

# individual **Blue**<sup>SM</sup>

## **I500 PLAN**

Contract Booklet



**BlueCross BlueShield  
of Alabama**

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

# AMENDMENT TO INDIVIDUAL BLUE PLANS

## 750 and 1500 CONTRACT BOOKLETS

Effective Date of Amendment: September 1, 2008

This is an amendment to the Individual Blue 750 and 1500 Plan Contract Booklets MKT-254 and 255. You should retain this amendment with your contract booklet.

1. Under the **Overview of the Plan** section of your contract booklet, the **Using My Blue Cross to Get More Information Over the Internet** subsection is amended by deleting “and student verification” in bullet number 2 in such subsection.
2. Under the **Eligibility** section of your contract booklet, the *Dependent Children* subsection is hereby deleted and replaced with a new subsection to read as follows:

### *Dependent Children*

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

1. Is a resident of Alabama;
2. Is not eligible for, or entitled to, Medicare;
3. Has been accepted by us for coverage under our health underwriting guidelines; and,
4. Is unmarried and under the age of 25 and depends on you for over one-half support.

In addition, the child must be the subscriber’s natural child; stepchild residing in the household of the eligible subscriber; legally adopted child; child placed for adoption; or, other unmarried child for whom the subscriber has permanent legal custody and who depends solely on the subscriber for support and regularly and permanently resides with the subscriber in a parent-child relationship.

If a covered child becomes incapacitated, while covered, before the age of 25, the child may continue to be covered as a dependent for so long as he or she remains incapacitated. A child is incapacitated if we determine that the child is not able to support himself or herself and if the child depends on you for support. Note that the incapacity of the child must begin during the period of time the child is covered under the plan. If we determine that the incapacity began before the child became covered, the child will not be entitled to this extension of coverage.

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

3. Under the **Eligibility** section of your contract booklet, the first sentence of paragraph 1. of the subsection entitled **Are There Any Continuation of Coverage Rights Under the Plan?** is amended by deleting the phrase “(e.g., you turn age 19 but do not continue your education as a full-time student)” and replacing it with the phrase “(e.g., you turn age 25)”.

Under the **Eligibility** section of your contract booklet, the subsection entitled **Limitation of Effect on Amendments** is amended by deleting the phrase “for full-time students” in the second sentence of such subsection.



Gene Linton  
Vice President Large Group Marketing and LTC

---

# INSERT

**Individual Blue  
1500 Plan  
Effective January 1, 2008**

This insert amends the Contract Booklet – MKT 255 (9-2007). Effective January 1, 2008, the 1500 Plan has been amended as noted below.

---

1. The **Benefits** section of your Contract booklet, under the tables entitled **Physician Preventive Benefits**, has been amended as follows:

**Physician Preventive Benefits**

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Prostate Cancer Screening (Prostate specific antigen test and digital rectal exam) One screening each year for males age 40 and over</b>	100% of the allowed amount	Not covered
<b>Routine Human Papillomavirus (HPV) Testing  One routine test every three calendar years for females age 30 and over</b>	100% of the allowed amount	Not covered

2. In our continuing efforts to enhance your experience using our Blue Cross and Blue Shield of Alabama web site, [www.bcbsal.com](http://www.bcbsal.com), we have changed the names of some of the sections on the site. You will have access to all the same information currently available but in some cases will need to use new web site references to access the information. The references listed in your contract booklet that are affected are listed below:

\*All references to **Customer Access** are replaced with **My BlueCross**.

\*All references to **I am the Customer** are replaced with **Pharmacy**.

\*All references to **Prescription Drug Guides** are replaced with **Prescription Drug Guide and Drug Lists**.

---



Tommy Hudgins  
Vice President, Sales

---

# TABLE OF CONTENTS

OVERVIEW OF THE PLAN .....	1
Purpose of the Plan .....	1
Free Review Period .....	1
Definitions .....	1
Receipt of Medical Care .....	2
Beginning of Coverage .....	2
Coverage of Family Members .....	2
Limitations, Exclusions, and Waiting Periods .....	2
Nature of Coverage .....	2
Using Customer Access to Get More Information Over the Internet .....	2
Medical Necessity and Precertification .....	3
In-Network Benefits .....	3
Relationship Between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association .....	3
Claims and Appeals .....	4
Arbitration .....	4
Changes in the Plan .....	4
Termination of Coverage .....	4
ELIGIBILITY .....	4
Who Is Eligible For This Plan? .....	4
May My Employer Endorse or Sponsor the Plan? .....	4
May I Cover My Family Members When I Apply For the Plan? .....	5
Spouse .....	5
Dependent Children .....	5
May I Add a Spouse or Child After I Have Obtained Coverage Under the Plan? .....	6
Adding Newly Acquired Dependents: .....	6
Adding Individuals Who Lose Other Coverage .....	6
When Does Coverage Begin? .....	6
Initial Enrollment: .....	6
Spouses and Dependents Added After Initial Enrollment .....	6
What Happens If Blue Cross Declines to Issue a Contract? .....	7
What Happens If I or One of My Covered Dependents Later Becomes Eligible for or Entitled to Coverage under Medicare? .....	7
General Information About Medicare .....	7
Significant Reduction in Benefits upon Eligibility for Medicare .....	7
What Happens If I or One of My Covered Dependents Later Becomes Covered Under Some Other Group or Individual Health Plan? .....	8
May I Switch Myself and My Family From One Individual Blue Plan to Another? .....	8
When Does Coverage End? .....	8
Are There Any Continuation of Coverage Rights Under the Plan? .....	9
Limitation on Effect of Certain Amendments .....	10
WAITING PERIODS .....	10
For Pre-Existing Conditions .....	10
Exclusion Period for Some Surgical Procedures .....	10
Exclusion Period for Maternity Care Benefits .....	10
Limitation on Effect of Certain Amendments .....	10
COST SHARING .....	11
Calendar Year Deductible .....	11
Calendar Year Out-of-Pocket Maximum .....	11
Lifetime Maximum .....	12
Other Cost Sharing Provisions .....	12

Out-of-Area Copayments and Coinsurance .....	12
BENEFITS.....	13
Inpatient Hospital Benefits.....	13
Outpatient Hospital Benefits.....	15
Physician Benefits .....	15
Physician Preventive Benefits .....	17
Mental health disorders and substance abuse Benefits.....	18
Other Covered Services .....	20
Prescription Drug Benefits.....	21
Health Management Benefits .....	22
Additional Benefit Information .....	23
Organ, Tissue, and Bone Marrow/Cell Transplants.....	23
Mastectomy and Mammograms .....	24
Benefits for Colorectal Cancer Screening.....	24
HEALTH BENEFIT EXCLUSIONS .....	25
COORDINATION OF BENEFITS .....	29
SUBROGATION.....	32
Right of Subrogation.....	32
Right of Reimbursement.....	32
Right to Recovery .....	32
CLAIMS AND APPEALS.....	33
Post-Service Claims .....	33
Pre-Service Claims.....	34
Concurrent Care Determinations.....	34
Appeals.....	35
GENERAL INFORMATION.....	36
Discretionary Authority to Blue Cross.....	36
Arbitration .....	37
Correcting Payments .....	39
Health Plan Termination.....	39
Health Plan Changes.....	39
Responsibility for Providers.....	39
Misrepresentation .....	39
Respecting Your Privacy .....	40
DEFINITIONS .....	41

---

# OVERVIEW OF THE PLAN

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

## ***Atención por favor - Spanish***

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

## **Purpose of the Plan**

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

The plan is not a Medicare supplement policy. This means that you may not buy the plan or become covered under the plan if you are eligible for or entitled to benefits under Medicare at the time of application. Although you may keep the plan if you later become eligible for or entitled to benefits under Medicare, this plan will not pay primary, secondary or supplemental benefits to Medicare – even if you have not enrolled in Medicare. This means that you will have minimal or no benefits under the plan, without reduction in premiums and without regard to whether you have enrolled in Medicare. For more information, see the section of the plan called [What Happens If I or One of My Covered Dependents Later Becomes Eligible for or Entitled to Coverage under Medicare?](#)

**Attention:** You (meaning any member covered under the plan) must notify us when you become eligible for Medicare. This means that you must notify us when you turn age 65, qualify for Medicare because of disability, or qualify for Medicare because of End Stage Renal Disease (ESRD).

## **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.

## **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. That section also provides certain opportunities for continuation of coverage beyond the date on which coverage would normally end.

Even if you have purchased a family contract, new dependents are not automatically added to the plan. You must submit an application for coverage. If you fail to submit an application, or in some cases, if you submit your application too late, you may not be able to obtain coverage for your new family members.

## Limitations, Exclusions, and Waiting Periods

In order to maintain the cost of the plan at an overall level that is reasonable for all plan participants, the plan contains a number of provisions that limit benefits or in some cases subject them to a waiting period. These waiting periods are not reduced by your prior coverage under any plan. Please see the section of this booklet called [Waiting Periods](#). There are also exclusions that you need to pay particular attention to as well. These provisions are found throughout the remainder of this booklet. You need to be aware of the limits, waiting periods, and exclusions to determine if this plan will meet your health care needs.

## Nature of Coverage

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

Since this 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). See the section of this booklet called [May My Employer Endorse or Sponsor the Plan?](#) for more information about this.

## Using Customer Access to Get More Information Over the Internet

Blue Cross and Blue Shield of Alabama's home page on the Internet is [www.bcbsal.com](http://www.bcbsal.com). If you go there, you will see a section of our home page called Customer Access. Registering for Customer Access 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. Here is a partial list of information available to members who register for Customer Access:

1. a copy of this benefit booklet;
2. claims forms and student verification;
3. claim reports;

4. medical policies;
5. listings of provider networks; and,
6. health and wellness information and tools.

## **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 in the Customer Access portion of our web site. The definitions of medical necessity and investigational are found in the [Definitions](#) section of this booklet. In some cases (such as inpatient hospital admissions in non-emergency situations, diagnostic imaging, occupational therapy, physical therapy, home health and hospice care, and some prescription drugs), the plan requires that you or your treating provider to 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 health care costs and provide enhanced benefits is through negotiated discounts with medical providers. In-network providers are hospitals, physicians, and other health care providers that contract with Blue Cross and/or Blue Shield plans for furnishing health care services at a reduced price. Examples of in-network providers include PMD, Preferred Care and BlueCard PPO. In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or Preferred Care Services, Inc.

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 web site at <http://www.bcbs.com/healthtravel/finder.html>. 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. Assuming the services are covered, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance.

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 may be covered under some other portion of the plan, such as [Other Covered Services](#).

As you read the remainder of this booklet, you should pay attention to the type of in-network provider that is treating you, since benefit levels and your out-of-pocket costs may vary.

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

## Arbitration

In order to provide for an efficient and fair resolution of disputes, the plan contains arbitration provisions. These provisions are explained in the section of this booklet called [General Information](#). When you submitted your application to us, you agreed to be bound by these arbitration provisions.

## Changes in the Plan

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

## Termination of Coverage

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

---

# ELIGIBILITY

## Who Is Eligible For This Plan?

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

1. You are a resident of Alabama under the age of 65;
2. You are not eligible for, or entitled to, Medicare; and,
3. We have determined that you meet our health underwriting guidelines, and have accepted you for coverage.

If the applicant is under the age of 19, a parent or legal guardian must submit an application for coverage on the child's behalf and assume responsibility for payment of all premiums. Upon turning age 19, the child will become responsible for the payment of premiums in order to keep coverage under the plan in force.

## May My Employer Endorse or Sponsor the Plan?

No, because this plan is individual insurance and is not designed to satisfy the rules for group insurance. Therefore, your employer is not allowed to endorse or sponsor the plan. The terms "endorse" and "sponsor" have special meanings developed by the courts, and at a minimum we will apply these special meanings if the question arises whether your employer is endorsing or sponsoring the plan. Among other things, this means the following:

1. Your employer is not permitted to pay for or reimburse you for any portion of the premiums that you are required to pay under the plan.
2. Your employer is not allowed to offer the plan to you through a Section 125 Plan. A Section 125 Plan is a plan established by an employer under Section 125 of the Internal Revenue Code that allows employees to pay for certain fringe benefits (health insurance being one of them) on a pre-tax basis. Thus, although employees may be paying for the full cost of the insurance, if their employer allows them to do this on a pre-tax basis through a Section 125 Plan, the employer will be considered to have endorsed or sponsored the plan.

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

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

### *Spouse*

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

1. Is a resident of the State of Alabama under the age of 65;
2. Is not eligible for, or entitled to, Medicare; and,
3. Has met our health underwriting guidelines and has been accepted by us for coverage.

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

### *Dependent Children*

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

1. Is a resident of Alabama;
2. Is not eligible for, or entitled to, Medicare; and,
3. Has been accepted by us for coverage under our health underwriting guidelines; and meets the following:
  - a. Is unmarried and under the age of 19; or,
  - b. Is unmarried and age 19 to 25 while a full-time student in a state accredited school, not working full-time, and chiefly depending on you for support.

In addition, the child must be the subscriber's natural child; stepchild residing in the household of the eligible subscriber; legally adopted child; child placed for adoption; or, other unmarried child for whom the subscriber has permanent legal custody and who depends solely on the subscriber for support and regularly and permanently resides with the subscriber in a parent-child relationship.

If a covered child becomes incapacitated, while covered, before the age of 19 (or 25 if a full-time student), the child may continue to be covered as a dependent for so long as he or she remains incapacitated. A child is incapacitated if we determine that the child is not able to support himself or herself and if the child depends on you for support. Note that the incapacity of the child must begin during the period of time the child is covered under the plan. If we determine that the incapacity began before the child became covered, the child will not be entitled to this extension of coverage.

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

## **May I Add a Spouse or Child After I Have Obtained Coverage Under the Plan?**

There is no open enrollment period under the plan for adding a spouse or dependent to your plan. You may, however, add a spouse or dependent to your plan under limited circumstances described below. In addition, if you are covering only yourself under the plan, you will first have to convert your coverage to family coverage and pay any additional premiums.

### *Adding Newly Acquired Dependents:*

If you acquire a new dependent as a result of marriage, birth, placement for adoption, or adoption, you may enroll your spouse and/or your new dependent(s) if you submit your application for enrollment within 30 days of the event.

If the event is marriage, your new spouse and any new dependents will have to satisfy the eligibility standards outlined above for coverage of dependents, including satisfaction of our health underwriting guidelines. In addition, if accepted for coverage, your spouse and his or her eligible children will need to satisfy the plan's waiting period for pre-existing conditions (described in the section below called [Waiting Periods](#)).

If the event is birth, placement for adoption, or adoption, we will waive the application of our health underwriting guidelines and we will not apply the plan's waiting period for pre-existing conditions.

### *Adding Dependents Who Lose Other Coverage*

A spouse or dependent (1) who did not enroll at the time of application or during the 30 day window for special enrollees because that spouse or dependent had other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or coverage by other health plans which ended due to "loss of eligibility" (as described below) or failure of the employer to pay toward that coverage, and (3) who requests enrollment within 30 days of the exhaustion or termination of coverage, may enroll in the plan. A person who applies for coverage under this situation will be required to satisfy the eligibility standards outlined above for coverage of dependents, including satisfaction of our health underwriting guidelines. In addition, if accepted for coverage, the person will need to satisfy the plan's waiting period for pre-existing conditions (described in the section below called [Waiting Periods](#)).

Loss of eligibility 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, 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 cause (for example, making a fraudulent claim or intentional misrepresentation of a material fact). Loss of eligibility also includes a situation where an individual incurs a claim that would meet or exceed a lifetime limit on all plan benefits.

## **When Does Coverage Begin?**

### *Initial Enrollment:*

If we accept your application, we will send you an identification card. Your coverage begins on the effective date shown on your identification card provided that you pay your premiums at the time of application or in full within the 30-day grace period following your effective date. If you fail to pay your premiums in full either at the time of application or during the 30-day grace period, your coverage will be canceled as of the effective date.

### *Spouses and Dependents Added After Initial Enrollment*

If properly added in accordance with the rules described above under [May I Add a Spouse or Child After I Have Obtained Coverage Under the Plan?](#) the effective date of coverage will be as follows:

1. For a newborn baby, the date of birth;
2. For a dependent added by adoption, the effective date of placement for adoption;
3. For a spouse or dependent added by marriage, the date of the marriage; and,
4. For a spouse or dependent added as a result of losing other coverage, the first day of the month following the date of our acceptance of the application to add such spouse or dependent.

### **What Happens If Blue Cross Declines to Issue a Contract?**

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

### **What Happens If I or One of My Covered Dependents Later Becomes Eligible for or Entitled to Coverage under Medicare?**

#### *General Information About Medicare*

The following information is general in nature, and is subject to change as federal laws and regulations change. Original Medicare generally consists of three parts – Parts A, B and D. Part A provides certain hospital benefits. Part B provides certain physician benefits. Part D provides certain outpatient prescription drug benefits. For individuals who elect to remain under Original Medicare, it often makes sense to purchase a Medicare supplement contract that fills in the deductible, copays, and coinsurance left by Original Medicare. Individuals may also have the choice, depending upon the insurance market where they live, to join a Medicare Advantage plan and/or a Medicare prescription drug plan, through which they will receive benefits under Original Medicare plus (in some cases) additional benefits. Individuals who enroll in a Medicare Advantage plan may not purchase a Medicare supplement contract.

The federal government publishes two informative booklets about Medicare. The first is called Your Medicare Benefits; the second is called Medicare and You. Both booklets can be obtained from your local Social Security Office or from Medicare's web site ([www.medicare.gov](http://www.medicare.gov)).

#### ***Significant Reduction in Benefits upon Eligibility for Medicare***

**Attention:** Once you become eligible for Medicare you will have minimum or no benefits under this plan without any reduction in premiums. Because of this, we strongly encourage you to cancel your coverage under this plan when you become eligible for Medicare.

If you become eligible for, or entitled to, Medicare (regardless of whether you actually obtain coverage under Medicare), you may continue to keep your coverage under the plan, but the only benefits payable under the plan will be for services that are not included in the coverage of Medicare. This same rule applies to any of your covered dependents that become eligible for or entitled to Medicare. This means that for services or supplies that are included in the coverage of Medicare or that would be covered upon proper application for Medicare (most or all hospital services, physician services, and prescription drugs), the plan will not pay primary, secondary, or supplemental benefits. The plan will not pay for the copays and deductibles left by Medicare, regardless of whether you have enrolled in Medicare; nor will the plan pay for services or supplies that would have been covered under Medicare had you enrolled.

By "Medicare eligibility" or "eligibility for Medicare" we mean that you (meaning any member covered under the plan) have met the eligibility conditions to enroll in Medicare, regardless of whether you in fact do so.

You (meaning any member covered under the plan) must notify us immediately once you become eligible for Medicare. You are responsible for determining when you are eligible to enroll in Medicare.

**Attention:** Our payment for services or supplies beyond the date you become eligible for Medicare (even if we have notice of that fact) does not mean that the plan provides these benefits. We reserve the right to retroactively recall any payments we have made for services or supplies after your Medicare eligibility date, without any retroactive or prospective reduction in premiums.

Because Medicare does not cover dependents, any family members who are covered by the plan will be given the option to continue coverage if your coverage under the plan terminates as a result of your eligibility to enroll in Medicare. For more information about this, see the section called [Are There Any Continuation of Coverage Rights Under the Plan?](#)

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

If you obtain coverage under some other group or individual health policy or plan, you should see the section later in the booklet called [Coordination of Benefits](#) for information about how coverage under this plan will coordinate with other health plan coverage.

### **May I Switch Myself and My Family From One Individual Blue Plan to Another?**

Currently, during the month of November, we will allow you and your covered spouse and children to replace your Individual Blue plan with another Individual Blue plan that has a higher calendar year deductible. If you follow the rules we establish for making this switch, we will waive the application of the new plan's health underwriting guidelines and you will receive credit under the new plan for any time served under the waiting period of this plan.

By contrast, if you wish to switch to a plan with a lower calendar year deductible, you and your family members will be required to submit new applications for coverage, and you will all be treated as new applicants. This means that you will all need to satisfy our normal health underwriting guidelines and, if accepted for coverage, will need to satisfy the new plan's waiting period for pre-existing conditions.

Before you decide to switch to another Individual Blue plan, you should carefully compare the benefits for that plan with the benefits available under this plan. There may be more differences in benefits than just a different calendar year deductible between this plan and the other Individual Blue plan.

### **When Does Coverage End?**

Subject to any right to continue coverage under [Are There Any Continuation of Coverage Rights Under the Plan?](#), Plan coverage ends for you and your dependents when the first of the following happens:

1. You fail to pay all applicable fees for coverage within the first 30 days following the effective date of your coverage, in which case coverage for you and your dependents will be cancelled as of the effective date of coverage;
2. You fail to pay subsequent fees for coverage within the 30 day grace period;
3. You are no longer a resident of the State of Alabama;
4. For spouses, the first day of the month following divorce or other termination of marriage;
5. For children, the first day of the month following the date a child ceases to be a dependent;
6. For all covered dependents, the first day of the month following the date of a subscriber's death unless proper documentation is received within 30 days from the date of death to

allow coverage to continue (we will not notify the subscriber's dependents upon the date of death of his/her options to continue coverage);

7. For any member, the date of his or her death;
8. Upon discovery of fraud or intentional misrepresentation or omission of a material fact;
9. Upon termination of the plan as explained later in this booklet in the section called [General Information](#).

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

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

### **Are There Any Continuation of Coverage Rights Under the Plan?**

Yes, but only in the following circumstances:

**Attention:** We will not provide a separate notice to you at the time of termination of coverage telling you about your continuation of coverage rights. You are responsible for remembering that these options are available.

1. If you are covered under the plan as a dependent child and you lose dependent status (e.g., you turn age 19 but do not continue your education as a full-time student), you may apply for your own plan. We will rely on our normal health underwriting guidelines and other eligibility criteria when considering your application. If you submit your application within 30 days of losing coverage and if we accept your application, we will count your coverage under your prior plan when applying your new plan's waiting period for pre-existing conditions (described in the section below called [Waiting Periods](#)).
2. Upon divorce, other termination of marriage, or death of the subscriber, covered family members may elect to continue coverage (usually under a new plan number) if we are properly notified within 30 days of the event. If we receive timely notice, we will not apply our usual health underwriting guidelines and will count coverage under the prior plan when applying the new plan's waiting period for pre-existing conditions (described in the section below called [Waiting Periods](#)).
3. If the subscriber's coverage under the plan terminates in connection with his or her eligibility for Medicare, covered family members may elect to continue coverage if we are properly notified within 30 days of the termination of the subscriber's coverage. If we receive timely notice, we will not apply our usual health underwriting guidelines and will count coverage under the prior plan when applying the new plan's waiting period for pre-existing conditions (described in the section below called [Waiting Periods](#)).
4. If the subscriber establishes residency outside of the State of Alabama and thereby loses coverage under the plan, any covered family members who remain residents of the State of Alabama may elect to continue coverage if we are properly notified within 30 days of the event. If we receive timely notice, we will not apply our usual health underwriting guidelines and will count coverage under the prior plan when applying the new plan's waiting period for pre-existing conditions (described in the section below called [Waiting Periods](#)).

**Attention:** Because this plan is not a group insurance plan, it does not provide benefits under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986). The only continuation of coverage rights are those outlined in this section of the plan.

### **Limitation on Effect of Certain Amendments**

Except as otherwise required by law, no amendment or change to this section of the booklet ([Eligibility](#)) will result in the disenrollment, loss of eligibility, or early termination of eligibility of a member properly enrolled under the terms of the plan as of the effective date of the amendment. For example, if you have a child enrolled under the plan and we amend the plan to decrease the eligibility age for full-time students from 25 to 23, that change would not apply to any of your currently covered children. It would apply to any children you add to the plan after the effective date of the amendment.

---

## **WAITING PERIODS**

**Attention:** Because this plan is not a group insurance plan, the waiting periods described below for pre-existing conditions are not reduced by your prior creditable coverage, if any, under HIPAA (the Health Insurance Portability and Accountability Act of 1996).

### **For Pre-Existing Conditions**

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

### **Exclusion Period for Some Surgical Procedures**

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

### **Exclusion Period for Maternity Care Benefits**

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

### **Limitation on Effect of Certain Amendments**

Except as otherwise required by law, no amendment or change to this section of the booklet (Waiting Periods) will result in an extension of the waiting period, an extension of the exclusion period for surgical procedures listed above, an expansion of the list of procedures subject to the waiting period, or an extension of the exclusion period for maternity care benefits for any member covered under the plan and currently serving a waiting period or exclusion period as of the effective date of the amendment. For example, if you are serving your 365 day waiting period for pre-existing conditions and we amend the

plan to increase the waiting period from 365 days to 724 days (2 years), that change would not apply to you or any other member of your family currently serving the waiting period. It would apply to any members of your family added to the plan after the effective date of the amendment.

---

## COST SHARING

<b>Calendar Year Deductible</b>	\$1,500 individual per year; \$4,500 family maximum per year
<b>Calendar Year Out-Of-Pocket Maximum</b>	\$4,500 individual per year
<b>Lifetime Maximum</b>	\$1,000,000 per individual

### Calendar Year Deductible

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

All amounts applied to individual deductibles will count toward the family deductible. Therefore, it is not necessary for any one family member to completely satisfy his or her individual deductible in order for the family deductible to be met. Only one deductible is required when two or more family members have expenses resulting from injuries received in one accident.

### Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is specified in the table above. The calendar year out-of-pocket maximum applies on a per person per calendar year basis, and does not include the calendar year deductible. The out-of-pocket maximum only applies to coinsurance to in-network providers (other than coinsurance to in-network or out-of-network providers for mental health disorders or substance abuse treatment or prescription drugs). As explained below under the Section called [Cost Sharing Provisions](#), coinsurance is the amount that you must pay as a percent of the allowed amount for services or supplies.

Once the out-of-pocket maximum has been reached, you will no longer be required to pay coinsurance of the type that counted towards the out-of-pocket maximum for the remainder of the calendar year; however, all other cost sharing requirements under the plan will continue to apply. Thus, there may be many circumstances in which you are required to make additional out-of-pocket expenses during the remainder of the calendar year even though you have met the out-of-pocket maximum. The following are some examples:

- Coinsurance to out-of-network providers (including coinsurance to out-of-state providers who are not designated by the local Blue Cross and Blue Shield plan as a BlueCard PPO providers even though the out-of-state providers may have some other contractual relationship with that local Blue Cross and Blue Shield plan);
- The calendar year deductible itself;
- Per admission deductibles;
- Copays;
- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges);

- Amounts paid for services or supplies in excess of any plan limits (for example, a limit on the number of covered visits for a particular type of provider); and,
- Amounts paid as a penalty (for example, failure to precertify);

## **Lifetime Maximum**

The lifetime maximum benefit for each covered member under the plan is specified in the table above. The lifetime maximum is the maximum amount each covered member is eligible to receive for applicable covered services in his or her lifetime. Lifetime maximum amounts are accumulated from claim payment amounts under the plan and any prior non-group plans issued by us under which you have been covered as a subscriber or member. The lifetime maximum does not begin again if you lose coverage and then reapply and obtain a new contract

After the lifetime maximum has been reached, certain In-Network hospital services, In-Network physician services and In-Network hospice services may be covered subject to plan benefits

## **Other Cost Sharing Provisions**

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

1. Per admission deductibles. A per admission deductible is an amount that must be paid upon your admission as a hospital inpatient.
2. Copays. A copay is a fixed dollar amount you must pay on receipt of care. The most common example is a copay that must be paid when you go to a doctor's office.
3. Coinsurance. Coinsurance is the amount that you must pay as a percent of the allowed amount. A common example is the 20% of the allowed amount that you must pay when you receive Other Covered Services.
4. Amounts in excess of the allowed amount. As a general rule, and as explained in more detail in the [Definitions](#), the allowed amount may be less than the provider's actual charges. When you receive benefits from an out-of-network provider, for example, you may be responsible for paying the provider's charges in excess of the allowed amount.

## **Out-of-Area Copayments and Coinsurance**

When you obtain health care services through the BlueCard Program outside of the Alabama service area, the amount you pay for covered services is calculated on the lower of:

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

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Plan. Sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your payment for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate payment calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or

require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

---

## BENEFITS

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

### Inpatient Hospital Benefits

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

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

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

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

In many cases your provider will initiate the preadmission certification process for you. You should be sure to check with your admitting physician or the hospital admitting office to confirm whether preadmission certification has been obtained. 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, you will be required to pay a \$250.00 per admission penalty. You will also have to pay the billed charges for the inpatient admission if we later determine that it is not medically necessary.

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
First 365 days of care during each confinement (combined in-network and out-of-network)	100% of the allowed amount after \$300 per day copay for days 1-5 for each admission	50% of the allowed amount subject to \$3,000 per admission deductible
Days of confinement extending beyond the 365 day benefit maximum	80% of the allowed amount subject to calendar year deductible	50% of the allowed amount subject to 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.

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

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

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

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

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

## Outpatient Hospital Benefits

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Outpatient surgery (including ambulatory surgical centers)	100% of the allowed amount after \$300 hospital copay	50% of the allowed amount subject to calendar year deductible
Emergency room-medical emergency	100% of the allowed amount after \$300 hospital copay	50% of the allowed amount subject to calendar year deductible
Emergency room-accident	100% of the allowed amount after \$300 hospital copay	50% of the allowed amount subject to calendar year deductible
Outpatient diagnostic lab, X-ray and pathology	100% of the allowed amount after \$300 hospital copay	50% of the allowed amount subject to calendar year deductible
Outpatient dialysis, IV therapy, chemotherapy and radiation therapy	100% of the allowed amount	50% of the allowed amount subject to calendar year deductible
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 calendar year deductible	50% of the allowed amount subject to calendar year deductible
Outpatient hospital services or supplies not listed above	80% of the allowed amount subject to calendar year deductible	50% of the allowed amount subject to calendar year deductible

**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.

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.

Certain outpatient diagnostic imaging services may require prior authorization as to the medical necessity of the diagnostic service. Information about these prior authorization requirements can be found on our web site at [www.bcbsal.com](http://www.bcbsal.com). Your in-network provider should help you comply with these requirements

## Physician Benefits

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Office visits and consultations	100% of the allowed amount after \$40 copay	50% of the allowed amount subject to calendar year deductible
Emergency room physician	100% of the allowed amount after \$100 copay	50% of the allowed amount subject to calendar year deductible
Surgery and anesthesia for a covered service	80% of the allowed amount subject to calendar year deductible	50% of the allowed amount subject to calendar year deductible
Maternity care	80% of the allowed amount subject to calendar year deductible	50% of the allowed amount subject to calendar year deductible
Inpatient visits	80% of the allowed amount subject to calendar year deductible	50% of the allowed amount subject to calendar year deductible
Inpatient consultations by a specialty provider (limited to one consult per specialist per day)	80% of the allowed amount subject to calendar year deductible	50% of the allowed amount subject to calendar year deductible
Diagnostic lab, X-rays and pathology	100% of the allowed amount	50% of the allowed amount subject to calendar year deductible
Chemotherapy and radiation therapy	80% of the allowed amount subject to calendar year deductible	50% of the allowed amount subject to calendar year deductible
Allergy testing and treatment	80% of the allowed amount subject to calendar year deductible	50% of the allowed amount subject to 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.
- Certain diagnostic imaging services performed in a physician's office may require prior authorization as to the medical necessity of the diagnostic service. Information about these prior authorization requirements can be found on our web site at [www.bcbsal.com](http://www.bcbsal.com). Your in-network provider should help you comply with these requirements.

## Physician Preventive Benefits

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Routine newborn exam (in hospital)	100% of the allowed amount	Not covered
Routine well child care exams: First 24 months – 9 visits Age 2 – 1 visit Age 3 – 1 visit Age 4 – 1 visit Age 5 – 1 visit Age 6 – 1 visit	100% of the allowed amount after \$40 copay	Not covered
Routine Immunizations  (See <a href="http://www.bcbsal.com/immunizations">www.bcbsal.com/immunizations</a> for a listing of the specific immunizations)	100% of the allowed amount	Not covered
Routine office visit: Limited to one every two calendar years for ages 7-34 and one every year for ages 35 and over	100% of the allowed amount after \$40 copay	Not covered
Routine pap smear: One per calendar year	100% of the allowed amount	Not covered
Routine screening mammogram: One exam for females ages 35-39 and one exam per calendar year for females ages 40 and over  See the <a href="#">Mastectomy and Mammograms</a> section for additional information	100% of the allowed amount	Not covered
Routine PSA (prostate specific antigen): One exam each calendar year for males age 40 and over	100% of the allowed amount	Not covered
Routine cholesterol test Limited to one every five years	100% of the allowed amount, no deductible or copayment	Not covered
Routine sigmoidoscopy See the <a href="#">Colorectal Cancer Screening</a> section for additional information.	100% of the allowed amount, no deductible or copayment, limited to one every three years for ages 50 and over	Not covered
Routine hemocult stool check/fecal occult blood test (FOBT) See the <a href="#">Colorectal Cancer Screening</a> section for additional information.	100% of the allowed amount, no deductible or copayment, limited to one every year for ages 50 and over	Not covered

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Colonoscopy See the <a href="#">Colorectal Cancer Screening</a> section for additional information.	100% of the allowed amount, no deductible or copayment, limited to one every 10 years for ages 50 and over  Note: Claims for facility charges will be processed under your outpatient hospital benefits and subject to any applicable outpatient copayments	Not covered
Double-contrast barium enema See the <a href="#">Colorectal Cancer Screening</a> section for additional information.	100% of the allowed amount, no deductible or copayment, limited to one every five years for ages 50 and over  Note: Claims for facility charges will be processed under your outpatient hospital benefits and subject to any applicable outpatient copayment	Not covered
Routine laboratory tests; complete blood count, urinalysis, TB skin test	100% of the allowed amount, no deductible or copayment, limited to one of each per year when performed with a routine office visit	Not covered

### Mental Health Disorders and Substance Abuse Benefits

You and your dependents may receive mental health and substance abuse benefits under the plan only through an EPS provider. There are no mental health and substance abuse benefits under the plan unless treatment is rendered or coordinated by an Expanded Psychiatric Service (EPS) provider – even if you do not live near an EPS provider or are otherwise unable to take advantage of this mental health and substance abuse benefit under the plan.

EPS providers participate in a program called Expanded Psychiatric Service (EPS). The EPS program provides members with a broad range of services for treatment of mental health disorders and substance abuse without any deductibles or copayments when care is coordinated by an EPS provider. In some cases, EPS providers will furnish care directly to you. In other cases, EPS providers will contract with other providers or facilities to furnish care to you. The plan pays a fixed, per member, fee to the EPS network in exchange for the network’s coordination and management of your care. Providers who participate in the EPS network are available throughout Alabama and in a few locations in states bordering Alabama. A list of EPS providers can be found in the Expanded Psychiatric Services Network directory. To find an EPS provider call Customer Service or search the online [provider finder](#) on our web site at [www.bcbsal.com](http://www.bcbsal.com). Look under Quick Links for “Find a doctor.” Once there, select “Find a doctor by location, then scroll down in the box called “Select a Specialty” until you find “Psychiatric Services (Expanded).”

SERVICE OR SUPPLY	
<p>The following treatment, services, or supplies are covered under the EPS program:</p> <p><b>Inpatient:</b></p> <ul style="list-style-type: none"> <li>• Up to 30 days of inpatient care each calendar year for treatment of mental health disorders, chemical detoxification, and rehabilitation; includes facility, physician and therapy expenses</li> </ul> <p><b>Outpatient:</b></p> <ul style="list-style-type: none"> <li>• Outpatient visits</li> <li>• Individual, group, and family therapy or counseling</li> <li>• Psychological and laboratory testing</li> <li>• Services by professional staff members such as psychologists and social workers in mental health and chemical dependency</li> </ul>	<p>100% of the allowed amount; no deductible or copayment</p>

The following services or supplies are not included under the EPS program:

- Speech therapy;
- Diagnosis or treatment of mental retardation;
- Rehabilitation of a temporary or permanent disability or for hearing or vision impairment;
- Treatment for chronic pain or solely for obesity;
- Services related to narcotic maintenance therapy such as methadone maintenance therapy;
- Services related to nicotine addiction;
- Sex therapy programs or treatment for sex offenders;
- Prescription drugs; and,
- Residential psychiatric facilities, psychiatric specialty hospitals and substance abuse facilities.

## 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 service is received within 90 days of the 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: Professional services of a licensed chiropractor practicing within the scope of his license Limited to \$600 per person each calendar year	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
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 <b>Note:</b> 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	80% of the allowed amount, subject to the calendar year deductible (for DME the allowed amount will generally be the smaller of the rental or purchase price)	50% of the allowed amount, subject to the calendar year deductible (for DME the allowed amount will generally be the smaller of the rental or purchase price)
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 maximum of 30 visits per calendar year (combined in-network and out-of-network)	80% of the allowed amount, subject to the calendar year deductible In Alabama, precertification required after 15 therapy visits.  Your provider should help you comply with these precertification requirements.	50% of the allowed amount, subject to the calendar year deductible
Home health and hospice care within the state of Alabama	80% of the allowed amount, subject to the calendar year deductible	Not covered

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Home health and hospice care outside the state of Alabama	80% of the allowed amount, subject to the calendar year deductible; precertification is required – call 1-800-821-7231	In Alabama: Not covered 50% of the allowed amount, subject to the calendar year deductible; the remaining percentage applies toward the annual out-of-pocket maximum; precertification is required – call 1-800-821-7231

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

In-network hospice benefits consist of physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management. An in-network hospice must furnish the services and supplies to a member certified by his physician to have less than six months to live. When these services are provided outside of Alabama, benefits are paid **only** if precertification is obtained by calling 1 800 821-7231.

**Prescription Drug Benefits**

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs No benefits are available for drugs purchased at a non-participating pharmacy	<b>Generic drugs:</b> You pay \$10 per prescription copay <b>Preferred brand drugs:</b> You pay \$60 per prescription copay <b>Other brand name drugs:</b> Not Covered <b>Specialty drugs:</b> 50% with a \$5,000 out of pocket maximum for specialty drugs. Once this out-of-pocket maximum for specialty drugs has been reached, you will no longer be required to pay coinsurance for covered specialty drugs for the remainder of the calendar year <b>Fertility drugs:</b> Not Covered	Not covered

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

- To determine whether a drug is a preferred brand drug, see the [Prescription Drug Guides](#) found in the “I am the Customer” section of our web site. Once there, you can download a copy of the current preferred brand drug list of search for the drug by name.
  - The preferred brand drug list consists of brand name drugs that are generally believed within the industry to be cost effective and have been approved for inclusion on the list by a panel of

physicians and pharmacists on Blue Cross and Blue Shield of Alabama's Pharmacy and Therapeutics Committee. The preferred brand drug list is updated periodically.

- Any brand name drug that is not on the preferred drug list or the specialty drug list is not covered under the plan. Any brand name drug (whether preferred brand name or other brand name) for which a generic equivalent is available is also not covered under the plan.
- A generic drug is one that does not have a brand name or trademark.
- To determine whether a drug is a specialty drug, see the Prescription Drug Guides found in the "I am the Customer" section of our web site. Once there you can download a copy of the current specialty drug list or search for the drug by name.
  - Specialty drugs are high-cost drugs that may be used to treat certain complex 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.
  - A drug included on the specialty drug list may also be considered a generic, preferred brand name, or other brand name drug. If a drug falls into multiple categories, the drug will be considered a specialty drug, and not a generic drug or other type of drug, as long as it remains on the specialty drug list.

**Attention:** Just because a drug is on the preferred brand drug list, the specialty drug list, or any other list on our web site or is a generic equivalent does not mean the drug is safe or effective for you. Only you and your prescribing physician can make that determination.

- Even though your physician has written a prescription for a drug, the drug may not be covered if there is an equivalent non-legend (over-the-counter) drug available. Your in-network pharmacist should tell you when this is the case.
- 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 "I am a Customer" section of our web site. The guidelines in some instances require you to obtain prior authorization as to the medical necessity of the drug. Your in-network pharmacist should help you comply with the Drug Coverage Guidelines.
- Compound drugs may be covered if at least one of the drugs in the compound is a legend drug.
- Drugs can be dispensed up to a maximum 90-day supply. You must satisfy the copayment requirement for each 30-day supply. Refills of prescriptions are allowed only after 60% of the allowed amount of the previous prescription has been used (e.g., 18 days in a 30-day supply).
- Insulin, needles, and syringes purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. Blood glucose strips and lancets purchased on the same day in the same quantity will have one copay. Otherwise, each has a separate copay. Glucose monitors always have a separate copay. These are the only diabetic supplies available as prescription drug benefits under the plan.

## Health Management Benefits

### HEALTH MANAGEMENT BENEFITS

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

Unfortunately, some people suffer from catastrophic, long-term or chronic illness or injury. If you suffer due to one of these conditions, a Blue Cross Registered Nurse may work with you, your physician, and other health care professionals to design a benefit plan to best meet your health care needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to 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).

You may also qualify to participate in the care management program. Care management is designed for individuals whose long-term medical needs require disciplined compliance with a variety of medical and lifestyle requirements. If the manager of the care management program determines from your claims data that you are a good candidate for care management, the manager will contact you and ask if you would like to participate. Participation in the program is completely voluntary. If you would like to obtain more information about the program, call our Customer Service department.

## **Additional Benefit Information**

### *Baby Yourself Program*

If you or your spouse is pregnant, Baby Yourself offers individual care by a registered nurse. Please call our nurses at 1-800-222-4379 (or 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, Tissue, and Bone Marrow/Cell Transplants*

The organs and tissue for which there are transplant benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas; (5) kidney; (6) heart-valve; (7) skin; (8) cornea; and (9) small bowel. Bone marrow transplants, which include stem cells and tissue to restore or make stronger the bone marrow function, are also included. The transplant must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve a facility for transplant services it is limited to the specific types of transplants stated. Donor organ costs are limited to search, removal, storage and transporting of the organ and removal team.

There are no transplant benefits for: (1) any artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) recipient or donor room, food, or transportation costs we did not approve in writing; (7) a condition or disease for which a transplant is

considered investigational; (8) transplants performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

### *Mastectomy and Mammograms*

#### Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema.

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

#### Benefits for Mammograms

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

- If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.
- If you are at high risk of developing breast cancer or you have a family history of breast cancer - within the meaning of our medical guidelines - and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.
- In all other cases the claim will be subject to the routine mammogram benefit provisions and limits described elsewhere in this booklet.

### *Benefits for Colorectal Cancer Screening*

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

- If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.
- If you are at high risk of developing colon cancer or you have a family history of colon cancer - within the meaning of our medical guidelines - and if the provider properly files the claim with this information, we will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.
- In all other cases the claim will be subject to the routine colorectal cancer screening benefit provisions with the age and frequency limitations described elsewhere in this booklet.

---

## HEALTH BENEFIT EXCLUSIONS

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

### A

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

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

**Anesthesia** services or supplies or both by local infiltration.

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

### C

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

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

Services or expenses for treatment or supplies in a **college** or school infirmary.

Services or expenses for a **claim we have not received within 24 months** after services were rendered or expenses incurred.

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

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

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

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

Services or expenses for treatment of injury sustained in the commission of a **crime** or for treatment while confined in a prison, jail, or other penal institution.

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

## D

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

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

**Drugs** or medicines dispensed from a pharmacy that is an out-of-network pharmacy or for brand name drugs that are not on the preferred brand name drug list or the specialty drug list or for brand name drugs for which there is a generic equivalent available.

## E

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

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

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

## F

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

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

## G

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

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

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

## L

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

## M

Treatment for **mental and nervous** disorders or disease (including alcoholism and drug addiction) unless treatment is rendered or coordinated by an Expanded Psychiatric Service (EPS) provider.

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

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

## N

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

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

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

## P

Private duty nursing.

## R

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

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

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

Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed physical therapist.

**Routine well child care** and routine immunizations except for the limited services described in the [Physician Preventive Benefits](#) section.

**Routine physical examinations** except for the limited services described in the [Physician Preventive Benefits](#) section.

## S

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

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

Treatment for **substance abuse** disorders or disease (including alcoholism and drug addiction) unless treatment is rendered or coordinated by an Expanded Psychiatric Service (EPS) provider.

## T

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

Services provided through **teleconsultation**.

Treatment for or related to **temporomandibular joint (TMJ) disorders**. This includes Phase I and Phase II Treatment, therapy or exams, according to the guidelines approved by the Academy of

Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.

**Travel**, even if prescribed by your physician.

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

## W

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

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

Services or expenses for treatment of any condition including, but not limited to, obesity, diabetes, or heart disease, which is based upon **weight reduction** or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion includes Bariatric Surgery and Gastric Restrictive procedures and any complications arising from Bariatric Surgery and Gastric Restrictive procedures.

---

## COORDINATION OF BENEFITS

We coordinate the benefits under this plan with other group and non-group health plans. 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 health care 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 forgoing.
3. **Non-Group Health Plan:** If the other plan is a non-group health plan not issued by us, the following rules apply:
  - a. The benefits of the plan which covers the person as an applicant, 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 health care expenses or health care 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 health care expenses or health care 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 health care expenses or health care 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 health care expenses or health care 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 health care 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 health care 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.

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

For 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 health care expenses, including coinsurance, co-payments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

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

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

For separate rules concerning coordination of plan benefits with Medicare, see the section under [Eligibility](#) that discusses Medicare.

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

## **Right to Receive and Release Needed Information**

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

## **Facility of Payment**

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

### **Right of Recovery**

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

---

## **SUBROGATION**

### **Right of Subrogation**

If we provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. This means that we may use your right to recover money from that other person or organization.

### **Right of Reimbursement**

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

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

### **Right to Recovery**

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

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney’s fees charged you by your attorney for obtaining the recovery. If

you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

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

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

---

## CLAIMS AND APPEALS

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

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

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

### Post-Service Claims

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

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

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

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

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

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

incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid.

## **Pre-Service Claims**

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

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission.

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

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing within three days. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing the information to us.

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

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

## **Concurrent Care Determinations**

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

**Requests by You to Extend Previously Approved Care:** If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may

make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows: (205) 988-2245 (in Birmingham) or 1 800 248-2342 (toll-free).

## Appeals

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

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

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

**How to Appeal Post-Service Claim Determinations:** If you wish to file an appeal of a post -service claim determination, we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our Customer Service Department. You may also go to our Internet web site at [www.bcbsal.com](http://www.bcbsal.com). Once there, you may ask us to send a copy of the form to you.

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

1. The patient's name;
2. The patient's contract number;
3. Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number, if available (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
4. A statement that you are filing an appeal.

You must send your appeal to the following address:

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

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

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

If in writing, you should send your letter to

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

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

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

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

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

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

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

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

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

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

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

---

## GENERAL INFORMATION

### Discretionary Authority to Blue Cross

We have the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with the administration of the plan. Whenever we make reasonable decisions that are neither arbitrary nor

capricious, our decisions will be determinative, subject only to your right of review under the plan and thereafter to arbitration to determine whether our decision was arbitrary or capricious.

### **Arbitration**

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

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

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

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

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

**BLUE CROSS AND BLUE SHIELD OF ALABAMA  
LEGAL DEPARTMENT  
450 RIVERCHASE PARKWAY EAST  
BIRMINGHAM, AL 35242**

**THE ARBITRATION SHALL BE CONDUCTED BEFORE A SINGLE ARBITRATOR WHO SHALL BE CHOSEN BY THE JOINT AGREEMENT OF THE PARTIES, WITH THE SELECTION TO OCCUR ORDINARILY WITHIN ONE MONTH FROM THE**

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

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

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

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

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

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

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

**Correcting Payments**

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

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

**Health Plan Termination**

We may terminate the plan under the following two circumstances:

1. If we decide to discontinue offering the Individual Blue product, we may elect to terminate your plan (which will terminate your coverage and the coverage and all of your dependents) by giving you at least 90 days prior written notice. If we do this, and if we offer other health products in the individual market, we will give you the option to purchase any of these other products without regard to your health status or the health status of your dependents.
2. If we decide to discontinue offering all coverage in the individual health insurance market, we may elect to terminate your plan (which will terminate your coverage under the plan and all dependents) by giving you at least 180 days prior written notice.

**Health Plan Changes**

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

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

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

**Responsibility for Providers**

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

**Misrepresentation**

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

## **Respecting Your Privacy**

To administer this plan we need your personal health information from physicians, hospitals and others. To decide if your claim should be paid or denied or whether other parties are legally responsible for some or all of your expenses, we need records from health care providers other insurance companies, and other plan administrators. By applying for coverage and participating in this plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer this plan or to perform any function authorized or permitted by law. You further direct all other persons to release all records to us about you and your minor dependents that we need to administer this plan. If you or any provider refuses to provide records, information or evidence we request within reason, we may deny your benefit payments.

Additionally, we may use or disclose your personal health information for treatment, payment, or health care operations, or as permitted or authorized by law, pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have prepared a privacy notice that explains our obligations and your rights under the HIPAA privacy regulations. To request a copy of our notice or to receive more information about our privacy practices or your rights, please contact us at the following contact office:

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

---

## DEFINITIONS

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

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

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

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

See [Out-of-Area Copayments and Coinsurance Provisions](#), 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 health care factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

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

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

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

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

**Blue Cross:** Blue Cross and Blue Shield of Alabama.

**BlueCard PPO Program:** An arrangement among Blue Cross Plans by which a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur. The BlueCard program is explained in more detail in other sections of this booklet, such as [In-Network Benefits](#) and [Out-of-Area Copayments and Coinsurance](#).

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

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

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

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

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

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

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

**Home Health Care Agency:** An organization that provides care at home for homebound patients who need skilled nursing or skilled therapy. In order to be considered a home health care agency under the terms of the plan, the organization must meet the conditions for participation in Medicare or satisfy the credentialing requirements of other organizations as we determine to be applicable.

**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 or satisfy the credentialing requirements of other organizations as we determine to be applicable.

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

**In-Network Providers:** A provider is considered to be an in-network provider if, and only to the extent that, the provider is furnishing a service or supply that is specified as an in-network benefit under the terms of the contract between the provider and the Blue Cross and/or Blue Shield plan (or its affiliates). Examples include BlueCard PPO providers, Preferred Medical Doctors (PMD physicians), and Participating Pharmacies. A provider will be considered an in-network provider only if the local Blue Cross and/or Blue Shield plan designates the provider as a BlueCard PPO provider for the service or supply being furnished. This means that if you receive a service or supply from a provider that has a contractual relationship with a Blue Cross and/or Blue Shield plan but is not designated by the local Blue Cross and/or Blue Shield plan as a BlueCard PPO provider, we will pay at the out-of-network level of benefits and your out-of-network coinsurance will not apply to the calendar year out-of-pocket maximum under the plan.

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

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

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

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

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

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

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

- Psychologists who are licensed by the state in which they practice (Ph.D., Psy.D. or Ed.D.), as defined in Section 27-1-18 of the Alabama Code or other applicable state law.
- In-network Certified Registered Nurse Practitioners who are practicing within the scope of their license and in collaboration with an in-network M.D. or D.O.

- Certified Nurse Midwives who are practicing within the scope of their license and in collaboration with an in-network M.D. or D.O.
- Physician Assistants (P.A.s) (including P.A.s who assist in surgery) when (1) the P.A. is employed by and acting under the direct supervision of a M.D. or D.O. who is an in-network provider; (2) the P.A. is acting within the scope of his or her license and is in compliance with the rules, regulations, and parameters applicable under local law to the P.A.; and (3), the services of the P.A. would have been covered if provided directly by the M.D. or D.O.

**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.

**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.

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

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

**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.

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

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

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

**Customer Service:**

1 888 258-1628 toll-free

**Preadmission Certification:**

988-2245 (in Birmingham)  
or 1 800 248-2342 toll-free

Web site:

**[www.bcbsal.com](http://www.bcbsal.com)**



**BlueCross BlueShield  
of Alabama**

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