for this treatment will be subject to the same calendar year deductible and coinsurance provisions that apply for other medical and surgical benefits.

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 provisions and limitations described elsewhere in this booklet, including the section called [Physician Preventive Benefits](#).

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 provisions and limitations described elsewhere in this booklet, including the section called Physician Preventive Benefits.

Air Medical Transportation

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

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

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

COORDINATION OF BENEFITS (COB)

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

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

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

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

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

2. **Group Health Plan:** If the other plan is a group health plan (for example, a plan sponsored by an employer for its employees and their eligible dependents) the benefits of the other plan are determined before the benefits of this plan. This rule applies regardless of whether the other plan covers the patient as an employee, retiree, COBRA beneficiary, subscriber, or eligible dependent of any of the foregoing.
3. **Non-Group Health Plan:** If the other plan is a non-group health plan, the following rules apply:
 - a. The benefits of the plan which covers the person as an applicant, subscriber, or policyholder (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.
 - b. Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. The term "birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.
 - c. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

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

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

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

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

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

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

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

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

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

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

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

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

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for dental services and supplies, vision care or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit.

The plan **does not** pay primary, secondary or supplemental benefits to Medicare. This means that you will have minimal or no benefits under the plan, without reduction in premiums. If you are enrolled in Medicare, we strongly suggest that you consider buying a Medicare supplement plan, a Medicare Part D prescription drug plan and/or a Medicare Advantage plan.

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

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, this plan may pay that amount to the organization that made that payment. The amount will then be treated as though it were a benefit paid under this plan. This plan will not have

to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

SUBROGATION

Right of Subrogation

If we pay or 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. That means that we may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we have paid plan benefits. This means that you promise to repay us from any money you recover the amount we have 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 are not 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.

HEALTH BENEFIT EXCLUSIONS

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

A

Services, expenses or supplies for **abortion** (except when the life of the woman would be endangered).

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

Anesthesia services or supplies or both by local infiltration.

Appliances (including orthodontia) or restorations to alter vertical dimensions from its present state or restoring or maintaining the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from the grinding of teeth or the wearing down of the teeth, fabrication of mouth guard, and restoration from the misalignment of teeth.

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

B

Bone grafts when done in connection with extractions, Apicoectomies, or non-covered implants.

C

Dental services or expenses for intraoral delivery of or treatment by **chemotherapeutic** agents.

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, including care in a nursing home.

Services or expenses for cosmetic surgery and other cosmetic services or supplies. **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.

- 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 field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.
- Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.

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

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

D

Unless otherwise covered under the [Pediatric Dental Benefits](#) section of this booklet, **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 or expenses we determine are not **dentally necessary** or for which do not meet generally accepted standards of dental practice. This means dental procedures that are considered strictly cosmetic in nature including but not limited to charges for personalization or characterization of prosthetic appliances are not covered.

E

Dental services you receive from a dental or medical department maintained by or on behalf of an **employer**, a mutual benefit association, a labor union, trustee or similar person or group.

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 examinations or fittings, except under the limited circumstances set forth in the section of this booklet called [Other Covered Services](#) and [Routine Vision Benefits](#).

Unless otherwise covered under the [Routine Vision Benefits](#) section of this booklet, 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, except under the limited circumstances.

F

Charges for your **failure** to keep a scheduled visit with any healthcare provider.

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

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

G

Gold foil restorations.

Unless otherwise required by applicable law, services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other **governmental** agency that provides or pays for care, through insurance or any other means.

H

Hearing aids or examinations or fittings for them.

I

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

Charges by a healthcare provider related to **infection** control of the healthcare setting.

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

L

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

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

M

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

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

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

Methadone maintenance treatment programs for opioid addiction.

N

Services or expenses for or related to **nicotine addiction** except for nicotine withdrawal prescription drugs prescribed by a physician and dispensed by a licensed pharmacist from an in-network pharmacy or under the limited circumstances set forth in the section of this booklet called [Tobacco Cessation Program](#).

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

O

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.

Charges for **oral** hygiene (including a plaque control program).

Services or expenses provided by an **out-of-network provider** for any benefits under this plan, unless otherwise specifically stated in the plan.

P

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

Private duty nursing.

Services or supplies provided by **psychiatric specialty hospitals** that do not participate with nor

are considered members of any Blue Cross and/or Blue Shield plan.

R

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

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

Services or expenses for learning or vocational **rehabilitation**.

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

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

Routine well child care and routine immunizations except for the services described at www.bcbsal.com/preventiveservices.

Routine physical examinations except for the services described at www.bcbsal.com/preventiveservices.

S

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

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

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

Services or expenses of any kind for or related to reverse **sterilizations**.

Services or supplies furnished by a facility that is solely classified as a **substance abuse outpatient or residential facility**. This does not exclude covered substance abuse services or supplies furnished by a General Hospital or Psychiatric Specialty Hospital.

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

- Hot and cold packs;
- Standard batteries used to power medical or durable medical equipment;
- Solutions used to clean or prepare skin or minor wounds including alcohol solution or wipes, povidone- iodine solution or wipes, hydrogen peroxide, and adhesive remover;
- Standard dressing supplies and bandages used to protect minor wounds such as band aids, 4 x 4 gauze pads, tape, compression bandages, eye patches;

- Elimination and incontinence supplies such as urinals, diapers, and bed pans; and
- Blood pressure cuffs, sphygmometers, stethoscopes and thermometers.

T

Unless otherwise covered under the [Pediatric Dental Benefits](#) section of this booklet, services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or “dead” teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. For example, braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw or because of injury of natural teeth. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under [Other Covered Services](#).

Services provided through **teleconsultation**.

Unless otherwise covered under the [Pediatric Dental Benefits](#) section of this booklet, treatment for or related to **temporomandibular joint (TMJ) disorders**. This includes Phase II according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.

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

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

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

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

W

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

Services or expenses 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.

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

CLAIMS AND APPEALS

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

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of your booklet explains how we process these different types of claims and how you can appeal the denial of a claim.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can obtain the form by calling our customer service department. You can also go to our website at www.bcbsal.com and ask us to mail you a copy of the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, we will presume that your provider is your authorized representative unless you tell us otherwise in writing.

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.

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. 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. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper type of 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.

If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

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. If we do this, we will send you a copy of our request. However, you will remain responsible for getting us the information on time.

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

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

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan.

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. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD physician). CURP is a program implemented by us and in-network hospitals in the Alabama service area to simplify the administration of preadmission certifications and concurrent utilization reviews. If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you.

If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Our notification may be oral, unless you ask for it in writing. We will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters and (2), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

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. 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 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. If we do so, we will send you a copy of our request. 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. If we decide that we cannot provide you with a courtesy pre-determination (for example, we cannot get the information we need to make an informed decision), we will let you know. In either case, 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 enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

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:

- For inpatient hospital care, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy (if covered by your plan) call 205-220-7202.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, we will give you our decision within 24 hours of

when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above.

Your Right to Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If we obtained advice from a healthcare professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. 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.

Appeals to Blue Cross and Blue Shield of Alabama

The rules in this section of the booklet allow you or your authorized representative to appeal any denial of a claim, any denial of initial eligibility under the plan and any retroactive rescission of plan coverage for fraud or intentional material misrepresentation. 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 all cases other than determinations by us to limit or reduce previously approved care, you have 180 days following our adverse benefit determination within which to submit an appeal.

How to Appeal Initial Eligibility Determinations and Retroactive Rescissions: If you wish to file an appeal of our denial of your or your dependents' initial eligibility under the plan or of our retroactive rescission of plan coverage for fraud or intentional material misrepresentation, you may send us a letter and state that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross Blue Shield of Alabama
Attn: Customer Accounts Department – Consumer Products Appeals
P.O. Box 11686
Birmingham, AL 35282

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 website 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 the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy (if covered by your plan) call 205-220-7202.

If in writing, you should send your letter to the appropriate address listed below:

- For inpatient hospital care and admissions:

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

Or,

- For in-network physical therapy, occupational therapy, speech therapy, or care from an in-network chiropractor (when covered by your plan):

Blue Cross and Blue Shield of Alabama
Attention: Health Management –
Appeals P. O. Box 362025
Birmingham, Alabama 35236

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.

Conduct of the Appeal: We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are medically necessary), we will consult a healthcare professional who has appropriate expertise. If we consulted a healthcare professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

Time Limits For Our Consideration Of Your Appeal: If your appeal arises from our denial of a post-service claim, our denial of your or your dependents' initial eligibility under the plan or our retroactive rescission of plan coverage for fraud or intentional misrepresentation, 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, but in any event before we impose the limit or reduction.

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 These Mandatory Plan Administrative Appeals Remedies: If you filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- You may ask our Customer Service Department for further help;
- You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below); or,
- You may file a claim for arbitration, as explained under the section of this booklet dealing with arbitration.

External Reviews

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with us for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address: Blue Cross and Blue Shield of Alabama, Attention: Customer Service Appeals, P.O. Box 10744, Birmingham, AL 35202-0744.

If you request an external review, an independent organization will review our decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give us copies of this additional information to give us an opportunity to reconsider our denial. Both of us will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding, subject to arbitration as explained in the section dealing with arbitration below.

Expedited External Reviews for Urgent Pre-Service Claims: If your pre-service claim meets the definition of urgent under law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling us at 1-800-248-2342 (toll-

free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll- free).

Alabama 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 FOR WHICH AN EXTERNAL REVIEW (AS DESCRIBED ABOVE) IS NOT AVAILABLE OR FOR WHICH YOU (OR WE) HAVE FURTHER RIGHTS UNDER ANY APPLICABLE LAW FOLLOWING SUCH EXTERNAL REVIEW 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 35244**

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

ALL DISPUTES CONCERNING ARBITRATION PROCEDURES SHALL BE RESOLVED BY THE ARBITRATOR.

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

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

THE ARBITRATOR SHALL BE EMPOWERED TO GRANT WHATEVER RELIEF WOULD BE AVAILABLE IN COURT UNDER LAW OR EQUITY, EXCEPT AS EXPRESSLY LIMITED BY THE CONTRACT. THE ARBITRATOR'S DECISION SHALL BE IN WRITING, SHALL CONTAIN FINDINGS OF FACT AND CONCLUSIONS OF LAW, AND SHALL SPECIFY THE TYPE OF ANY DAMAGES OR RELIEF AWARDED.

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

THIS PLAN IS MADE PURSUANT TO A TRANSACTION INVOLVING INTERSTATE COMMERCE, AND IS BE GOVERNED BY THE FAA. IF ANY PORTION OF THIS ARBITRATION PROVISION IS DEEMED INVALID OR UNENFORCEABLE, THE REMAINING PORTIONS SHALL CONTINUE IN FULL FORCE AND EFFECT. EXCEPT AS OTHERWISE REQUIRED BY LAW, NO AMENDMENT OR CHANGE TO THE ARBITRATION PROVISIONS ABOVE WILL APPLY TO CLAIMS INCURRED BEFORE THE EFFECTIVE DATE OF THE AMENDMENT.

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will show in your claims report.

Health Plan Termination

We may terminate the plan under the following two circumstances:

1. If we decide to discontinue offering this product, we may elect to terminate your plan (which will terminate your coverage and the coverage for 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. (If the change causes a change in the Summary of Benefits and Coverage for the plan and the change occurs mid-policy year, then we will give you written notice at least 60 days before the effective date of the changes). The changes will apply to all benefits for services you receive on or after the effective date of the changes (except as expressly limited by other portions of this booklet). If you submit payment for coverage to us after the effective date of the changes, your payment will be considered your acceptance of the benefit plan changes. Any changes we make will apply on a uniform basis to all policyholders who have purchased this 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, 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 commit fraud or make any intentional misrepresentation of material fact 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. You have the right to appeal our decision. Your rights to appeal are explained in the [Claims and Appeals](#) section of this booklet.

Alabama Insurance Fraud Investigation Unit and Criminal Prevention Act

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

No Assignment

As discussed in more detail in the [Claims and Appeals](#) section of this benefit booklet, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network provider (as required by our contract with your in-network

provider) – even if you have assigned payment of your claim to someone else. When we pay you or your in-network provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

DEFINITIONS

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

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act, and its implementing rules and regulations.

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

1. **In-Network Providers:** Blue Cross and/or Blue Shield plans also contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the member) as payment in full for covered care. The negotiated price applies only to services that are covered under the plan and also covered under the contract that has been signed with the in-network provider.

Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2), which subset of those providers will be considered BlueCard PPO providers, and (3), the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.

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

2. **Out-of-Network Providers:** The allowed amount for care rendered by out-of-network providers is often 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. In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:
 - The charge or average charge for the same or a similar service;
 - Pricing data from the local Blue Cross and/or Blue Shield plan where services are rendered;
 - The relative complexity of the service;
 - The in-network allowance in Alabama for the same or a similar service;
 - Applicable state healthcare factors;
 - The rate of inflation using a recognized measure; and,
 - Other reasonable limits, as may be required with respect to

outpatient prescription drug costs.

For emergency services for medical emergencies provided within the emergency room department of an out-of-network hospital, the allowed amount will be determined in accordance with the Affordable Care Act.

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

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

Assisted Reproductive Technology (ART): Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

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

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

BlueCard® Program: A national program among the Blue Cross and/or Blue Shield plans by which a member of one Blue Cross Plan receives benefits available through another Blue Cross plan located in the area where services occur. The BlueCard® program is explained in more detail in other sections of this booklet, such as [In-Network Benefits](#) and [Out-of-Area Services](#).

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

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

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

Dentally Necessary or Dental Necessity: Services or supplies which are necessary to treat your illness, injury, or symptom. To be dentally necessary, services or supplies must be determined by Blue Cross to be:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your dental condition;
- Provided for the diagnosis or direct care and treatment of your dental condition;
- In accordance with standards of good dental practice accepted by the organized dental community;

- Not primarily for the convenience and/or comfort of you, your family, your dentist, or another provider of services; and
- Not "investigational."

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.

Health Insurance Marketplace: The Exchange established by the Affordable Care Act in the state of Alabama in which individuals and their families may purchase individual health plans.

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

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

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

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

In-Network Provider: See the [In-Network Benefits](#) subsection of the [Overview of the Plan](#) section of this booklet.

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

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 manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or, (iii) serious dysfunction 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”;
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when we make medical necessity determinations, we are making them solely for the purpose of determining whether to pay for a medical service or supply.

All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

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

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

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

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

Physician: Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

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

Preadmission Certification: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission based upon medically recognized criteria.

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.

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

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

Substance Abuse: The uncontrollable or excessive abuse of addictive substances, such as (but not limited to) alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use.

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

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

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

We cover what matters.



An Independent Licensee of the Blue Cross and Blue Shield Association

450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

Customer Service:
1-855-350-7441 (TTY 711)

www.AlabamaBlue.com