UA System Office

Effective January 1, 2014
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NOTICE OF HEALTH INFORMATION PRACTICES

SELF-FUNDED GROUP HEALTH PLAN (#79912) FOR UA SYSTEM OFFICE EMPLOYEES AND DIVISIONS 004, 005, 006, 05S

Administered by Blue Cross and Blue Shield of Alabama

Effective Date of Notice: January 1, 2007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Will Follow This Notice

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HIPAA PRIVACY RULE about the duties and privacy practices of The University of Alabama SELF-FUNDED GROUP HEALTH PLAN (Group #79912) (and specifically those divisions of the Plan that cover UAS employees, retirees, and COBRA members) (the “Plan”) to protect the privacy of your medical information. The Plan (specifically, Divisions 004, 005, 006, 05S) is sponsored by The University of Alabama (the “Plan Sponsor”). The University of Alabama is a hybrid covered entity, and this Notice applies only to Divisions 004, 005, 006, and 05S of the UA System Office Group Health Plan and administrative departments at the University of Alabama or the University of Alabama System Office that may provide legal, billing, auditing, technology support, or other administrative support for these divisions of the Plan, including but not limited to The University of Alabama System Office of Counsel, The University of Alabama System Office of Internal Audit, The University of Alabama’s Privacy Officer, UA System Office Human Resources and its Privacy Officer, and UA System Office Risk Management. For purposes of this Notice, the Group Health Plan and its affiliated University of Alabama and University of Alabama System Office administrative support departments, when providing administrative support for Divisions 004, 005, 006, and 05S of the UA System Office Group Health Plan, will be referred to as the “Plan.”

The Plan provides health benefits to you as described in your Blue Cross and Blue Shield of Alabama Summary Plan Description. The Plan receives and maintains your medical information in the course of providing these health benefits to you. The Plan hires business associates, such as Blue Cross and Blue Shield of Alabama, to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan.

Our Pledge Regarding Medical Information

The Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. This Notice will tell you about the ways in which the Plan (or its business associates, like Blue Cross and Blue Shield of Alabama) may use and disclose medical information about you. This Notice also describes your rights and certain obligations the Plan has regarding the use and disclosure of medical information. The Plan is required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to medical information about you;
- follow the terms of the notice that is currently in effect.
Changes To This Notice

The Plan is required to follow the terms of this notice until it is replaced. The Plan reserves the right to change the terms of this notice at any time. If the Plan makes material changes to this notice, the Plan will, within 60 days of making those material revisions, provide a new notice to all subscribers then covered by the Plan. The Plan reserves the right to make the new changes apply to all your medical information maintained by the Plan before and after the effective date of the new notice.

Purposes for which the Plan May Use or Disclose Your Medical Information Without Your Consent or Authorization

The following categories describe different purposes that the Plan may use and/or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and/or disclose information will fall within one of the categories.

- **Health Care Providers’ Treatment Purposes.** For example, the Plan may disclose your medical information to your doctor, at the doctor’s request, for your treatment by him.

- **Payment.** For example, the Plan may use or disclose your medical information to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment or for payment activities associated with another covered health plan, such as a flexible spending plan.

- **Health Care Operations.** For example, the Plan may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage, plan or develop the Plan’s business, including conducting or arranging for legal, billing, auditing, compliance and other administrative support functions and/or services.

- **Health Services.** The Plan may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your medical information to its business associates to assist the Plan in these activities.

- **As required by law.** The Plan will disclose medical information when required to do so by federal, state or local law. For example, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose your medical information as authorized by and to the extent necessary to comply with workers’ compensation or other similar laws.

- **To Business Associates.** The Plan may disclose your medical information to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information. For example, Blue Cross and Blue Shield of Alabama is the Third Party Administrator for the Plan, and is required to sign a Business Associate Agreement agreeing to comply with the HIPAA Privacy and Security Regulations and to provide appropriate safeguards to protect the privacy of your medical information.

- **To Plan Sponsor.** The Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor the fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your medical information to Designated Plan Sponsor Employees to perform customer service functions on your behalf and/or to perform administrative functions. These Designated Employees must agree to comply with HIPAA Privacy and Security Rules and they may be subject to sanctions for non-compliance. The Plan Sponsor and its Designated Employees must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor, except as otherwise permitted by HIPAA.

The Plan may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
• To law enforcement officials for limited law enforcement purposes.
• To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.
• To your personal representatives appointed by you or designated by applicable law.
• For research purposes in limited circumstances.
• To a coroner, medical examiner, or funeral director about a deceased person.
• To an organ procurement organization in limited circumstances.
• To avert a serious threat to your health or safety or the health or safety of others.
• To governmental agency authorized to oversee the health care system or government programs.
• To federal officials for lawful intelligence, counterintelligence and other national security purposes.
• To public health authorities for public health purposes.
• To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosures with Your Permission

The Plan will not use or disclose your medical information for any other purposes unless you give the Plan your written authorization to do so. If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has taken action in reliance on your authorization.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information that the Plan maintains:

• Request Restrictions: To put additional restrictions on the Plan’s use and disclosure of your medical information. The Plan does not have to agree to your request; however, if the Plan agrees to comply, it will comply unless the information is needed to provide emergency treatment.
• Request Confidential Communications: To communicate with you in confidence about your medical information by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence. Even though you requested that we communicate with you in confidence, the Plan may give subscribers cost information.
• Inspect and Copy: To see and get copies of your medical information. In limited cases, the Plan does not have to agree to your request.
• Amend: To correct your medical information. In some cases, the Plan does not have to agree to your request.
• Accounting: To receive a list of disclosures of your medical information that the Plan and its business associates made for certain purposes for the last 6 years (but not for disclosures before April 14, 2003).
• Paper Copy of Notice: To have the Plan send you a paper copy of this notice if you received this notice by e-mail or on the internet. (Please send request to UAS Contact Office).

If you want to exercise the first five rights listed above, please contact Blue Cross and Blue Shield of Alabama Customer Service at the number you currently use to obtain Plan benefits assistance/information, and which should be located on the back of your health plan ID card. You will be provided the necessary information and forms for you to complete and return to that office, and Blue Cross and Blue Shield of Alabama will advise the Plan of your request. In some cases, you may be
charged a nominal, cost-based fee to carry out your request.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. All complaints must be submitted in writing. You may file a complaint with the Plan by sending it to the UAS Human Resources Privacy Officer at our UAS Contact Office (below). We will not retaliate against you if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

UA System Office Contact

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us at the following Contact Office:

Contact Office: UA System Office
Telephone: 205-348-7880 Fax: 205-348-5915
E-mail: jgarner@uasytem.ua.edu
Address: 500 University Boulevard East Tuscaloosa, AL 35401
OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact Customer Service at 1-800-292-8868. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atención por favor
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 1-800-292-8868. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

Welcome

This is your Blue Cross and Blue Shield of Alabama health care Summary Plan Description (SPD) for The UA System Office self-funded Group Health Plan effective January 1, 2012. Read this document at your first opportunity and keep it for future reference because it describes the health care benefits you have. The UA System Office has contracted with Blue Cross and Blue Shield of Alabama to be the Claims Administrator for your health care plan. This document together with the University's Group Application or Letter of Agreement and the Administrative Services Financial Agreement with Blue Cross make up the Contract. If the Summary Plan Description (SPD) is inconsistent with the Letter of Agreement, then the SPD will take precedence over the other document.

The UA System Office also provides a Medicare Coordinated (MEDCO) plan for eligible University retirees and their covered spouse/dependents which are eligible for or covered by Medicare and who wish to remain on the The University's Group Health Plan. Under MEDCO, Blue Cross coordinates the Medicare coverage with the University's group health coverage.

Both Blue Cross and the UA System Office do periodic reviews of utilization of medical services under this plan. Blue Cross may request additional information from you or a medical provider as part of their review process.

Please read all sections of this Summary Plan Description carefully. If you have any questions, contact the UA System Office Benefits Office at (205) 348-7880 or you may call Blue Cross and Blue Shield of Alabama Customer Service in Birmingham at 1-800-292-8868.

Group Number 79912

- Division 004 for Active Employees
- Division 005 for Other Active Employees
- Division 006 for Retirees and (MEDCO)
- Division 05S for COBRA for former members of Division 005

Purpose of the Plan

The plan is intended to help you and your covered dependents pay for the costs of medical care. The plan does not pay for all of your medical care. For example, you may be required to contribute through payroll deduction before you obtain coverage under the plan. You may also be required to pay deductibles, copayments, and coinsurance.
Using myBlueCross to Get More Information Over the Internet

Blue Cross and Blue Shield of Alabama's home page on the Internet is www.AlabamaBlue.com. If you go there, you will see a section of our home page called myBlueCross. Registering for myBlueCross is easy and secure. 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.

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 these definitions so that you will understand your benefits.

Receipt of Medical Care

Even if the plan does not cover benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Beginning of Coverage

The section of this booklet called Eligibility will tell you what is required for you to be covered under the plan and when your coverage begins.

Limitations and Exclusions

In order to maintain the cost of the plan at an overall level that is reasonable to all plan members, the plan contains a number of provisions that limit benefits. There are also exclusions that you need to pay particular attention to as well. These provisions are found through the remainder of this booklet. You need to be aware of these limits and exclusions in order to take maximum advantage of this plan.

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 these standards on the Internet at www.AlabamaBlue.com/providers/policies. The definition of medical necessity is found in the Definitions section of this booklet.

In some cases, the plan requires that you or your treating provider precertify the medical necessity of your care. The provisions later in this booklet will tell you when precertification is required. Look on the back of your ID card for the phone number that you or your provider should call. In some cases, our contracts with providers require the provider to initiate the precertification process for you. Your provider should tell you when these requirements apply. You are responsible for making sure that your provider initiates and complies with any precertification requirements under the plan. 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 our administration of the plan 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 healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of in-network provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and
coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. As one example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the plan. Additionally, out-of-network providers have not contracted with us or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the plan.

In-network providers are hospitals, physicians, pharmacies, and other healthcare providers or suppliers that contract with us or any Blue Cross and/or Blue Shield plans (directly or indirectly through, for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced price. Examples of in-network providers include PMD, Preferred Care, and BlueCard PPO. To locate in-network providers in Alabama, go to www.AlabamaBlue.com.

- First, click “Find a Doctor.”
- Second, select a healthcare provider type: doctor, hospital, pharmacy, other healthcare provider, or other facility or supplier.
- Third, enter a search location by using the zip code for the area you would like to search, or by selecting a state.

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder website at http://provider.bcbs.com. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross plan where services are rendered. The local Blue Cross plan will then forward the claims to us for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the plan or is not covered under the contract between the provider and the local Blue Cross plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the plan, such as Other Covered Services.

**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 and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

**Claims and Appeals**

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

Termination of Coverage

The section below 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 that began before the plan or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your group coverage terminates. COBRA coverage is explained in detail later in this booklet.

ELIGIBILITY

Eligibility for the Plan

You are eligible to enroll in this plan if all of the following requirements are satisfied:

- You are an employee of your employer and are treated as such by your group. Examples of persons who are not employees include independent contractors, board members, and consultants;
- You occupy a position of at least 0.5 FTE (full-time equivalency);
- There must be a reasonable expectation of continued funding for the position you occupy;
- You are in a category or classification of employees or retirees that is covered by the plan;
- You meet any additional eligibility or participation rules established by your us or your employer; and,
- You satisfy any applicable waiting period, as explained below.

You must continue to meet these eligibility conditions for the duration of your participation in the plan.

Enrollment Waiting Periods

There may be a waiting period under the plan, as determined by your group. You should contact your group to determine if this is the case. Your group will also tell you the length of any applicable waiting period. Under federal law, any waiting period established by your group cannot be longer than 90 days.

Coverage will begin on the date specified below under Beginning of Coverage, but in no event later than the 91st day in which you first meet the eligibility or participation rules established by your group (other than any applicable waiting period).

Applying for Plan Coverage

Fill out an application form completely and give it to your group. You must name all eligible dependents to be covered on the application. Your group will collect all of the employees' applications and send them to us. Some employers provide for electronic online enrollment. Check with your group to see if this option is available.

Eligible Dependents

Your eligible dependents are:

- Your spouse;
- A married or unmarried child up to age 26; and,
• An unmarried, incapacitated child who (1) is age 26 and over; (2) is not able to support himself; and (3) depends on you for support, if the incapacity occurred before age 26.

The child may be the employee's natural child; stepchild; legally adopted child; child placed for adoption; or other child for whom the employee has a final custody order or final disposition of legal custody.

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

**Sponsored Dependent**

The University of Alabama System Office (UAS) also offers benefit eligible employees the opportunity to cover a Sponsored Adult Dependent and/or Child Dependent under various benefit programs as long as they meet the guidelines that have been established within each benefit plan.

**Minimum Eligibility Requirements**

**Sponsored Adult Dependent** – A benefit eligible UAS employee may choose to add one Sponsored Adult Dependent for benefit coverage if the Sponsored Adult Dependent meets all of the following criteria:

• Shares a primary residence with the covered UAS employee, other than as a tenant/renter, and has lived with the UAS employee for at least the 12 continuous months immediately prior to the effective date of coverage under the benefit plan

• Is at least age 19 (current age of majority in the State of Alabama)

• Is not a relative of the employee. Definition of relatives: Parents, children, husbands, wives, brothers, sisters, brothers- and sisters-in-law, mothers- and fathers-in-law, uncles, aunts, cousins, nieces, great-nieces, nephews, great-nephews, grandmothers, grandfathers, great-grandmothers, great-grandfathers, sons- and daughters-in-law and half- or step-relatives of the same relationships.

• Is not employed by the UAS employee and was not employed by the employee during the period of the shared residence

• Neither the Sponsored Adult Dependent nor the UAS employee is married and neither one was married during the period of shared residence while enrolled in the benefit plan(s)

**Sponsored Child Dependent** – is defined as a dependent child of the Sponsored Adult Dependent and may be covered under any of the eligible benefit plans if he/she meets the following guidelines:

• Is under age 26 OR is age 26 or more, unmarried, was permanently incapacitated before age 26, is not able to support him or herself and depends on the UAS employee and/or the Sponsored Adult Dependent for his/her support due to physical or mental impairment, and

• Is the natural born child of Sponsored Adult Dependent, or

• Is a legally adopted child of the Sponsored Dependent (includes a child placed for adoption), or

• Is a child in the permanent legal custody of the Sponsored Adult Dependent

The above is not intended to be a comprehensive list of eligibility criteria. Please refer to the applicable updated Summary Plan Descriptions and Certificates of Coverage for complete definitions of eligibility for coverage.

**Enrollment Process for Eligible Sponsored Adult and/or Sponsored Child Dependent(s)**

Generally, there are four times when an employee can add an eligible Sponsored Adult and/or Sponsored Child Dependent to his or her UAS benefits:

1. Within 30 days of becoming a newly hired or newly eligible employee
2. Within 30 days of experiencing an enrollment event consistent with benefit plan rules
3. During the annual Open Enrollment period
4. Within 30 days of meeting the 12 month residency requirement
In order to cover an eligible Sponsored Adult and/or Sponsored Child Dependent(s), the sponsoring employee must complete and submit the following to the HR Service Center:

- Enrollment form for each benefit
- Documentation of 12 or more continuous months of residency of the Sponsored Adult Dependent with the UAS employee
- Signed affidavit by the UAS employee verifying he or she has met the eligibility requirements for Sponsored Dependents
- Any other documentation necessary to confirm eligibility, e.g. birth certificates, adoption paperwork, divorce decrees, etc. as requested

**Important Notification Requirement:** It is the sponsoring employee's responsibility to notify the UAS HR Service Center within 30 days if a Sponsored Dependent becomes eligible or ineligible for coverage or if the Sponsored Dependent obtains or loses coverage from another employer.

**Tax Implications**

Sponsoring employees may be subject to taxes due to the value of the benefits provided to their Sponsored Dependents, because the IRS requires that the value of the benefits (the fair market value) provided for a person who is not the employee's dependent for federal income tax purposes is considered a taxable employer-provided benefit to the employee. This added "employer-provided benefit" is called imputed income and is taxed as additional compensation. All applicable taxes apply.

If a sponsored dependent(s) qualifies as a dependent as defined by IRS under Section 152 the imputed income may not apply. This is not intended as tax advice but rather to alert employees of potential tax consequences. Employees are strongly encouraged to consult with a CPA, attorney, or tax advisor before declaring that a Sponsored Adult Dependent or child of a Sponsored Adult Dependent satisfies the requirement to be considered a qualifying Section 152 dependent as defined by the IRS.

**Continuation of Coverage for Sponsored Dependent (Adult and/or Child)**

A Sponsored Adult or Sponsored Child Dependent is not recognized under COBRA, unless the Sponsored Adult Dependent produces a marriage certificate from a state, territory or foreign country that recognizes same-sex marriage. However, UAS will provide continuation benefits to Sponsored Dependents on the same terms and conditions as if they were qualified beneficiaries under COBRA.

Possible situations involving Sponsored Dependents and COBRA issues are as follows:

- If a Sponsored Dependent's insurance is cancelled as a result of termination of the sponsoring employee's employment, or the Sponsored Dependent no longer qualifies as a dependent, the individual who loses the coverage will be eligible to continue the insurance voluntarily for a period of 18 to 36 months, depending upon the reason for the loss of coverage.
- If an employee with a covered Sponsored Dependent terminates employment and chooses COBRA coverage for 18 months, the employee may continue coverage for his or her Sponsored Dependents for the same 18 month period.
- If the employee does not elect COBRA coverage, the employee's covered Sponsored Dependents may not make a separate election to continue their coverage.
- A former employee on COBRA may add a Sponsored Dependent in the same manner as is permitted for active employees with spouses. However, should the former employee die or should the Sponsored Dependent cease to meet the eligibility requirements, the Sponsored Dependent may not make an election under COBRA or this policy as a second qualifying event.

Questions related to COBRA, continuation coverage under this policy and notification of qualifying events should be directed to the UAS HR Service Center, located at 500 University Boulevard East Tuscaloosa, AL 35401. Written notification of qualifying events (such as loss of eligibility) for COBRA or continuation coverage must be provided within 60 days or coverage will not be available.
Ineligible Dependents

- Stepchildren, who live in the same household, but who are not legal dependents of the covered employee or their lawful spouse, are not eligible for coverage under this health plan.
- Ex-spouses of covered employees are not eligible for coverage after being removed from a covered family contract by divorce or other legal reasons once the ex-spouse's COBRA rights have expired.

Beginning of Coverage

Regular Enrollment
If you apply within 30 days after the date on which you meet the plan's eligibility requirements (including any applicable waiting periods established by your group), your coverage will begin the first day of the month after you have met the eligibility requirements and applied. If you are a new employee, coverage will not begin earlier than the first day on which you report to active duty.

Annual Enrollment
You may also enroll during your group's annual open enrollment period, if any. Your coverage will begin on the date specified by your group following your enrollment.

Special Enrollment Period for Individuals Losing Other Coverage
An employee or dependent (1) who does not enroll during the first 30 days of eligibility because the employee or dependent has 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. Coverage will be effective no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment, 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).

Special Enrollment Period for Newly Acquired Dependents
If you have a new dependent as a result of marriage, birth, placement for adoption, or adoption, you may enroll yourself and/or your spouse and your new dependent provided that you request enrollment within 30 days of the event. The effective date of coverage will be the date of birth, placement for adoption, or adoption. In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

Special Enrollment Period Related to Medicaid and SCHIP
An employee or dependent who loses coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage may enroll in the plan provided that the employee or dependent requests enrollment within 60 days of the termination of coverage. An employee or dependent who becomes eligible for premium assistance under Medicaid or SCHIP for coverage under the plan may also enroll in the plan provided that the employee or dependent requests enrollment within 60 days of becoming eligible for such premium assistance. Coverage will be effective no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

If we accept your application, you will receive an identification card. If we decline your application, all the law requires us to do is refund any fees paid.
Qualified Medical Child Support Orders

If the group (the plan administrator) receives an order from a court or administrative agency directing the plan to cover a child, the group will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The group has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting your group.

The plan will cover an employee's child if required to do so by a QMCSO. If the group determines that an order is a QMCSO, we will enroll the child for coverage effective as of a date specified by the group, but not earlier than the later of the following:

- If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.
- If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the group may increase the employee's payroll deductions. During the period the child is covered under the plan as a result of a QMCSO, all plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the QMCSO is in effect we will make benefit payments—other than payments to providers—to the parent or legal guardian who has been awarded custody of the child. We will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the plan. We will also send claims reports directly to the child's custodial parent or legal guardian.

Relationship to Medicare

You must notify your group when you or any of your dependents become eligible for Medicare. Except where otherwise required by federal law (as explained below), the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare in accordance with the rules explained below, this plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible. For more information about how this plan coordinates with Medicare, please read the section entitled Coordination of Benefits.

In determining the size of your group for purposes of the following provisions, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if your group participates in an association plan.

Employers with 20 or More Employees

If your group employs 20 or more employees and if you continue to be actively employed when you are age 65 or older, you and your spouse will continue to be covered for the same benefits available to employees under age 65. In this case, the plan will pay all eligible expenses first. If you are enrolled in Medicare, Medicare will pay for Medicare eligible expenses, if any, not paid by the plan.

If both you and your spouse are over age 65, you may elect to enroll in Medicare and disenroll completely from the plan. This means that you will have no benefits under the plan. You may also purchase a Medicare Supplement contract suited for the parts of Medicare in which you have enrolled. In addition, the group is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract.
If you are age 65 or older, considering retirement, and think you may need to buy COBRA coverage after you retire, you should read the section below dealing with COBRA coverage—particularly the discussion under the heading Medicare and COBRA Coverage.

Other Medicare Rules

Disabled Individuals: If you or your spouse is eligible for Medicare due to disability and is also covered under the plan by virtue of your current employment status with the group, Medicare will be considered the primary payer (and the plan will be secondary) if your group normally employed fewer than 100 employees during the previous calendar year. If your group normally employed 100 or more employees during the previous calendar year, the plan will be primary and Medicare will be secondary.

End-Stage Renal Disease: If you are eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), the plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility (regardless of the size of the group). Thereafter, Medicare will be primary and the plan will be secondary.

Medicare Part D Prescription Drug Coverage

If the plan does not provide "creditable" prescription drug benefits—that is, the plan's prescription drug benefits are not at least as good as standard Medicare Part D prescription drug coverage, you should enroll in Part D of Medicare when you become eligible for Medicare. Your group will tell you whether the plan's prescription drug benefits are at least as good as Medicare Part D.

If you have any questions about coordination of your coverage with Medicare, please contact your group for further information. You may also find additional information about Medicare at www.medicare.gov.

Termination of Coverage

Plan coverage will terminate the last day of the month following the date of one of the following events:

- The end of the month following the date in which the employee fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the Leaves of Absence rules below);
- For spouses, the end of the month following the date of divorce or other termination of marriage;
- For children, the end of the month in which a child reaches age 26;
- For the employee and his or her dependents, the end of the month following the date of the employee's death;
- For eligible incapacitated children over age 26, the end of the month following the date the child no longer meets incapacitated eligibility requirements;
- You fail to pay your group any contribution amount due within 30 days after the day due; or
- Upon discovery of fraud or intentional misrepresentation of a material fact by you.

In all cases, the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and your dependents 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.

Our contract with your group (and your coverage as administered by us) will end as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

- Your group fails to pay us the amount due within 30 days after the day due;
- Upon discovery of fraud or intentional misrepresentation of a material fact by your group;
- Any time your group fails to comply with the contribution or participation rules in the plan documents;
- When none of your group's members still live, reside or work in Alabama; or,
• On 30-days advance written notice from your group to us.

In all cases except the last item above, the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and all other employees 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.

• If an employee terminates employment before the 15th day of the month, their health care coverage will end on the last day of the month in which they were employed during the month the employee was terminated.

• If an employee terminates employment on or after the 15th day of the month, their health care coverage will end on the last day of the next month provided that all necessary employee contributions were collected by the employer during the month the employee was terminated.

• If an employee with single coverage dies, then their coverage ends on the day after their date of death.

• If an employee with family coverage dies before the 15th day of the month, then the family coverage for the surviving spouse and dependents will end on the last day of the month the employee died.

• If an employee with family coverage dies after the 15th day of the month, then the family coverage for the surviving spouse and dependents will end on the last day of the next month after the employee died.

**HIPAA Certificates of Creditable Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) creates a concept known as “creditable coverage.” Your coverage under this plan is considered creditable coverage under HIPAA. If you have sufficient creditable coverage under this plan and you do not incur a break in coverage (63 continuous days of no creditable coverage), you may be able to reduce or eliminate the application of a pre-existing illness exclusion in another health plan. For plan years beginning in 2014, pre-existing condition exclusions are prohibited.

At any time up to 24 months after the date on which your coverage ceases under the plan, you may request a copy of a certificate of creditable coverage. In order to request this certificate, you or someone on your behalf must call or write Customer Service.

**Leaves of Absence**

If your group is covered by the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to employers who employ 50 or more employees working each day during 20 or more calendar work weeks during the current or preceding calendar year within a 75 mile radius of the worksite. You should contact your group to determine whether a leave qualifies as FMLA leave.

**Approved Leaves of Absence**

If you are an eligible employee, and are either ineligible for FMLA, or have exhausted your available FMLA leave, you may continue coverage for yourself and your eligible dependents during a company approved leave of absence at the manager’s discretion including sick leave, provided that you continue to pay the premiums. Coverage during your approved leave of absence will cease if you choose to drop coverage during such leave, you fail to pay the required premium by the applicable deadline, your leave continues longer than approved by The UA System Office, you do not return to active employment after such leave, or you inform The UA System Office that you do not intend to return to active employment after such leave. You and your eligible dependents may be eligible for COBRA continuation coverage (discussed below) as of the date that coverage ceases. Contact The UA System Office to determine whether your leave qualifies as an approved leave of absence and the procedure for paying premiums during your leave.
Leaves of Absence under Family and Medical Leave Act (FMLA)

If you are an eligible employee, you may continue coverage for yourself and your eligible dependents during an approved leave of absence that qualifies as FMLA leave. If you return to work immediately following your approved FMLA leave, your coverage and your eligible dependents' coverage will continue uninterrupted. Coverage during your approved FMLA leave will cease if you choose to drop coverage during such leave, you fail to pay the required premium by the applicable deadline, you do not return to active employment after such leave, or you inform The UA System Office that you do not intend to return to active employment after such leave. You and your eligible dependents may be eligible for COBRA continuation coverage (discussed below) as of the date that coverage ceases. You should contact The UA System Office to determine whether a leave qualifies as FMLA leave and the procedure for paying premiums during your leave.

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should see your group for information about your rights to continue coverage under the plan.

**COST SHARING**

<table>
<thead>
<tr>
<th>Calendar Year Deductible</th>
<th>$250</th>
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<tr>
<td>(three per family)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Calendar Year Out-of-Pocket Maximum</th>
<th>$1,250</th>
</tr>
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<tbody>
<tr>
<td>(12,700 aggregate per family)</td>
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</table>

Certain benefits pay at 100% of the allowed amount thereafter.

**Calendar Year Deductible**

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

Here are some special rules concerning application of the calendar year deductible:

- The calendar year deductible must be satisfied on a per person per calendar year basis, subject to the family maximum.
- Only one calendar year deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- The deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

**Calendar Year Out-of-Pocket Maximum**

The calendar year out-of-pocket maximum is specified in the table above. All cost-sharing amounts (calendar year deductible, copayment and coinsurance) for in-network covered services and out-of-network mental health and substance abuse covered services for medical emergencies that you or your family are required to pay under the plan apply to the calendar year out-of-pocket maximum. Once the maximum has been reached, covered expenses of the type that count towards the maximum will be paid at 100% of the allowed amount for the remainder of the calendar year.

There may be many expenses you are required to pay under the plan that do not count towards the calendar year out-of-pocket maximum, and that you must continue to pay even after you have met the calendar year out-of-pocket maximum. The following are some examples:
- Out-of-network cost-sharing amounts (deductibles, copayments, coinsurance) on out-of-network services (except out-of-network mental health and substance abuse covered services for medical emergencies);
- 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).

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

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

**Other Cost Sharing Provisions**

The plan may impose other types of cost sharing requirements such as the following:
- **Per admission deductibles:** These apply upon admission to a hospital. Only one per admission deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- **Copayments:** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor’s office.
- **Coinsurance:** Coinsurance is the amount that you must pay as a percent of the allowed amount. A common example is the percentage of the allowed amount that you must pay when you receive other covered services.
- **Amounts in excess of the allowed amount:** As a general rule, and as explained in more detail in Definitions, the allowed amount may often be significantly less than the provider’s actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with us or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount. For example: Out-of-network provider claims may include expensive ancillary charges (billed by the facility or a physician) such as implantable devices for which no extra reimbursement is available as these charges are not separately considered under the plan. This means you will be responsible for these charges if you use an out-of-network provider.

**Out-of-Area Services**

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

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

A. BlueCard® Program

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

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

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Alabama.

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

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

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

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the negotiated price [lower of either billed covered charges or negotiated price] (Refer to the description of negotiated price under Section A., BlueCard Program) made available to Blue Cross and Blue Shield of Alabama by the Host Blue.

C. Non-Participating Healthcare Providers Outside the Blue Cross and Blue Shield of Alabama Service Area

5. Member Liability Calculation

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

6. Exceptions

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

HEALTH BENEFITS

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

Inpatient Hospital Benefits

Attention: Preadmission certification is required for all hospital admissions except emergency hospital admissions and maternity admissions.

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

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

Preadmission certification does not mean that your admission is covered. It only means that we have approved the medical necessity of the admission.

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, no benefits will be payable for the hospital admission or the services of the admitting physician.

<table>
<thead>
<tr>
<th>SERVICE OR SUPPLY</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
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<tbody>
<tr>
<td>First 365 days of care during each confinement in a General Hospital or Psychiatric Specialty Hospital (combined in-network and out-of-network)</td>
<td>100% of the allowed amount, subject to a $250 deductible per admission</td>
<td>80% of the allowed amount, subject to a $250 deductible per admission</td>
</tr>
<tr>
<td>Days of confinement extending beyond the 365-day benefit maximum (available in a General Hospital only)</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>$5 per day allowance for the difference between private and semi-private room rate</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
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</tbody>
</table>

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.

Inpatient hospital benefits consist of the following if provided during a hospital stay:
• Bed and board and general nursing care in a semiprivate room;
• Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them;
• Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
• Administration of anesthetics by hospital employees and all necessary equipment and supplies;
• casts, splints, surgical dressings, treatment and dressing trays;
• Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and X-rays;
• Physical therapy, hydrotherapy, radiation therapy, and chemotherapy;
• Oxygen and equipment to administer it;
• All drugs and medicines used by you if administered in the hospital;
• Regular nursery care and diaper service for a newborn baby while its mother has coverage;
• 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.

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### Outpatient Hospital Benefits

<table>
<thead>
<tr>
<th>SERVICE OR SUPPLY</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery (including ambulatory surgical centers)</td>
<td>100% of the allowed amount, subject to a $75 facility copayment</td>
<td>80% of the allowed amount, subject to a $75 facility copayment</td>
</tr>
<tr>
<td>Emergency room – medical emergency</td>
<td>100% of the allowed amount, subject to a $75 facility copayment</td>
<td>100% of the allowed amount, subject to a $75 facility copayment</td>
</tr>
<tr>
<td>Emergency room – accident</td>
<td>100% of the allowed amount, subject to a $75 facility copayment</td>
<td>100% of the allowed amount, subject to a $75 facility copayment</td>
</tr>
<tr>
<td>MRI(s), CAT Scans, Cardiac Scans and Procedures, PET Scans, Thallium Scans</td>
<td>100% of the allowed amount, subject to a $75 facility copayment</td>
<td>80% of the allowed amount, subject to a $75 facility copayment</td>
</tr>
<tr>
<td>Outpatient diagnostic lab, X-ray, and pathology</td>
<td>100% of the allowed amount, no deductible or copayment Note: In Alabama, precertification is required for certain services. Go to <a href="http://www.AlabamaBlue.com">www.AlabamaBlue.com</a> for more information about this. If precertification is not obtained, no benefits will be payable under the plan.</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Outpatient dialysis, IV therapy, chemotherapy, and radiation therapy</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
</tbody>
</table>
### Service or Supply

<table>
<thead>
<tr>
<th>Service or Supply</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services billed by the facility for an emergency room visit when the patient's</td>
<td>80% of the allowed amount, subject to the calendar year deductible and a $75</td>
<td>80% of the allowed amount, subject to the calendar year deductible and a $75</td>
</tr>
<tr>
<td>condition does not meet the definition of a medical emergency (including any lab</td>
<td>facility copayment</td>
<td>facility copayment</td>
</tr>
<tr>
<td>and X-ray exams and other diagnostic tests associated with the emergency room fee)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient hospital services for mental health and/or substance abuse</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>100% of the allowed amount, no deductible or copayment</td>
</tr>
<tr>
<td>Outpatient hospital services or supplies not listed above and not listed in the</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>section of this booklet called Other Covered Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

If multiple surgical or diagnostic procedures are performed on the same day only one facility copay will apply if applicable.

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

### Physician Benefits

**Attention:** The benefits listed below apply only to the physician's charges for the services indicated. Claims for outpatient facility charges associated with any of these services will be processed under your outpatient hospital benefits and subject to any applicable outpatient copayments. Examples may include 1) laboratory testing performed in the physician's office, but sent to an outpatient hospital facility for processing; 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

<table>
<thead>
<tr>
<th>Service or Supply</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits, consultations, and psychotherapy</td>
<td>100% of the allowed amount, no deductible, subject to a $25 copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Note: Office visits for mental health and substance abuse will not be subject to a</td>
<td>Note: Nurse Practitioners and Midwives acting within the scope of their</td>
<td></td>
</tr>
<tr>
<td>copayment</td>
<td>license are subject to a $20 copayment</td>
<td></td>
</tr>
<tr>
<td>Emergency room physician</td>
<td>100% of the allowed amount, no deductible, subject to a $25 copayment</td>
<td>100% of the allowed amount, no deductible, subject to a $25 copayment</td>
</tr>
<tr>
<td>Note: Nurse Practitioners and Midwives acting within the scope of their license</td>
<td>Note: Nurse Practitioners and Midwives acting within the scope of their</td>
<td></td>
</tr>
<tr>
<td>are subject to a $20 copayment</td>
<td>license are subject to a $20 copayment</td>
<td></td>
</tr>
<tr>
<td>Surgery, second surgical opinion, and anesthesia for a covered service</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Note: Surgery in the physician's office is 100% of the allowed amount, subject to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a $25 copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity care</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Inpatient visits</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>SERVICE OR SUPPLY</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>Inpatient consultations by a specialty provider (limited to one consult per specialist per stay)</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Diagnostic lab, X-rays, and pathology</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Note: In Alabama, precertification is required for certain services. Go to <a href="http://www.AlabamaBlue.com">www.AlabamaBlue.com</a> for more information about this. If precertification is not obtained, no benefits will be payable under the plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy and radiation therapy</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Psychological testing</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Allergy testing and treatment</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Note: Office visit associated with allergy testing or treatment is subject to the applicable office visit copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI's, Cat Scans and Endoscopic Procedures</td>
<td>100% of the allowed amount, no deductible, subject to a $25 copayment</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Physician services for mental health and substance abuse</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>100% of the allowed amount, no deductible or copayment</td>
</tr>
</tbody>
</table>

**Attention:** If you receive care from an out-of-network physician in the Alabama service area, benefits will be subject to the calendar year deductible and limited to 50% of the allowed amount except for a medical emergency in the emergency room of a hospital.

**Attention:** If you receive other out-of-network physician services (such as out-of-network laboratory services) for a medical emergency in the emergency room of a hospital, those services will also be paid with the applicable in-network coinsurance and/or copayment amounts for such physician benefits described in the matrix above, but subject to the calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the applicable requirements of the Patient Protection and Affordable Care Act.

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.
### Physician Preventive Benefits

**Attention:** In some cases, routine immunizations and routine preventive services may be billed separately from your office visit or other facility visit. In that case, and in all cases where the primary purpose for your visit is not routine preventive services and/or routine immunizations, the applicable office visit or outpatient facility copayments under your Physician Benefits or Outpatient Hospital Benefits may apply.

<table>
<thead>
<tr>
<th>SERVICE OR SUPPLY</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine preventive services and immunizations:</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>(See <a href="#">www.AlabamaBlue.com/preventiveservices</a> for a listing of specific preventive services and immunizations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria vaccine (when approved)</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine Laboratory Tests, including</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Complete Blood Count and Urinalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automated Multichannel Lab Test</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Covers up to 22 clinical chemistry tests; limited to one each calendar year for ages 19 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Thyroid Profile</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Limited to one each calendar year for ages 50 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine EKG</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>One each calendar year for ages 50 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Chest X-Ray</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Limited to ages 35 and over at the PPO Physician's discretion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Lead Screening</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Limited to two screenings during the first four years of a child's life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB Skin Test:</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Limited to one each calendar year through age six, one between the ages of seven and 18, one between the ages of 19 and 34, and one for ages 35 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CA125 Blood Test</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Limited to female members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone Mineral Density Screening</td>
<td>100% of the allowed amount, no deductible or copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Limited to one scan every two years for ages 40 and over</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Other Covered Services

<table>
<thead>
<tr>
<th>SERVICE OR SUPPLY</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident-related dental services, which consist of treatment of natural teeth</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>injured by force outside your mouth or body if initial services are received within</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 days of the injury; if initial services are received within 90 days of the injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>subsequent treatment is allowed for up to 180 days from the date of injury without</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pre-authorization; subsequent treatment beyond 180 days must be pre-authorized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and is limited to 18 months from the date of injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident-related dental services, which consist of treatment of natural teeth</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>injured by force outside your mouth or body if initial services are received within</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 days of the injury; if initial services are received within 90 days of the injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>subsequent treatment is allowed for up to 180 days from the date of injury without</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pre-authorization; subsequent treatment beyond 180 days must be pre-authorized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and is limited to 18 months from the date of injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance services</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Chiropractic: Professional services of a licensed chiropractor practicing within the</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>Non-participating chiropractors in Alabama: 50% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>scope of his license</td>
<td></td>
<td>Non-participating chiropractors outside Alabama: 80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Limited to 24 visits per person each calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis services at a renal dialysis facility</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>DME: Durable medical equipment and supplies, which consist of the following: (1)</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>artificial arms and other prosthetics, leg braces, and other orthopedic devices;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bags and supplies, and splints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglasses or contact lenses: One pair will be covered if medically necessary to</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>replace the human lens function as a result of eye surgery or eye injury or defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health and hospice care within the state of Alabama</td>
<td>100% of the allowed amount, no deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Home health and hospice care outside the state of Alabama</td>
<td>100% of the allowed amount, no deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible; precertification is required – call 1-800-821-7231</td>
</tr>
<tr>
<td>Occupational therapy services for the hand and/or treatment of lymphedema</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 20 visits per person each calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical therapy</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Speech therapy</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
<td>80% of the allowed amount, subject to the calendar year deductible</td>
</tr>
<tr>
<td>Limited to a maximum of 20 visits per person each calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling by a Nutritionian</td>
<td>100% of the allowed amount, no deductible, subject to a $20 copayment</td>
<td>100% of the allowed amount, no deductible, subject to a $20 copayment</td>
</tr>
<tr>
<td>Limited to eight visits per member each calendar year</td>
<td></td>
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</tr>
</tbody>
</table>
## Prescription Drug Benefits

<table>
<thead>
<tr>
<th>SERVICE OR SUPPLY</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs</td>
<td>100% of the allowed amount subject to the following copays:</td>
<td>75% of the allowed amount subject to the following copays:</td>
</tr>
<tr>
<td><strong>Non-maintenance drugs (1-31-day supply):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15 copay for generic drugs</td>
<td></td>
<td>Non-maintenance drugs (1-31-day supply):</td>
</tr>
<tr>
<td>$35 copay for preferred brand name</td>
<td></td>
<td>$15 copay for generic drugs</td>
</tr>
<tr>
<td>$35 copay for non-preferred brand name</td>
<td></td>
<td>$35 copay for preferred brand name</td>
</tr>
<tr>
<td>$35 copay for any brand name drug with a generic alternative</td>
<td></td>
<td>$35 copay for non-preferred brand name</td>
</tr>
<tr>
<td><strong>Maintenance drugs (1-31-day supply):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15 copay for generic drugs</td>
<td></td>
<td>Maintenance drugs (1-31-day supply):</td>
</tr>
<tr>
<td>$35 copay for preferred brand name</td>
<td></td>
<td>$15 copay for generic drugs</td>
</tr>
<tr>
<td>$35 copay for non-preferred brand name</td>
<td></td>
<td>$35 copay for preferred brand name</td>
</tr>
<tr>
<td>$35 copay for any brand name drug with a generic alternative</td>
<td></td>
<td>$35 copay for non-preferred brand name</td>
</tr>
<tr>
<td><strong>Maintenance drugs (32 up to a 60-day supply):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$30 copay for generic drugs</td>
<td></td>
<td>Maintenance drugs (32 up to a 60-day supply):</td>
</tr>
<tr>
<td>$70 copay for preferred brand name</td>
<td></td>
<td>$30 copay for generic drugs</td>
</tr>
<tr>
<td>$70 copay for non-preferred brand name</td>
<td></td>
<td>$70 copay for preferred brand name</td>
</tr>
<tr>
<td>$70 copay for any brand name drug with a generic alternative</td>
<td></td>
<td>$70 copay for non-preferred brand name</td>
</tr>
<tr>
<td><strong>Specialty drugs: (limited to a 31-day supply):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$35 copay per month for generic, preferred brand or non-preferred brand name drugs</td>
<td></td>
<td>Specialty drugs: (limited to a 31-day supply):</td>
</tr>
</tbody>
</table>

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

- In-network pharmacies are pharmacies that have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense prescription drugs.

- To determine whether a drug is a preferred brand drug, see the [Prescription Drug Guide](#) found in the “My Blue Cross” section of our website. Once there, you can download a copy of the current preferred brand drug list or 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 is considered a non-preferred drug.
  
  - A generic drug is one that the FDA has approved under an Abbreviated New Drug Application (ANDA) and no New Drug Application (NDA) is on file. A generic drug is also one that is manufactured by more than one manufacturer and is designated as a multi-source product by the major drug database providers, Medispan and First DataBank.
When a member gets a brand name prescription when generic alternative is available, the member is responsible for the difference in drug cost between brand and generic, plus the retail copay.

**Attention:** Just because a drug is on the preferred brand drug list or any other list on our website 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.

- To be eligible for benefits, drugs must be FDA approved legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, “Caution: Federal law prohibits dispensing without a prescription.”

- 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 this is the case.

- Drugs dispensed from non-participating pharmacies outside Alabama have the same benefits as drugs dispensed from participating pharmacies. If you use a non-participating pharmacy you must pay any difference above the amount we would pay a participating pharmacy.

- 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 “My Blue Cross” section of our website. Even though your physician has written a prescription for a drug, the drug may not be covered or a clinical edit(s) may apply (i.e., prior authorization, step therapy, quantity limitation). The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. You may call the customer service number on your card for more information. 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.

- Specialty drugs are prescription drugs often referred to as biotech drugs or biologics, which include high cost oral, injectable, and infusion drugs that are administered for specific chronic conditions, such as (including but not limited to) hemophilia, fertility, multiple sclerosis, and rheumatoid arthritis. Visit the most current Specialty Drug List at [www.bcbsal.com](http://www.bcbsal.com).

- Drugs can be dispensed up to a maximum 31-day supply. You must satisfy the copayment requirement for each 31-day supply. Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used (e.g., 23 days in a 30-day supply).

- Maintenance drugs (including certain diabetic supplies) can be dispensed up to a maximum of a 60-day supply. You must satisfy the copayment requirement for each 30-day supply. In-network pharmacies should have a list of maintenance drugs.

- Insulin, needles, and syringes purchased on the same day will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day will have one copayment. Otherwise, each has a separate copayment. Glucose monitors always have a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan.
## Mail Order Prescription Drug Benefits

<table>
<thead>
<tr>
<th>SERVICE OR SUPPLY</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs may be purchased through a mail-order program with PrimeMail (1-800-391-1886) <a href="http://www.caremark.com">www.caremark.com</a></td>
<td>100% of the allowed amount, subject to the following copays:</td>
<td>Non-covered</td>
</tr>
<tr>
<td><strong>Maintenance drugs</strong> (1 - 31-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$5 copay for generic drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20 copay for preferred brand name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20 copay for non-preferred brand name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20 copay for any brand name drug with a generic alternative</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(32-60-day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10 copay for generic drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$35 copay for preferred brand name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$35 copay for non-preferred brand name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$35 copay for any brand name drug with a generic alternative</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(61-90-day supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15 copay for generic drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$70 copay for preferred brand name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$70 copay for non-preferred brand name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$70 copay for any brand name drug with a generic alternative</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-maintenance drugs</strong> (limited to a 31-day supply)</td>
<td></td>
<td></td>
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<tr>
<td>$5 copay for generic drugs</td>
<td></td>
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<tr>
<td>$20 copay for preferred brand name</td>
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<tr>
<td>$20 copay for non-preferred brand name</td>
<td></td>
<td></td>
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<tr>
<td>$20 copay for any brand name drug with a generic alternative</td>
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<tr>
<td><strong>Specialty drugs</strong> (limited to a 31-day supply):</td>
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<tr>
<td>$25 copay per month for generic, preferred brand or non-preferred brand name drugs</td>
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</table>

- Prescriptions are also available by mail through a participating mail order pharmacy for maintenance drugs only. Contact your group for a brochure and order form.
- Mail order non-maintenance drugs can be dispensed up to a 31-day supply. The copay is due for each 31-day supply.
• Mail order maintenance drugs can be dispensed up to a 90-day supply. Copayments are applicable according to the information in the Mail Order Prescription Drug Benefits table above.

• Copayments are applicable according to information in the prescription drug benefits information above.

Health Management Benefits

<table>
<thead>
<tr>
<th>HEALTH MANAGEMENT BENEFITS</th>
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<tbody>
<tr>
<td>Individual Case Management</td>
</tr>
<tr>
<td>Disease Management</td>
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</tbody>
</table>

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

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

Additional Benefit Information

Air Medical Services

Air ambulance service to a hospital near home is covered if you were hospitalized while traveling more than 150 miles from home. To arrange transportation, call AirMed at 1-877-872-8624.

American Cancer Society Smoking Quitline

A tobacco cessation program for employees, spouses, and dependents age 18 and over that provides support to participant through telephone based counseling and nicotine replacement therapy. Call 1-888-768-7848 for participation information.

Baby Yourself Program

If a covered female employee or a covered female spouse of a covered male employee 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 and thorough prenatal 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.)

The hospital deductible will be waived on maternity inpatient admissions if the covered female employee or a covered female spouse of a covered male employee enrolls during the first trimester of pregnancy and participates in the Baby Yourself Program until the completion of the pregnancy.

**Mastectomy and Mammograms**

**Women's Health and Cancer Rights Act Information:**

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

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

**Benefits for Mammograms:**

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

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

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

- In all other cases the claim will be subject to the provisions and limitations described elsewhere in this booklet, including the section called **Physician Preventive Benefits**.

**Organ and Bone Marrow Transplants**

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

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

Transplant benefits for living donor expenses are limited to:

- solid organs: testing for related and unrelated donors as pre-approved by us
- bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrow registry
- prediagnostic testing expenses of the actual donor for the approved transplant
- hospital and surgical expenses for removal of the donor organ, and all such services provided to the donor during the admission
- transportation of the donated organ
- post-operative hospital, medical, laboratory and other services for the donor related to the organ transplant limited to up to 90 days of follow-up care after date of donation.
All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copays, coinsurance, and other plan limitations. For example, if the member's coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

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

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

**Air Medical Transportation**

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

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

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

**Routine Vision Care**

<table>
<thead>
<tr>
<th>ROUTINE VISION CARE BENEFITS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
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<tbody>
<tr>
<td>Routine vision care</td>
<td>80% of the allowed amount, not subject to the calendar year deductible</td>
<td>80% of the allowed amount, not subject to the calendar year deductible</td>
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<tr>
<td>Limited to one exam per person each calendar year</td>
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**COORDINATION OF BENEFITS (COB)**

COB is a provision designed to help manage the cost of healthcare by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary. A primary plan is one whose benefits for a person's healthcare coverage must be determined first without taking the existence of any other plan into consideration. A secondary plan is
one which takes into consideration the benefits of the primary plan before determining benefits available under its plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

**Order of Benefit Determination**

Which plan is primary is decided by the first rule below that applies:

**Noncompliant Plan:** If the other plan is a noncompliant plan, then the other plan shall be primary and this plan shall be secondary unless the COB terms of both plans provide that this plan is primary.

**Employee/Dependent:** The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

**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.

**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:

1. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
   a. first, the plan of the custodial parent;
   b. second, the plan covering the custodial parent's spouse;
   c. third, the plan covering the non-custodial parent; and,
   d. last, the plan covering the non-custodial parent's spouse.
2. If a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.
   a. If the court-ordered parent has no healthcare coverage for the dependent child, benefits will be determined in the following order:
      a. first, the plan of the spouse of the court-ordered parent;
      b. second, the plan of the non-court-ordered parent; and,
      c. third, the plan of the spouse of the non-court-ordered parent.
   b. If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of “Dependent Child – Parents Not Separated or Divorced” (the “birthday rule”) above shall determine the order of benefits.
3. 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, as applicable, under the “birthday rule” as if those individuals were parents of the child.
Active Employee or Retired or Laid-Off Employee:
1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

COBRA or State Continuation Coverage:
1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the “COBRA plan”) and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the “COBRA plan”) and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

Longer/Shorter Length of Coverage: If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

Equal Division: If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Determination of Amount of Payment
1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is a secondary plan on a claim, should it wish to coordinate benefits (that is, pay benefits as a secondary plan rather than as a primary plan with respect to that claim), this plan shall calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. When paying secondary, this plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage. In some instances, 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.
COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term “allowable expense” means any healthcare expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

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

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for mental health disorders and substance abuse, dental services and supplies, vision care, prescriptions drugs, or hearing aids, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term “allowable expense” does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

Birthday: 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.

Custodial Parent: The term “custodial parent” means:

- A parent awarded custody of a child by a court decree; or,
- 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.

Group-Type Contract: The term “group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. The term does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Hospital Indemnity Benefits: The term “hospital indemnity benefits” means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Noncompliant Plan: The term “noncompliant plan” means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are “excess” or “always secondary.”

Plan: The term “plan” includes 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 non-group or individual health or medical reimbursement insurance contracts. The term “plan” also 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.

Primary Plan: The term “primary plan” means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:
• The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or,
• All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan: The term “secondary plan” means a plan that is not a primary plan.

Right to Receive and Release Needed Information
Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable 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 are not required to 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 these COB rules and to determine benefits payable as a result of these rules.

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

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

Special Rules for Coordination with Medicare
Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare’s coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare’s coverage if you fail to enroll in Medicare when eligible.

SUBROGATION

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

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

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

**Right to Recovery**

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

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney’s fees charged you by your attorney for obtaining the recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney’s fee for your attorney.

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

**HEALTH BENEFIT EXCLUSIONS**

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

A

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

Anesthesia services or supplies or both by local infiltration.

Services or expenses for or related to Assisted Reproductive Technology (ART). ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.
Services or expenses of a hospital stay, except one for an emergency, unless we certify it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 48 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.

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

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

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

Services or expenses for sanitarium care, convalescent care, or rest care, including care in a nursing home.

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 field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.

Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.

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

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

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

Eyeglasses or contact lenses or related examinations or fittings, except under the limited circumstances set forth in the section of this booklet called Other Covered Services. This exclusion does not apply to benefits stated in Routine Vision Care benefits.

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. This exclusion does not apply to benefits stated in Routine Vision Care benefits.

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

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

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.

Hearing aids or examinations or fittings for them.

Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including investigational services that are part of a clinical trial. Under federal law, the plan cannot deny a member participation in an approved clinical trial, is prohibited from dropping coverage because member chooses to participate in an approved clinical trial, and from denying coverage for routine care that the plan would otherwise provide just because a member is enrolled in an approved clinical trial. This applies to all approved clinical trials that treat cancer or other life-threatening diseases.
Services or expenses that you are not **legally obligated to pay**, or for which no charge would be made if you had no health coverage.

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

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.

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

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.

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 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 does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines of Blue Cross. Benefits will only be provided for one surgical procedure for obesity (morbid) per member under this plan. Benefits will be provided for a subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) only if medically necessary and in compliance with the guidelines of Blue Cross. However, no benefits will be provided for subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) (including revisions or adjustments to a covered surgical procedure or conversion to another covered bariatric procedure) if the complications arise from non-compliance with medical recommendations regarding patient activity and lifestyle following the procedure. This exclusion for subsequent surgery for complications that arise from non-compliance with medical recommendations applies even if the subsequent surgery would otherwise be medically necessary and would otherwise be in compliance with the guidelines of Blue Cross.

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

**Private duty nursing.**

Services or supplies provided by **psychiatric specialty hospitals** that do not participate with nor are considered members of any Blue Cross and/or Blue Shield plan.
R

Services or expenses for recreational or educational therapy.

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

Services or expenses for learning or vocational rehabilitation.

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

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

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

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

S

Services or expenses for, or related to, sexual dysfunctions or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition) or which are related to surgical sex transformations.

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

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

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

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

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 for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under Other Covered Services.

Services provided through teleconsultation.

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

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

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

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

W

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

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

CLAIMS AND APPEALS

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 a partial or complete denial of a claim.

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

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

Post-Service Claims

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

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our customer service department and ask for a claim form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper
type of 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.

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

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

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

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

**Pre-Service Claims**

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If we grant a pre-service claim, we are not telling you that the service or supply is, or will be, covered; we are only telling you that the service or supply meets our medical necessity guidelines.

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

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD Physician). If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you. For home healthcare and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

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

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

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

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

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

**Concurrent Care Determinations**

**Determinations by Us to Limit or Reduce Previously Approved Care:** If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

**Requests by You to Extend Previously Approved Care:** If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

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

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, we will give you our decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above.
Your Right To Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If 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. If we obtained advice from a healthcare professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Appeals

The rules in this section of this booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

- Any determination we make with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- Our denial of a pre-service claim;
- An adverse concurrent care determination (for example, we deny your request to extend previously approved care); or,
- Your group's denial of your or your dependents' initial eligibility for coverage under the plan or your group's retroactive rescission of your or your dependents' coverage for fraud or intentional misrepresentation of a material fact.

In all cases other than determinations by us to limit or reduce previously approved care and determinations by your group regarding initial eligibility or retroactive rescission, you have 180 days following our adverse benefit determination within which to submit an appeal.

How to Appeal Your Group's Adverse Eligibility and Rescission Determinations: If you wish to file an appeal of your group’s adverse determination relating to initial eligibility for coverage or retroactive rescission of coverage, you should check with your group regarding your group's appeal procedures.

How to Appeal Post-Service Adverse Benefit Determinations: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our customer service department. You may also go to our Internet website at www.AlabamaBlue.com. Once there, you may request a copy of the form.

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

- The patient's name;
- The patient's contract number;
- 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,
- A statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P.O. Box 12185
Birmingham, Alabama 35202-2185
Please note that if you call or write us without following the rules just described 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.

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

If over the phone, you should call the appropriate phone number listed below:
- For inpatient hospital care and admissions, call 205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network physical therapy or occupational therapy (if covered by your plan) call 205-220-7202.
- For care from an in-network chiropractor (if covered by your plan) call 205-220-7202.

If in writing, you should send your letter to the appropriate address listed below:
- For inpatient hospital care and admissions:
  Blue Cross and Blue Shield of Alabama
  Attention: Health Management – Appeals
  P.O. Box 2504
  Birmingham, Alabama 35201-2504

  or

- For in-network physical therapy, occupational therapy, or care from an in-network chiropractor (when covered by your plan):
  Blue Cross and Blue Shield of Alabama
  Attention: Health Management – Appeals
  P.O. Box 362025
  Birmingham, Alabama 35236

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

Please note that if you call or write us without following the rules just described 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.

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

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

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

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

If your appeal arises out of a determination by us to limit or reduce a hospital stay or course of treatment that we previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), we will make a decision on your appeal as soon as possible, but in any event
before we impose the limit or reduction.

If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), we will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

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

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

- You may ask our Customer Service Department for further help;
- You may file a voluntary appeal (discussed below);
- You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below); or
- You may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

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 adverse benefit 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.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

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

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

Expeditied External Reviews for Urgent Pre-Service Claims
If your pre-service claim meets the definition of urgent under law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be
adequately controlled while you wait for a decision on the external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling us at 1-800-248-2342 (toll-free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll-free).

COBRA

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to temporarily continue coverage under the plan beyond the point at which coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, COBRA coverage may be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. You are not entitled to buy COBRA coverage if you are employed as a nonresident alien who received no U.S. source income, nor may your family members buy COBRA. Not all group health plans are covered by COBRA. As a general rule, COBRA applies to all employer sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan. You must contact your plan administrator (normally your group) to determine whether this plan is covered by COBRA.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the group changes the plan coverage, coverage will also change for you. You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes.

If the group stops providing healthcare through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact your group to determine if you have further rights under COBRA.

COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, your group continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your group that you do not intend to return to work, whichever occurs first.

If the plan provides health coverage for retired employees, sometimes filing a proceeding in bankruptcy under Title 11 of the United States Bankruptcy Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the group, and the bankruptcy results in the loss of coverage of any covered retired employee, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage.
COBRA Rights for a Covered Spouse and Dependent Children

If you are covered under the plan as a spouse or a dependent child of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- The covered employee dies;
- The covered employee’s hours of employment are reduced;
- The covered employee’s employment ends for any reason other than his or her gross misconduct;
- The covered employee becomes enrolled in Medicare;
- Divorce of the covered employee and spouse; or,
- For a dependent child, the dependent child loses dependent child status under the plan.

When the qualifying event is a divorce or a child losing dependent status under the plan, you must timely notify the plan administrator of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. See the section called Notice Procedures for more information about the notice procedures you must use to give this notice.

If you are a covered spouse or dependent child, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time. If, however, the covered employee became enrolled in Medicare before the end of his or her employment or reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last.

If you are a child of the covered employee or former employee and you are receiving benefits under the plan pursuant to a qualified medical child support order, you are entitled to the same rights under COBRA as a dependent child of the covered employee.

If your coverage is canceled in anticipation of divorce and a divorce later occurs, the divorce may be a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the plan administrator of your divorce and can establish that your coverage was canceled in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce).

Extensions of COBRA for Disability

If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the plan administrator, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under Extensions of COBRA for Second Qualifying
For this disability extension of COBRA coverage to apply, you must give the plan administrator timely notice of Social Security’s disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security’s determination. You must also notify the plan administrator within 30 days after any revocation of Social Security disability benefits. See the section called Notice Procedures for more information about the notice procedures you must use to give this notice.

Extensions of COBRA for Second Qualifying Events

For a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the plan administrator timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, or gets divorced, or if the child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or child to lose coverage under the plan if the event had not occurred. For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because, for almost all plans that are subject to COBRA, this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the section Notice Procedures for more information about the notice procedures you must use to give this notice.

Notice Procedures

If you do not follow these notice procedures or if you do not give the plan administrator notice within the required 60-day notice period, you will not be entitled to COBRA or an extension of COBRA as a result of an initial qualifying event of divorce or loss of dependent child status, a second qualifying event or Social Security’s disability determination.

Any notices of initial qualifying events of divorce or loss of dependent child status, second qualifying events or Social Security disability determinations that you give must be in writing. Your notice must be received by the plan administrator or its designee no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the plan and for your notice of a second qualifying event, you must mail or hand-deliver your notice to the plan administrator. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

For your notice of Social Security’s disability determination, if you are instructed to send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to Blue Cross at the following address: Blue Cross and Blue Shield of Alabama, Attention: Customer Accounts, 450 Riverchase Parkway East, Birmingham, Alabama 35298-0001, or fax your notice to Blue Cross at 205-220-6884 or 1-888-810-6884 (toll-free). If you do not send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to the plan administrator. Your notice must also include a copy of Social Security’s disability
determination. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

Adding New Dependents to COBRA

You may add new dependents to your COBRA coverage under the circumstances permitted under the plan. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the plan administrator of Social Security’s disability determination as explained above.

Medicare and COBRA Coverage

You should consider whether it is beneficial to purchase COBRA coverage. After you retire, your COBRA coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Medicare. This means that, regardless of whether you have enrolled in Medicare, your COBRA coverage after retirement will not cover most of your hospital, medical and prescription drug expenses. Call the benefits coordinator at your group for more information about this.

If you think you will need both Medicare and COBRA after your retirement, you should enroll in Medicare on or before the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your retirement or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months from the date of your retirement. If you do not enroll in Medicare on or before the date on which you make your election to buy COBRA coverage, your COBRA benefits will end when your Medicare coverage begins. Your covered dependents will have the opportunity to continue their own COBRA coverage.

If you do not want both Medicare and COBRA for yourself, your covered family members will still have the option to buy COBRA when you retire. However, if your covered family members become enrolled in Medicare after electing COBRA, their COBRA coverage will end. See the Early Termination of COBRA section of this booklet for more information about this.

Electing COBRA

After the plan administrator receives timely notice that a qualifying event has occurred, the plan administrator is responsible for (1) notifying you that you have the option to buy COBRA, and (2), sending you an application to buy COBRA coverage.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the plan, or (2), the date on which the group notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date sent back to the group.

Once the group has notified us that your coverage under the plan has ceased, we will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, we will
retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that we may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

**COBRA Premiums**

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment.

After you make your first payment for COBRA coverage, you must make periodic payments for each subsequent coverage period. Each of these periodic payments is due on the first day of the month for that coverage period. There is a grace period of 30 days for all premium payments after the first payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

Payment of your COBRA premiums is deemed made on the day sent.

**Early Termination of COBRA**

Your COBRA coverage will terminate early if any of the following events occurs:

- The group no longer provides group health coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA coverage, you become covered under another group health plan that does not contain any exclusion or limitation on any pre-existing condition that you may have or you have sufficient creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you (for plan years beginning in 2014, pre-existing condition exclusions are prohibited);
- After electing COBRA coverage, you become enrolled in Medicare; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan. For example, if you submit fraudulent claims, your coverage will terminate.

If your group stops providing healthcare through Blue Cross, you will cease to receive any benefits through us for any and all claims incurred after the effective date of termination of our contract with the group. This is true even if we have been billing your COBRA premiums prior to the date of termination. It is the responsibility of your group, not Blue Cross, to notify you of this termination. You must contact your group directly to determine what arrangements, if any, your group has made for the continuation of your COBRA benefits.

If you have any further questions about COBRA or if you change marital status, or you or your spouse or child changes address, please contact your plan administrator. Additional information about COBRA can also be found at the website of the Employee Benefits Security Administration of the United States Department of Labor.
RESPECTING YOUR PRIVACY

The confidentiality of your personal health information is important to us. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and healthcare operations and to put in place appropriate safeguards to protect your protected health information. This section of this booklet explains some of HIPAA’s requirements. Additional information is contained in the plan’s notice of privacy practices. You may request a copy of this notice by contacting your group’s human resources office.

Disclosures of Protected Health Information to the Plan Sponsor:

In order for your benefits to be properly administered, the plan needs to share your protected health information with the plan sponsor (your group). Following are circumstances under which the plan may disclose your protected health information to the plan sponsor:

- The plan may inform the plan sponsor whether you are enrolled in the plan.
- The plan may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The plan may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the plan.

Following are the restrictions that apply to the plan sponsor’s use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan’s privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet. There are some exceptions.
- The plan sponsor will amend, or allow the plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor’s custody or control that the plan sponsor has received from the plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the
plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- Executive Vice Chancellor for Finance and Operations for the University of Alabama System
- Director of Financial Operations for the University of Alabama System
- Director of HR and System Benefits for the University of Alabama System
- Risk Management Employees for the University of Alabama System
- UA/UAS Information Technology/Technology Support Employees
- University of Alabama System Financial Affairs Payroll/Billing/HR Operation Employees
- University of Alabama System Office of Counsel
- University of Alabama System Auditors
- University of Alabama System Privacy and Security Officers
- University of Alabama Senior Insurance Administrator
- Director, Benefits and Training at UAHuntsville

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions—which may include termination of employment. If the plan sponsor becomes aware of any such violation, the plan sponsor will promptly report the violation to the plan and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

Security of Your Personal Health Information:

Following are restrictions that will apply to the plan sponsor’s storage and transmission of your electronic protected health information:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

The plan sponsor will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information:

As a business associate of the plan, we (Blue Cross and Blue Shield of Alabama) have an agreement with the plan that allows us to use your personal health information for treatment, payment, healthcare operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.
GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

The group has delegated to us 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 our provision of benefits and/or administrative services under the plan.

Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan (including, when applicable, arbitration) and thereafter to judicial review to determine whether our determination was arbitrary or capricious.

Notice

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so.

Unless otherwise specified in this booklet, if you are required to provide notice to us, you should do so in writing, including your full name and contract number, and mail the notice to us at 450 Riverchase Parkway East, P.O. Box 995, Birmingham, Alabama 35298-0001.

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 be reflected in your claims report.

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 are not responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you commit fraud or make any intentional material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.

Governing Law

The law governing the plan and all rights and obligations related to the plan shall be ERISA, to the extent applicable. To the extent ERISA is not applicable, the plan and all rights and obligations related to the plan shall be governed by, and construed in accordance with, the laws of the state of Alabama, without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the plan.
Termination of Benefits and Termination of the Plan

Our obligation to provide or administer benefits under the plan may be terminated at any time by either the group or us by giving written notice to the other as provided for in the contract. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If the group fails to pay us the amounts due under the contract within the time period specified therein, our obligation to provide or administer benefits under the plan will terminate automatically and without notice to you or the group as of the date due for payment. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

Subject to any conditions or restrictions in our contract with the group, the group may terminate the plan at any time through action by its authorized officers. In the event of termination of the plan, all benefit payments by us will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by the group or us. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If for any reason our services are terminated under the contract, you will cease to receive any benefits by us for any and all claims incurred after the effective date of termination. In some cases, this may mean retroactive cancellation by us of your plan benefits. This is true for active contract holders, retirees, COBRA beneficiaries and dependents of either. Any fiduciary obligation to notify you of our termination belongs to the group, not to us.

Changes in the Plan

Subject to any conditions or restrictions in our contract with the group, any and all of the provisions of the plan may be amended by the group at any time by an instrument in writing. In many cases, this instrument will consist of a new booklet (including any riders or supplements to the booklet) that we have prepared and sent to the group in draft format. This means that from time to time the benefit booklet you have in your possession may not be the most current. If you have any question whether your booklet is up to date, you should contact your group. Any fiduciary obligation to notify you of changes in the plan belongs to the group, not to us.

The new benefit booklet (including any riders or supplements to the booklet) will state the effective date applicable to it. In some cases, this effective date may be retroactive to the first day of the plan year to which the changes relate. The changes will apply to all benefits for services you receive on or after the stated effective date.

Except as otherwise provided in the contract, no representative, employee, or agent of Blue Cross is authorized to amend or vary the terms and conditions of the plan or to make any agreement or promise not specifically contained in the plan documents or to waive any provision of the plan documents.

No Assignment

We will not honor an assignment of your claim to anyone. 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. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

DEFINITIONS

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

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.
Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that we recognize for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by us to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

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 Services, earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Alabama.

Out-of-Network Providers: The allowed amount for care rendered by out-of-network providers is often determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to in-network providers or may be based on the average charge for the care in the area. In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;
- Pricing data from the local Blue Cross and/or Blue Shield plan where services are rendered;
- The relative complexity of the service;
- The in-network allowance in Alabama for the same or a similar service;
- Applicable state healthcare factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

For 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.

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

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

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

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

BlueCard 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 Services**.

**Concurrent Utilization Review Program (CURP):** A program implemented by us and in-network hospitals in the Alabama service area to simplify the administration of preadmission certifications and concurrent utilization reviews.

**Contract:** Unless the context requires otherwise, the terms "contract" and "plan" are used interchangeably. The contract includes our financial agreement or administrative services agreement with the group.

**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.

**Group:** The employer or other organization that has contracted with us to provide or administer group health benefits pursuant to the plan.

**Home Health Coverage:** Skilled nursing visits ordered by a physician, rendered in a patient's home by a Registered Nurse or Licensed Practical Nurse and billed by a home health agency. Any pre-certification requirements and/or any specified benefit maximums are applicable to the skilled nursing visits only. Other services included are home infusion therapy and medications administered by a home health agency. Services such as speech therapy, occupational therapy and physical therapy may be billed by a home health agency; however, they are considered under the major medical/other covered services portion of the contract and not considered under home health coverage.

**Hospice Coverage:** Hospice service includes supplies or drugs included in the daily fee for hospice care rendered by a hospice provider to a terminally ill member when a physician certifies the member's life expectancy to be less than six months.

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

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

**In-Network Provider:** 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), Blue Choice Behavioral Health Network providers, 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 an In-Network 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.

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

**Investigational:** Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

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

**Medical Emergency:** A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

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

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

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

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

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

Plan: The plan is the group health benefit plan of the employer, as amended from time to time. The plan documents consist of the following:

- This benefit booklet, as amended;
- Our contract with the group, as amended;
- Any benefit matrices upon which we have relied with respect to the administration of the plan; and,
- Any draft benefit booklets that we are treating as operative. By “operative,” we mean that we have provided a draft of the booklet to the group that will serve as the primary, but not the sole, instrument upon which we base our administration of the plan, without regard to whether the group finalizes the booklet or distributes it to the plan's members.

If there is any conflict between any of the foregoing documents, we will resolve that conflict in a manner that best reflects the intent of the group and us as of the date on which claims were incurred. Unless the context requires otherwise, the terms "plan" and "contract" have the same meaning.

Plan Administrator: The group that sponsors the plan and is responsible for its overall administration. If the plan is covered under ERISA, the group referred to in this definition is the “administrator” and "sponsor" of the plan within the meaning of section 3(16) of ERISA.

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

Preferred Medical Doctor: A physician who has an agreement with Blue Cross and Blue Shield of Alabama to provide surgical and medical services to members entitled to benefits under the PMD program.
Pregnancy:  The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body – usually, but not always, in the uterus – and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Preventive or Routine:  Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

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

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

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

Substance Abuse Facility:  Any institution that is classified as a substance abuse facility by such relevant credentialing organizations as we or any Blue Cross and/or Blue Shield plan (or its affiliates) determine and that solely provides residential and/or outpatient substance abuse rehabilitation services.

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

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

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

CUSTOMER SERVICE

If you have questions about your coverage, or need additional information about how to file claims, contact the person in your company who handles employee benefits, or contact BlueCross BlueShield of Alabama.

BlueCross BlueShield of Alabama Customer Service (located in Birmingham) is open for phone inquiries Monday through Friday at 1-800-292-8868.

Use this number when you need to talk with a customer service representative.  When you call about a claim, be sure to include the following information:

• Your contract number, as listed on your BlueCross BlueShield ID card (e.g. PPA123456789);
• The name of your employer;
• Your BlueCross BlueShield group number shown on your BlueCross BlueShield ID card;
• The date of service
• The name of the provider

Call the UAS Benefits Office at (205) 348-7880 to report address changes, marital status changes, dependent status changes, employment changes, deaths, births, etc.

WAYS TO SAVE HEALTH CARE DOLLARS

1.  Make it clear to your doctor that all tests must be specifically approved by you before ordered.  Ask why you need the test.  Ask how reliable the test is and what is the chance of a false result and how can those risks be minimized.  Find out what alternatives you have if you refuse the test.  Ask how much the test will cost.  Also try to use a Preferred Medical Doctor (PMD) when possible.  A
PMD doctor will file all necessary claims for you and accept BCBS payment in full after you pay any copays due.

2. **Don't substitute an emergency room for your doctor.** Never go to an emergency room (except in absolute emergencies) before contacting your doctor first. If your doctor cannot make provisions for seeing patients at a relatively short notice during office hours, you may need to find another doctor. Besides incurring additional costs by visiting emergency rooms, you're likely to experience long waits. If you do not have a personal physician, you can choose a PMD or non-PMD doctor. To verify if your doctor is PMD, you can call BCBS at **1-800-292-8868** toll free in Alabama.

3. **Ask for generic prescriptions when available.** Generic drugs are fully regulated by the U.S. Food and Drug Administration and by law the only difference between a generic and brand-name drug is its color or the binder which holds it together. Generic drugs are less costly because they are offered to the public after the brand-name drug patent has expired. This means the manufacturer of the generic drug can sell it at a much lower price because they have not incurred the expense of research and development. Generic drugs have a lower co-pay versus co-pays for brand-name drugs for our group. If you elect to purchase a brand-name drug when a generic is available, the co-pay is higher and you pay the difference in the drug cost between brand and generic.

4. **For minor health problems, try over-the-counter remedies first.** It's no secret that over-the-counter medications have been greatly improved during the past decade. In fact, several medications that were previously available only with a prescription, can now be purchased without one (and they're cheaper too). For minor medical problems such as a sore throat, cold, headache or an occasional upset stomach, try over-the-counter remedies first. It'll save you time and money.

5. **Ask your doctor for free samples.** Physicians regularly receive free samples of prescription and over-the-counter medications from pharmaceutical companies. Ask for a few days' worth of an unknown drug until you are sure that you and it are compatible. Think of it as a test drive, something any good consumer would do first.

6. **Ask for itemized bills.** Even if you visit a Preferred Care Provider and your charges are covered at 100%, ask to see an itemized bill, because some hospital bills may contain errors or miscalculations. Review your itemized bill. Question the doctor or hospital if you disagree with a service or charge. If you cannot resolve the difference, call the UA System Office at **(205) 348-7880**, or if you suspect fraud, call BC/BS of Alabama at **1-800-824-4391**.

7. **Seek the best alternative(s) when elective surgery is proposed.** Ask your doctor if there are additional ways your condition can be treated that may not involve surgery. If your doctor says you need to be admitted to the hospital, discuss what options may be available to have the procedure performed on an outpatient basis through one day surgery or in an office setting.

8. **Be more safety conscious.** Wear your car's safety belt and use child restraint seats for children. Keep all medicines, cleaners and insecticides out of children's reach to avoid accidental poisoning. Wear a helmet and other protective gear when riding bicycles, go-carts, ATVs, motorcycles, scooters or skateboards.

9. **Become a knowledgeable health care consumer.** Reading about your condition will enable you to make more informed decisions about your treatment. Go into your doctor's visit with specific questions to ask him or her. Make informed decisions. Remember, it's your health and you should be in control of it.

10. **Be healthy.** Prevention is still the best medicine. Eat properly, stay active physically, and mentally, get plenty of rest, stop smoking, avoid or limit alcoholic beverages and watch your weight.
450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

Customer Service:
1-800-292-8868 toll-free

Preadmission Certification:
205-988-2245
or 1-800-248-2342 toll-free

Website:
www.AlabamaBlue.com

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Health Plan
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