The University of Alabama in Huntsville
Student Health Plan

August 12, 2024-August 11, 2025

Revised 10/3/2024

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OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits and you purchased insurance directly from us, please contact our Customer Service Department at 1-855-249-3803. If needed, simply request a translator and one will be provided to assist you in understanding your benefits.

Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si tiene preguntas sobre sus beneficios y compró un seguro directamente de nosotros, comuníquese con nuestro Departamento de Servicio al Cliente al 1-855-249-3803. Si es necesario, simplemente solicite un traductor y se le proporcionará uno para ayudarlo a comprender sus beneficios.

Purpose of the Plan

The plan is a student health insurance plan underwritten by Blue Cross and Blue Shield of Alabama for eligible students of The University of Alabama Huntsville (the School) and your eligible dependents.

The plan is intended to help you, as an eligible student and your covered dependents pay for the cost of healthcare. The plan does not pay for all of your healthcare. For example, you are required to timely pay your premiums for the plan. Coverage is provided under this plan pursuant to applicable laws and is limited to those services, supplies and/or drugs that may be legally performed, prescribed or dispensed by a licensed health care provider, supplier or pharmacy.

You may also be required to pay deductibles, copayments, and coinsurance.

Participating in the plan requires you and your covered dependents to designate a Primary Care Select physician. If you do not designate a Primary Care Select physician, no benefits are payable under the plan – even if the plan does not require a referral by the Primary Care Select physician for those services.

Using *my*BlueCross to Get More Information

By being a member of the plan, you get exclusive access to *my*BlueCross – an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at AlabamaBlue.com/Register. With *my*BlueCross, you have 24 hour access to personalized healthcare information, PLUS easy-to-use online tools that can help you save time and efficiently manage your healthcare:

- Pay your bill online and set up recurring payments, if applicable.
- Download and print your benefit booklet or Summary of Benefits and Coverage.
- Request replacement or additional ID cards.
- View all your claim reports in one convenient place.
- Find a doctor.
- Track your health progress.
- Take a health assessment quiz.
- Get fitness, nutrition and wellness tips.
- Get prescription drug information.

Nature of Coverage

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

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

Policy Year

The policy year of the plan is August 12 2024 through August 11 2024. The plan is a non-renewable, one year term policy.

Definitions

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

Receipt of Medical Care

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

Limitations and Exclusions

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

Medical Necessity and Precertification

The plan will only pay for care that is medically necessary and not investigational, as determined by us. We develop medical necessity standards to aid us when we make medical necessity determinations. We publish many of these standards at AlabamaBlue.com. The definitions of medical necessity and investigational are found in the Definitions section of this booklet. In some cases, the plan requires that you or your treating provider precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered. The section called Medical Necessity and Precertification later in this booklet tells you when precertification is required and how to obtain it.

In-Network Benefits

One way in which the plan tries to manage your costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be

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

Examples of the plan's Alabama in-network providers are:

- Student Health Center
- BlueCard PPO
- Participating Hospitals
- Preferred Outpatient Facilities
- Participating Ambulatory Surgical Centers
- Participating Renal Dialysis Providers
- Preferred Medical Doctors (PMD)
- Primary Care Select Network
- Blue Choice Behavioral Health Network
- Oncology Select Network
- Participating Chiropractors
- Participating Nurse Practitioners
- Participating Physician Assistants
- Preferred Occupational Therapists
- Preferred Physical Therapists
- Preferred Speech Therapists
- Participating CRNA
- Participating Ground Ambulance
- Participating Licensed Registered Dietician Network
- Pharmacy Vaccine Network
- Pharmacy Select Network
- Home Delivery Network
- Preferred Dentist
- Blue Achievement-Knee and Hips Network
- Preferred Medical Laboratories
- Participating Air Medical Transport
- Prime Participating Pharmacy Network
- Preferred Home Health Network
- Preferred Home Infusion Network
- Participating Audiology Network

To locate Alabama in-network providers, go to AlabamaBlue.com.

1. Enter a search location by using the zip code or city and state for the area you would like to search.
2. In the search box, you can select the category you would like to search (doctor, hospital, dentist, pharmacy, etc.) or keep on "All Categories" to search all. Type in the provider's name to search or leave blank to see all results
3. In the "Network or Plan" section, use the drop down menu to select a specific provider network (as noted above).

Search tip: If your search returns zero results, try expanding the number in the "Distance" drop down.

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 1-800-810BLUE (2583) or visit AlabamaBlue.com/FindADoctor and log into your *my*BlueCross. Search for a specific provider by typing their name in the Search Term box or click Search to see all in-network providers for your plan. 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 and/or Blue Shield plan where services are rendered. The local Blue Cross and/or Blue Shield 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 Blue Cross and Blue Shield of Alabama or the local Blue Cross and/or Blue Shield 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.

Continuity of Care

If you qualify as a continuing care patient, and your healthcare provider or facility is no longer in your network due the termination of a contractual relationship, you may request to continue treatment with such provider or facility until your treatment is complete or for 90 days from notification, whichever is shorter, at in-network cost-sharing rates under the plan. A continuing care patient is defined as an individual who:

- Is or was determined to be terminally ill and is receiving treatment for such illness;
- Is undergoing a course of treatment for a serious and complex condition;
- Is pregnant and undergoing a course of treatment for the pregnancy;
- Is undergoing a course of institutional or inpatient care;
- Is scheduled to undergo non-elective surgery, including receipt of post-operative care, with respect to such a surgery; or
- Is in an ongoing course of treatment for a health condition for which your treating provider attests that discontinuing care by provider would worsen the condition or interfere with anticipated outcomes.

Under these circumstances, the provider or facility cannot bill you for amounts in excess of the in-network allowed amounts under the plan. Continuity of care does not apply if your provider or facility was involuntarily terminated from your network for failure to meet applicable quality standards or for fraud.

If you have successfully transitioned to another in-network provider, if you have met or exceeded benefit limitations of the plan, or if care is not medically necessary, you will no longer be eligible for this continuity of care. If we deny your request for continuity of care, you may file an appeal following the procedures described in the Claims and Appeals section of this booklet.

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

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

Claims and Appeals

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

Arbitration

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

Respecting Your Privacy

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

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

You may also go to AlabamaBlue.com for a copy of our privacy notice.

Your Rights

As a member of the plan, you have the right to:

- Receive information about us, our services, in-network providers and your rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the plan provides.
- Make recommendations regarding our member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service Department number on the back of your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, or submit a complaint online at https://www.cms.gov/nosurprises.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.
Visit https://www.aldoi.gov for more information about your rights under Alabama law.

Your Responsibilities

As a member of the plan, you have the responsibility to:

- Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ELIGIBILITY

Your Eligibility for the Plan

You are eligible for the plan if you are a registered student of the School who actively attends classes. Home study, correspondence, and fully online programs do not fulfill the eligibility requirements that you actively attend classes, except during extenuating circumstances as defined by the university and with the approval of the university.

Domestic Undergraduate Students enrolled in six or more semester hours and Domestic Graduate Students not on assistantship enrolled in three or more semester hours are eligible to enroll in this insurance plan on a voluntary basis. Exceptions may be given for students in a registered experiential learning opportunity. All students eligible to enroll should live locally and not be in a fully online program.

All International students are automatically enrolled in this insurance plan at registration. J1 Exchange Visitors are required to provide proof of comparable insurance or purchase this insurance plan. Visiting Scholars are eligible to enroll in this insurance plan starting the first day of the month of their program. Graduate students on assistantship may choose to opt in to this plan and will subsequently be enrolled by their departments.

Eligible students who do enroll, may also insure their Dependents. Eligible Dependents are the student's legal spouse and dependent children under 26 years of age.

Your Eligible Dependents

Your eligible dependents are:

- Your spouse;
- Your 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 your natural child; stepchild; legally adopted child; child placed for adoption; or, eligible foster child. An eligible foster child is a child that is placed with you by an authorized placement agency or by court order.

You may cover your grandchild only if you are eligible to claim your grandchild as a dependent on your federal income tax return.

Beginning of Coverage

You may enroll only during school registration each semester term. Your coverage will begin on the date specified by the School (or its authorized representative) following your enrollment.

Special Enrollment Period for Individuals Losing Other Minimum Essential Coverage

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

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

Special Enrollment Period for Newly Acquired Dependents

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

If you have a new dependent (either spouse and/or dependent child) as a result of marriage, you may enroll your spouse and your new dependent as special enrollees provided that you request enrollment within 30 days of the event. In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first month beginning after the date the request for special enrollment is received (assuming you timely pay your premiums in full).

Termination of Coverage

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

1. You fail to pay all applicable fees for coverage before the effective date of your coverage, in which case coverage for you and your dependents will be canceled as of the effective date of coverage;

2. You fail to pay subsequent fees for coverage within your applicable grace period as explained above in this booklet in the subsection called Timely Payment of Premiums;

3. You are no longer a student actively attending classes as required by the plan;

4. For spouses, the first day of the month following divorce or other termination of marriage;

5. For children, the first day following the end of the plan year in which a child ceases to be a dependent;

6. For all covered dependents, the first day of the month following the date of the contract holder's death;

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

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

9. Upon termination of the plan at the end of the policy year.

All the dates of termination assume that payment for coverage in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

Limitation on Effect of Certain Amendments

Except as otherwise required by law, no amendment or change to this section of the booklet (Eligibility) will result in the disenrollment, loss of eligibility, or early termination of eligibility of a member properly enrolled under the terms of the plan as of the effective date of the amendment.

COST SHARING

	IN-NETWORK	OUT-OF-NETWORK
Policy Year Deductible August 12, 2024-August 11,2025 The in-network and out-of-network policy year deductibles are separate and do not apply to each other	$200 individual	$300 individual
Policy Year Out-of-Pocket Maximum (including the in-network policy year deductible) August 12, 2024-August 11,2025	$6,350 individual $12,700 family	There is no out-of-pocket maximum

Policy Year Deductible

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

- The individual policy year deductible must be satisfied on a per member per policy year basis, subject to the family policy year deductible maximum.

- The family policy year deductible is an aggregate dollar amount. This means that all amounts applied toward the individual policy year deductible will count toward the family policy year deductible amount. Once the family policy year deductible is met, no further family members must satisfy the individual policy year deductible.

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

satisfy both the in-network and out-of-network policy year deductibles. In certain circumstances as and when required by Federal law, the cost-sharing amounts (deductibles, copayments and coinsurance) that you are required to pay for out-of-network services will apply to the in-network policy year deductible. Those services include:

• Medical or Accident emergency
• Air Ambulance
• Certain Non-emergency services performed by out-of-network providers at certain in-network facilities

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

Policy Year Out-of-Pocket Maximum

The policy year out-of-pocket maximum is specified in the table above. Here is how the in-network policy year out-of-pocket maximum works.

All cost sharing amounts (deductibles, copayments and coinsurance) for covered in-network services and out-of-network mental health disorders and substance abuse services for medical emergencies that you or your family are required to pay under the plan apply to the policy year out-of-pocket maximum. In certain circumstances as and when required by the Affordable Care Act, if you receive services in an in-network facility from an out-of-network ancillary provider, any cost sharing amounts (deductibles, copayments, and coinsurance) that you are required to pay for that out-of-network ancillary provider will apply to the policy year out-of-pocket maximum. Once the maximum has been reached, you will no longer be subject to cost sharing for covered expenses of the type that count toward the policy year out-of-pocket maximum for the remainder of the policy year. In certain circumstances as and when required by Federal law, the cost-sharing amounts (deductibles, copayments and coinsurance) that you are required to pay for out-of-network services will apply to the in-network policy year out-of-pocket maximum. Those services include:

• Medical or Accident emergency
• Air Ambulance
• Certain non-emergency services performed by out-of-network providers at certain in-network facilities

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

- Most cost sharing amounts (deductibles, copayments, and coinsurance) paid for any out-of-network services or supplies that may be covered under the plan (except for covered out-of-network mental health disorders and substance abuse 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 services for a particular type of service); and,
- Amounts paid as a penalty (for example, failure to precertify).

The policy year out-of-pocket maximum applies on a per member per policy year basis, subject to the family policy year out-of-pocket maximum amount. Once a member meets its individual policy year out-of-pocket maximum, affected benefits for that member will pay at 100% of the allowed amount for the remainder of the policy year.

The family policy year out-of-pocket maximum is an aggregate dollar amount. This means that all amounts that count toward the individual policy year out-of-pocket maximum will count toward the family policy year

out-of-pocket maximum amount. Once the family policy 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 policy year.

Other Cost Sharing Provisions

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

1. **Copayments.** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is a copayment that must be paid when you go to a doctor's office.

2. **Coinsurance.** Coinsurance is the amount that you must pay as a percent of the allowed amount.

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

4. **Specialty Drug Financial Assistance.** Only the amount you pay out-of-pocket for your specialty drugs will apply to your cost-sharing responsibilities or out-of-pocket limit. The dollar amount of any financial assistance provided to you by providers or manufacturers will not count towards coinsurance, copays, or deductible cost-sharing responsibilities or out-of-pocket limit.

Out-of-Area Services

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield /Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of providers.

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

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

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

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, we may process your claims for covered healthcare services through Negotiated Arrangements for National Accounts.

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

C. Special Cases: Value-Based Programs

BlueCard Program
We have included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under this agreement.

Negotiated Arrangements
If we have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your members, we will follow the same procedures for Value-Based Programs as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded plans. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside the Blue Cross and Blue Shield of Alabama Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue’s nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, we may use other payment methods, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph.

F. Blue Cross Blue Shield Global® Core

If you are outside the United States (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered healthcare services. Blue Cross Blue Shield Global® Core is not served by a Host Blue.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global® Core Claim**

When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

MEDICAL NECESSITY AND PRECERTIFICATION

The plan will only pay for care that is medically necessary and not investigational, as determined by us. The definitions of medical necessity and investigational are found in the Definitions section of this booklet.

In some cases, described below, the plan requires that you or your treating provider precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered.

In some cases, your provider will initiate the precertification process for you. You should be sure to check with your provider to confirm whether precertification has been obtained. It is your responsibility to ensure that you or your provider obtains precertification.

Inpatient Hospital Benefits

Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions.

For medical emergency services, 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.
  For precertification call 1-800-248-2342 (toll-free).

Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the plan.

Outpatient Hospital Benefits, Physician Benefits, Other Covered Services

Precertification is required for certain outpatient hospital benefits, physician benefits and other covered services. The general categories or descriptions of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the filing of this booklet are set forth below. Examples are for illustrative purposes only. You can find more information about the specific services that require precertification at AlabamaBlue.com/Precert. This list will be updated no more than twice per calendar year. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services.

- Certain advanced imaging (such as, for example, MRA, MRI, CT, CTA and PET);
  For precertification, call 1-866-803-8002 (toll free).

- Intensive outpatient services and partial hospitalization.
  For precertification, call 1-800-548-9859 (toll free).

- Certain select procedures (such as, for example, implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, and surgery for obstructive sleep apnea);
  For precertification, call 1-800-248-2342 (toll free).

- Certain reconstructive procedures (such as, for example, blepharoplasty, rhinoplasty, and surgery for varicose veins);
  For precertification, call 1-800-248-2342 (toll free).

- Certain durable medical equipment;
  For precertification, call 1-800-248-2342 (toll free).

- Home health and hospice when services are rendered outside the state of Alabama.
  For precertification, call 1-800-821-7231 (toll free).

- Certain radiation therapy management services (such as, for example, proton beam therapy, cyberknife and stereotactic radiosurgery);
  For precertification, call 1-866-803-8002 (toll free).

- Certain genetic laboratory testing (such as, for example, breast cancer (BRCA) testing and genetic carrier screening);
  For precertification, call 1-866-803-8002 (toll free).

If precertification is not obtained, no benefits will be payable under the plan for the services.

Provider-Administered Drugs

Precertification (also sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find a list of the provider-administered drugs that require precertification at AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. This list will be updated monthly.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office or home healthcare setting. Provider-administered drugs also include gene therapy and cellular immunotherapy. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

For precertification, call the Customer Service Department number on the back of your ID card.

If precertification is not obtained, no benefits will be payable under the plan for the provider-administered drug.

Prescription Drug Benefits

Precertification (also sometimes referred to as prior authorization) is required for certain prescription drugs. You can find a list of the prescription drugs that require precertification at AlabamaBlue.com/2024SourcePlusRx1DrugList. This list will be updated monthly.

For precertification, call the Customer Service Department number on the back of your ID card.

If precertification is not obtained, no benefits will be payable under the plan for the prescription drug.

HEALTH BENEFITS

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

Attention: If you receive out-of-network physician benefits (such as out-of-network laboratory services) for a medical emergency or accidental injury in the emergency room of a hospital, those services will also be paid at the applicable in-network coinsurance amounts for such benefits described in the matrices below, and subject to the in-network policy year deductible. The allowed amount for such out-of- network physician benefits will be determined in accordance with the requirements of the applicable Federal law.

Attention: If you receive non-emergency services performed by an out-of-network provider at certain participating facilities, those services will be paid at the applicable in-network coinsurance and/or copayment amounts for such benefits described in the matrices below, and subject to the in-network policy year deductible, provided the out-of-network provider has not satisfied the applicable notice and consent requirements. The allowed amount for such non-emergency services performed by an out-of-network provider at certain participating facilities will be determined in accordance with the requirements of the applicable Federal law.

Inpatient Hospital Benefits

Attention: Precertification is required for all hospital admissions except for medical emergency, maternity admissions, and as required by Federal law. You can find more information about this in the Medical Necessity and Precertification section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Inpatient First 365 days of care during each confinement in a general hospital or psychiatric specialty hospital	100% of the allowed amount, subject to the policy year deductible	70% of the allowed amount, subject to the policy year deductible
Inpatient Days of confinement in a general hospital or psychiatric specialty hospital extending beyond the 365day benefit maximum	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

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

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

1. Bed and board and general nursing care in a semiprivate room;

2. Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them;

3. Use of operating, delivery, recovery, and treatment rooms and the equipment in them;

4. Administration of anesthetics by hospital employees and all necessary equipment and supplies;

5. Casts, splints, surgical dressings, treatment and dressing trays;

6. Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and X-rays;

7. Physical therapy, hydrotherapy, radiation therapy, and chemotherapy;

8. Oxygen and equipment to administer it;

9. All drugs and medicines used by you if administered in the hospital;

10. Regular nursery care and diaper service for a newborn baby while its mother has coverage;

11. Blood transfusions administered by a hospital employee.

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

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

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

Outpatient Hospital Benefits

> **Attention:** Precertification is required for certain outpatient hospital benefits. You can find more information about this in the **Medical Necessity and Precertification** section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Outpatient surgery (including ambulatory surgical centers)	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Emergency room – medical emergency	90% of the allowed amount, subject to the policy year deductible	90% of the allowed amount, subject to the policy year deductible
Emergency room – accident If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **Emergency room – medical emergency** above	90% of the allowed amount, subject to the policy year deductible	90% of the allowed amount, subject to the policy year deductible when services are rendered within 72 hours of the accident 50% of the allowed amount, subject to the policy year deductible when services are rendered more than 72 hours after the accident and not a medical emergency as defined by the plan
Outpatient diagnostic lab, X-ray, and pathology	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Outpatient dialysis, IV therapy, chemotherapy, and radiation therapy	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Intensive outpatient services and partial hospitalization for mental health disorders and substance abuse	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Services billed by the facility for an emergency room visit when the patient's condition does not meet the definition of a medical emergency (including any lab and X-ray exams and other diagnostic tests associated with the emergency room fee)	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Covered outpatient hospital services or supplies not listed above and not listed in the section of the booklet called Other Covered Services	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

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

Outpatient hospital benefits include provider-administered drugs. You can find more information about provider-administered drugs in the Medical Necessity and Precertification section of this booklet.

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: Precertification is required for certain physician benefits. You can find more information about this in the Medical Necessity and Precertification section of this booklet.

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 facility cost sharing. 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.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Student Health Center SHC Services Including in-house labs and diagnostics	100% of the allowed amount, subject to a $20 office visit copayment per visit.	Not covered
Office visits and consultations	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Emergency room physician	90% of the allowed amount, subject to the policy year deductible	90% of the allowed amount, subject to the policy year deductible
Second surgical opinion	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Urgent Care	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Surgery and anesthesia for a covered service	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Maternity Care	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18, for Autism Spectrum Disorders Precertification required	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Inpatient visits and inpatient consultations	90% of the allowed amount, subject to the policy year deductible **Mental health disorders and substance abuse services:** 100% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Diagnostic lab, X-rays, pathology, dialysis, IV therapy, psychological testing	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Chemotherapy and radiation therapy	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Allergy testing and treatment	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, and heart catheterization.

- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.

- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.

- Physician benefits include provider-administered drugs. You can find more information about provider-administered drugs in the Medical Necessity and Precertification section of this booklet.

Physician Preventive Benefits

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

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

To find a pharmacy that participates in the Pharmacy Vaccine Network:

1. Go to AlabamaBlue.com/ValueONEVaccinePharmacyLocatorAlabamaBlue.com/PreferredONEVaccinePharmacyLocatorAlabamaBlue.com/PrimeParticipatingVaccinePharmacyLocator
2. .Enter a search location by using the zip code or city and state for the area you would like to search.
3. Click the Search button to find a pharmacy in the Vaccine Network .

A list of the eligible vaccines these pharmacies may provide can be found at: AlabamaBlue.com/VaccineNetworkDrugList.

Under the Affordable Care Act, non-grandfathered plans are required to provide in-network coverage for all of the following without cost-sharing:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee to Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and,
- With respect to women, preventive care and screenings as provided in the binding, comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, including (but not limited to) all Food and Drug Administration (FDA)-approved contraceptive methods for women, sterilization procedures, and patient education and counseling for all women (including dependent daughters) with reproductive capacity.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Routine preventive services and immunizations See AlabamaBlue.com/PreventiveServices and AlabamaBlue.com/StandardACAPreventiveDrugList for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a paper copy of this listing	100% of the allowed amount, no deductible or copayment	Not covered

Pediatric Vision Benefits

Attention: The plan provides vision benefits only for members up to the end of the month in which the member turns 19. No benefits are payable thereafter even if treatment for the member began before this time period.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Pediatric eye exam (including refraction) Limited to one exam per member each policy year up to the end of the month in which the member turns 19; includes dilation if medically necessary	100% of the allowed amount, subject to a $20 copayment per visit	50% of the allowed amount, subject to the policy year deductible

Pediatric glasses or contact lenses Prescription glasses (lenses and frames) are limited to one pair per member each policy year, up to the end of the month in which the member turns 19; contact lenses are limited to one 12 month supply each policy year per member up to the end of the month in which the member turns 19	100% of the allowed amount, subject to a $40 copayment per visit	50% of the allowed amount, subject to the policy year deductible
Additional Lens Limited to one per member each policy year up to the end of the month in which the member turns 19; includes polycarbonate lenses and lenses with standard scratch resistant coating	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, subject to the policy year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost up to $130	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the policy year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost up to $130 - $160	100% of the allowed amount, subject to a $15 copayment per visit	50% of the allowed amount, subject to the policy year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost up to $160-$200	100% of the allowed amount, subject to a $30 copayment per visit	50% of the allowed amount, subject to the policy year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost up to $200-$250	100% of the allowed amount, subject to a $50 copayment per visit	50% of the allowed amount, subject to the policy year deductible

Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost greater than $250	60% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the policy year deductible
Pediatric Contact Lenses Fittings & Evaluation Limited to one per policy year	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, subject to the policy year deductible

Other Covered Services

> **Attention:** Precertification is required for certain other covered services. You can find more information about this in the Medical Necessity and Precertification section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Accident-related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury (or within the first 90 days of coverage under the Plan if not a Member at the time of the injury); if initial services are received within 90 days of the injury (or within the first 90 days of coverage under the Plan if not a Member at the time of the injury) subsequent treatment is allowed for up to 180 days from the date of injury (or within 180 days of coverage under the Plan if not a Member at the time of the injury) without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury (or within 18 months of coverage under the Plan if not a Member at the time of the injury)	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Ambulance services	90% of the allowed amount, subject to the policy year deductible	90% of the allowed amount, subject to the policy year deductible
Chiropractic services Professional services of a licensed chiropractor practicing within the scope of his license	90% of the allowed amount, subject to the policy year deductible	**In Alabama:** Not covered **Outside Alabama:** 50% of the allowed amount, subject to the policy year deductible
Dialysis services at a renal dialysis facility	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
DME: Durable medical equipment and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints (For DME the allowed amount will generally be the smaller of the rental or purchase price)	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Eyeglasses or contact lenses One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Home health and hospice care In-network home healthcare benefits consist of intermittent home nursing visits and home phototherapy for newborns ordered by your attending physician In-network hospice benefits consist of physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management provided to a member certified by his physician to have less than six months to live	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible **Note:** In Alabama, not covered

Home infusion Home infusion benefits include coverage of certain provider-administered drugs ordered by your attending physician and administered by a home infusion service provider in the home or in an infusion suite associated with the home infusion service provider. In-network benefits include coverage of the provider-administered drug and drug infusion related administration services. See **Provider-Administered Drugs** paragraph under the **Medical Necessity and Precertification** section of this booklet for precertification requirement of these drugs	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible Note: In Alabama, not covered
Medical Nutrition Therapy Medical Nutrition Therapy Services for adults and children, 6 hours each calendar year	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Rehabilitative occupational, physical, and speech therapy Limited to a combined occupational, physical and speech therapy maximum of 30 visits per member per policy year (combined in-network and out-of-network)	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Habilitative occupational, physical, and speech therapy Limited to a combined occupational, physical and speech therapy maximum of 30 visits per member per policy year (combined in-network and out-of-network)	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Occupational, physical and speech therapy for autism spectrum disorders ages 0-18	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible
Infertility Treatment Benefits limited to treat or correct underlying causes of infertility	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Physiotherapy Services Review of medical necessity after 12 visits per sickness or injury	90% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Pediatric Dental Benefits

> **Attention:** The plan provides dental benefits only for members up to the end of the month in which the member turns 19. No benefits are payable thereafter even if treatment for the member began before this time period.

Preferred Dentist are in-network dentists for this plan. There are no in-network dentists outside of the Alabama service area.

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

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

Pediatric Diagnostic and Preventive Dental Services

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Diagnostic and preventive services (Limited to members up to the end of the month in which the member turns 19)	50% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Pediatric diagnostic and preventive dental services consist of the following:

- Dental exams, up to twice per policy year.
- Dental X-rays:
- Full mouth X-rays, one set during any 60 months in a row.
- Bitewing X-rays, up to twice per policy year.
- Intraoral complete series X-rays, two per 12 months.
- Panoramic film, once per 36 months.
- Other dental X-rays, used to diagnose a specific condition.
- Tooth sealants on unrestored permanent molars, limited to one application per tooth each 36 months.
- Fluoride treatment, twice per 12 months.
- Topical fluoride varnish, twice per 12 months.
- Routine cleanings, twice per policy year.

- Space maintainers (not made of precious metals) that replace prematurely lost teeth.
- Diagnostic models.

Pediatric Basic Dental Services

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Basic services (Limited to members up to the end of the month in which the member turns 19)	50% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Pediatric basic dental services consist of the following:

- Fillings made of silver amalgam and tooth color materials.
- Simple tooth extractions.
- Direct pulp capping, removal of pulp, and root canal treatment (excluding surgical treatment and/or removal of the root tip of the tooth).
- Endodontic therapy on primary teeth, once per tooth per lifetime.
- Pulpotomy.
- Repairs and re-cementation to crowns, inlays, onlays, veneers, fixed partial dentures and removable dentures.
- Re-cementation of space maintainers.
- Pin retention, per tooth, in addition to restoration.
- Prefabricated post and core (excluding crown), once per tooth per 60 months.
- Resin infiltration/smooth surface, once per tooth per 36 months.
- Replacement of missing or broken teeth.
- Addition of tooth or clasp to existing partial denture.
- Consultation including oral exam requested by another practitioner.
- Emergency treatment for pain.

Pediatric Major Dental Services

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Major services (Limited to members up to the end of the month in which the member turns 19)	50% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Pediatric major dental services consist of the following:

- Oral surgery, i.e., to diagnose and treat mouth cysts and abscesses and for tooth extractions and impacted teeth.
- General anesthesia when given for oral or dental surgery. This means drugs injected or inhaled to relax you or lessen the pain, or make you unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.

- Therapeutic drug injections.
- Surgical treatment, removal of the root tip of the tooth, and/or post-surgical complications.
- Pulpal regeneration.
- Inlays.
- Crowns, onlays, core buildup (including pins) post and core (in addition to crowns), once per tooth per 60 months.
- Dentures, implants, and bridges, once per 60 months.
- Fixed partial denture retainers – inlays/onlays, once per 60 months.
- Implant supported complete and partial denture.
- Adjustments to dentures.
- Rebase and reline of dentures, once per 36 months, beginning 6 months after initial placement.
- Tissue conditioning.
- Occlusal guards, once per 12 months, age 13 and over.
- Periodontic exams, twice per 12 months.
- Periodontic scaling, once per 24 months.
- Periodontic maintenance, four per 12 months.
- Removal of diseased gum tissue and reconstructing gums, once per 36 months.
- Removal of diseased bone.
- Reconstruction of gums and mucous membranes by surgery.
- Full mouth debridement, once per lifetime.
- Removing plaque and calculus below the gum line for periodontal disease.

Pediatric Orthodontic Services

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Medically necessary orthodontic services for congenital or hereditary conditions requiring medical treatment and/or corrective surgery (Limited to members up to the end of the month in which the member turns 19)	50% of the allowed amount, subject to the policy year deductible	50% of the allowed amount, subject to the policy year deductible

Retail Prescription Prepaid Drug Benefits

Attention: Precertification (sometimes referred to as prior authorization) is required for certain prescription drugs. You can find more information about this in the Medical Necessity and Precertification section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Retail Prescription Prepaid Drug Benefits The retail pharmacy network for the plan is **Prime Participating Retail Network** Locate a **Prime Participating** Retail Network pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocat or** Prescription drugs (other than maintenance drugs) can be dispensed for up to a 30-day supply Some copays combined for diabetic supplies Maintenance drugs can be dispensed for a 90-day supply, but copayment is applicable for each 30-day supply View the **Source+Rx 1.0** list that applies to the plan at AlabamaBlue.com/2024SourcePlusRx1DrugList Tiers 5 and 6 (Specialty) drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Tiers 5 and 6 (specialty) drugs is the **Pharmacy Select Network** Go to AlabamaBlue.com/SelfAdministeredSpecialtyDrugList for a list of these Tiers 5 and 6 (specialty) drugs Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network. A list of the eligible vaccines these pharmacies may provide can be found at: AlabamaBlue.com/VaccineNetworkDrugList	100% of the allowed amount, subject to the following copayments: **Tier 1 drugs** $10 copay per prescription **Tier 2 drugs** $10 copay per prescription **Tier 3 drugs** $40 copay per prescription **Tier 4 drugs** $50 copay per prescription **Tier 5 drugs** $40 copay per prescription **Tier 6 drugs** $50 copay per prescription Covered Insulin Products: $99 maximum cost share per 30-day supply	Not covered

Select Generic Specialty and Biosimilar Drugs

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Select generic specialty and biosimilar drugs Generic specialty and biosimilar drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some generic specialty and biosimilar drugs is the Pharmacy Select Network. • View the Select Generic Specialty and Biosimilar Drug list that applies to the plan at AlabamaBlue.com/SelectGenericSpecialtyandBiosimilarDrugList.	100% of the allowed amount, no deductible or copayment	Not covered

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

- To be eligible for benefits, drugs must be FDA approved legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal law prohibits dispensing without a prescription."
- Drugs are classified in tiers generally by their cost to the plan with Tier 1 drugs having the lowest cost to the plan and Tier 6 having the highest cost to the plan. To determine the Tier in which a drug is classified by your plan, log into *my*BlueCross at AlabamaBlue.com. Once there, you can search for your drug by clicking the "Find Drug Pricing" link located in the Manage My Prescriptions section of our website. The Tier drug classifications are updated periodically.

- 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 pharmacy section of our website. Even though your physician has written a prescription for a drug, the drug may not be covered under the plan or clinical edit(s) may apply (i.e. prior authorization, step therapy, quantity limitation) in accordance with the guidelines. A drug may not be covered under the plan because, for example, there are safety and/or efficacy concerns or there are over-the-counter equivalent drugs available. 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 Department number on the back of your ID card for more information.

- Prescription drug benefits are provided only if dispensed by an in-network pharmacy. Except for certain specialty drugs, in-network pharmacies are pharmacies that have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense prescription drugs under the plan. For certain specialty drugs, in-network pharmacies must have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense these specialty drugs.

- Specialty drugs are high-cost drugs that may be used to treat certain complex and rare medical conditions and are often self-injected or self-administered. Specialty drugs often grow out of biotech research and may require refrigeration or special handling.

- Compounded drugs are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved

prescription ingredient and must not be a copy of a commercially available product. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded drugs may be subject to additional coverage criteria and utilization management edits. Compounds are covered only when medically necessary. Compound drugs are always classified as Tier 4 drugs.

Attention: Just because a drug is classified by the plan as Tier 1 or any other classification on our website does not mean the drug is safe or effective for you. Only you and your prescribing physician can make that determination.

- Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used (e.g., 23 days into a 30-day supply). Your pharmacist may be able to synchronize the refill date for your prescriptions. Ask your pharmacist if prescription drug medication synchronization is available for 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 and other diabetic supplies always have a separate copayment.

- If your drug is not covered and you think it should be, you may ask us to make an exception to the drug coverage rules your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception.

Mail Order Prescription Drug Benefits

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Mail order pharmacy service To enroll in the mail order pharmacy service, go to AlabamaBlue.com/HomeDelivery Network Mail order drugs are available through **Home Delivery Network** and when purchased through the mail order pharmacy service can be dispensed up to a 90-day supply with one copayment per prescription If you have less than a 90-day prescription, you will still have to pay the same copayment as a 90-day supply when using this mail order pharmacy service Tiers 5 and 6 (specialty) drugs are not available through this pharmacy service View the **Source+Rx 1.0** list that applies to the plan at AlabamaBlue.com/2024Source PlusRx1DrugList	100% of the allowed amount, subject to the following copayments for up to a 90-day supply for each prescription: **Tier 1 drugs**: $25 copayment per prescription **Tier 2 drugs**: $25 copayment per prescription **Tier 3 drugs**: $100 copayment per prescription **Tier 4 drugs:** $125 copayment per prescription **Tier 5 drugs:** Not covered **Tier 6 drugs:** Not covered	Not covered

Provider-Administered Drug Benefits

> **Attention:** Precertification (sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find more information about this in the Medical Necessity and Precertification section of this booklet.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office or home healthcare setting. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

Provider-administered drugs also include gene therapy and cellular immunotherapy. Gene therapy is generally a therapy designed to introduce genetic material into cells to compensate for abnormal genes or to make a beneficial protein. Cellular immunotherapy is generally the artificial stimulation of the immune system to treat cancer, such as cytokines, cancer vaccines oncolytic virus therapy, T-cell therapy and some monoclonal antibodies.

Provider-administered drug coverage is subject to Drug Coverage Guidelines and medical necessity policies found in the pharmacy section of our website. A drug may not be covered under the plan because, for example,

there are safety and/or efficacy concerns. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. The guidelines in some instances also require the drug be administered by a provider and/or facility approved by the drug manufacturer.

ADDITIONAL BENEFIT INFORMATION

Individual Case Management

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

Chronic Condition Management

You may also qualify to participate in the chronic condition management program. The chronic condition management program is available for members with heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD), asthma and other specialized conditions. 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 1888-841-5741 (Monday – Friday, 8 a.m. to 4:45 p.m. CST), or e-mail membermanagement@bcbsal.org.

Baby Yourself Program

Baby Yourself offers individual care by a registered nurse. Please call our nurses at 1-800-222-4379 (or 1-205733-7065 in Birmingham) or visit AlabamaBlue.com/BabyYourself as soon as you find out you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant.

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

Organ and Bone Marrow Transplants

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

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

Transplant benefits for living donor expenses are limited to:

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

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copayments, coinsurance and other plan limitations. For example, if the member's coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

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

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

Air Medical Transport Service(s)

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

Air medical 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 (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 available only twice per policy year per member and are not available to members travelling outside the United States for more than 90 consecutive days. Services are also not available for (1) any location where the US State Department has issued travel restrictions or declared to be high risk areas; (2) any member with tuberculosis or other chronic airborne pathogens; (3) in most instances a member beyond the second trimester of pregnancy; (4) members with simple injuries or mild illnesses which do not require hospitalization.

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 policy year deductible and coinsurance provisions that apply for other medical and surgical benefits.

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 group, 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.

    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.

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.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of the “birthday rule” 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 policy 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 policy 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.

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 this plan’s 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 to you by your attorney for obtaining the recovery. If you do not give us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

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

HEALTH BENEFIT EXCLUSIONS

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

A

Services, expenses or supplies for **abortion** (except when necessary to prevent a serious health risk to the woman or as required by applicable laws).

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.

Unless otherwise covered under the Pediatric Dental Benefits section of this booklet, **appliances** (including orthodontia) or restorations to alter vertical dimensions from its present state or restoring or maintaining the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from the grinding of teeth or the wearing down of the teeth, fabrication of mouth guard, and restoration from the misalignment of teeth.

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

B

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

C

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

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

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

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

Pediatric diagnostic and preventive dental services related to **cone beam** imaging and cone beam MRI procedures.

The following contraceptive prescription drugs or services:

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

Services or expenses for cosmetic surgery and other cosmetic services or supplies. **Cosmetic surgery** is any surgery done primarily to improve or change the way one appears. “Reconstructive surgery” is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. 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 must contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.

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

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

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

D

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

Services or expenses we determine are not **dentally necessary** or for which do not meet generally accepted standards of dental practice. This includes, but is not limited to dental procedures that are considered strictly cosmetic in nature including charges for personalization or characterization of prosthetic appliances precision attachments, precious metal bases and other specialized techniques.

Except as may be otherwise expressly covered in this booklet, **dietary** instructions.

E

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

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

Eyeglasses or contact lenses or related examinations or fittings, except under the limited circumstances set forth in the section of this booklet called Other Covered Services and Pediatric Vision Benefits.

Unless otherwise covered under the Pediatric Vision Benefits section of this booklet, services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy, except under the limited circumstances.

F

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

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

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

G

Gold foil restorations.

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

H

Hearing aids or examinations or fittings for them.

I

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

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

Services or expenses for or related to the diagnosis or treatment of an **intellectual disability** or **intellectual developmental disorder.**

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.

L

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

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

M

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

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

N

Services or expenses for or related to **nicotine addiction** except as provided under the section of this booklet called Physician Preventive Benefits.

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

O

Except as may be otherwise expressly covered in the booklet, services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion includes bariatric surgery and gastric restrictive procedures and any complications arising from bariatric surgery and gastric restrictive procedures. (This exclusion does not apply to cardiac or pulmonary rehabilitation, diabetes self-management programs or plan-approved programs for pediatric obesity.)

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

P

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

Private duty nursing.

R

Services or expenses for **recreational** or educational therapy (except for plan-approved diabetic self management programs, pulmonary rehabilitation programs, or Phase 1 or 2 cardiac rehabilitation programs.).

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

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

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

Replacement or upgrade of existing properly functioning durable medical equipment (including prosthetics), even if the warranty has expired.

Services or supplies furnished by a facility that is solely classified as a **residential treatment center.** This does not exclude covered substance abuse services or supplies furnished by a general hospital, psychiatric specialty hospital or substance abuse facility.

Residential treatment.

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

Routine well child care and routine immunizations except for the services described at AlabamaBlue.com/PreventiveServices.

Routine physical examinations except for the services described at AlabamaBlue.com/PreventiveServices.

S

Exclude coverage related to any injury sustained while participating in, traveling to and from, or practicing for any intercollegiate or professional **sport**.

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

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

Services or supplies furnished by a **skilled nursing facility**.

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

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

- Hot and cold packs;
- Standard batteries used to power medical or durable medical equipment;

- Solutions used to clean or prepare skin or minor wounds including alcohol solution or wipes, povidone-iodine solution or wipes, hydrogen peroxide, and adhesive remover;
- Standard dressing supplies and bandages used to protect minor wounds such as band aids, 4 x 4 gauze pads, tape, compression bandages, eye patches;
- Elimination and incontinence supplies such as urinals, diapers, and bed pans; and,
- Blood pressure cuffs, sphygmometers, stethoscopes and thermometers.

T

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

Unless otherwise covered under the Pediatric Dental Benefits section of this booklet, treatment for or related to **Phase II temporomandibular joint (TMJ) disorders** 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 unless otherwise required by law. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.

Topical medicament center.

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

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

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

W

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

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

CLAIMS AND APPEALS

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

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

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can obtain the form by calling our Customer Service Department. You can also go to 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

Filing a Claim: For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), we must receive a properly completed and filed claim from you or your provider. In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper type of form. When you receive the form, complete it, attach an itemized bill, and send it to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

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

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

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

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

Pre-Service Claims

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

In order to file a pre-service claim, you or your provider must call our Health Management Department at 1205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

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

You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD). CURP is a program implemented by us and in-network hospitals in the Alabama service area to simplify the administration of preadmission certifications and concurrent utilization reviews.

If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you.

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

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

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing. If we do

not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing information to us.

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

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

Concurrent Care Determinations

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

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

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

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

Your Right to Information

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

Appeals to Blue Cross and Blue Shield of Alabama

The rules in this section of the booklet allow you or your authorized representative to appeal any denial of a claim, any denial of initial eligibility under the plan and any retroactive rescission of plan coverage for fraud or intentional material misrepresentation. Please note that if you call or write us without following the rules for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

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

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

You must send your appeal to the following address:

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

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

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

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

You must send your appeal to the following address:

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

How to Appeal Pre-Service Claim Determinations: You may appeal a pre-service claim determination 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 1-205-988-2245 (in Birmingham) or 1-800-248- 2342 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy, call 1-205-220-7202.

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 Department – Appeals
P. O. Box 2504
Birmingham, Alabama 35201-2504

or,

- For in-network physical therapy, occupational therapy, speech therapy or care from an in-network chiropractor:

Blue Cross and Blue Shield of Alabama
Attention: Health Management Department – 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.

For urgent pre-service claims, you may file an external review at the same time you file your internal appeal with us.

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

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

Time Limits For Our Consideration Of Your Appeal: If your appeal arises from our denial of a post-service claim, our denial of your or your dependents' initial eligibility under the plan or our retroactive rescission of plan coverage for fraud or intentional misrepresentation, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a pre-service claim, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. You may also file an urgent pre-service external review at the same time you file your urgent pre-service appeal. 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 we do not complete your internal appeal within the time periods specified above, you may also file an external review (as discussed below).

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

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

External Reviews

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

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

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

external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling us at 1-800-248-2342 (toll-free) or by faxing your request to 1-205-220-0833 or 1-877-5063110 (toll-free).

Surprise Billing External Review

You may file a request with us for an independent, external review when an adverse benefit determination involves an item or service within the scope of the No Surprises Act. This includes items and services for out-of-network emergency services, nonemergency services performed by nonparticipating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. See the Your Rights and Protections Against Surprise Medical Bills section of this booklet.

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 Department - 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.

Alabama Department of Insurance

If you have general insurance questions or if you are dissatisfied with an appeal decision from Blue Cross and Blue Shield of Alabama, you have the right to contact the Alabama Department of Insurance. For health insurance questions, contact the DOI by phone at 1-334-241-4141. The mailing address is P.O. Box 303351, Montgomery, Alabama 36130-3351. The website is www.aldoi.gov.

Limitation on Effect of Certain Amendments

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

Continuation of Coverage

All insured students and eligible dependents who have been continuously insured under the university's student health insurance plan for at least three consecutive months and who no longer meet the eligibility requirements under that policy are eligible to continue their coverage for a period of not more than 90 days under the university's policy in effect at the time of such continuation.

Should Continuation of Coverage extend into the next policy year, the insured student and eligible dependents must purchase coverage under the new policy in effect at that time. Continuation of Coverage under the new policy is subject to the rate and benefits selected by the university for that policy year. Application must be made and premium must be paid and received within 14 days after the expiration date of the insured student and eligible dependents coverage.

GENERAL INFORMATION

Discretionary Authority to Blue Cross

We have the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with the administration of the plan. Whenever we make reasonable decisions that are neither arbitrary nor capricious, our decisions will be determinative, subject only to your right of review under the plan and thereafter to arbitration to determine whether our decision was arbitrary or capricious.

Arbitration

IN CONSIDERATION OF COVERAGE UNDER THE PLAN AND PAYMENT OF PREMIUMS, YOU (AND WE) AGREE THAT ANY ONE OR MORE OF THE FOLLOWING CLAIMS FOR WHICH AN EXTERNAL REVIEW (AS DESCRIBED ABOVE) IS NOT AVAILABLE OR FOR WHICH YOU (OR WE) HAVE FURTHER RIGHTS UNDER ANY APPLICABLE LAW FOLLOWING SUCH EXTERNAL REVIEW SHALL BE RESOLVED BY FINAL AND BINDING ARBITRATION:

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

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

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

THE CLAIMANT IS RESPONSIBLE FOR STARTING THE ARBITRATION PROCEEDINGS BY NOTIFYING THE OTHER PARTY IN WRITING OF THE

ARBITRATION DEMAND. IF THE CONTRACT HOLDER OR MEMBER IS THE CLAIMANT, THE WRITTEN ARBITRATION DEMAND SHOULD BE SENT TO THE FOLLOWING ADDRESS:

BLUE CROSS AND BLUE SHIELD OF ALABAMA
LEGAL DEPARTMENT
450 RIVERCHASE PARKWAY EAST
BIRMINGHAM, AL 35244

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

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

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

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

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

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

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

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will show in your claim 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 cannot be responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you commit fraud or make any intentional misrepresentation of material fact in applying for coverage, when we learn of this we may terminate your coverage back to your effective date. We need not even refund any payment for your coverage. You have the right to appeal our decision. Your rights to appeal are explained in the Claims and Appeals section of this booklet.

Alabama Insurance Fraud Investigation Unit and Criminal Prevention Act

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

No Assignment

As discussed in more detail in the Claims and Appeals section of this benefit booklet, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. However, regardless of who

files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network provider (as required by our contract with your in-network provider) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the provider. When we pay you or your provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

DEFINITIONS

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

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

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

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

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

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

2. **Out-of-Network Providers:** In accordance with Blue Cross and Blue Shield of Alabama's applicable provider payment policies in effect at the time the service is rendered, the allowed amount for care rendered by out-of-network providers may be based on the negotiated rate payable to in-network providers for the care in the area, may be based on the average charge for the care in the area, may be based on a percentage of what Medicare would typically pay for the care in the area (or, if no Medicare rates are available, an approximation of what Medicare would pay for care using various sources), or in accordance with applicable Federal law. 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;
   - 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 certain out-of-network providers, 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 out-of-network emergency services for medical emergencies or for air ambulance services, the allowed amount will be determined in accordance with the requirements of the applicable Federal law.

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

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

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

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

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

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

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

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

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

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your dental condition;
- Provided for the diagnosis or direct care and treatment of your dental condition;
- In accordance with standards of good dental practice accepted by the organized dental community;
- Not primarily for the convenience and/or comfort of you, your family, your dentist, or another provider of services; and,
- Not "investigational."

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

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

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

Habilitative services: Healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living.

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

Home Infusion Service Provider: A home infusion service provider is a state-licensed pharmacy that specializes in provision of infusion therapies to patients in their home or other alternate sites associated with the home infusion provider such as a home infusion suite.

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

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

In-Network Provider: See the In-Network Benefits subsection of the Overview of the Plan section of this booklet.

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

Intensive Outpatient: Mental health disorders and substance abuse services provided in a licensed facility by a licensed provider for a minimum of three hours per day at least three days per week with active psychosocial treatment and medication management as needed.

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

- The technology must have final approval from the appropriate government regulatory bodies;

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;

- The technology must improve the net health outcome;

- The technology must be as beneficial as any established alternatives; and,

- The improvement must be attainable outside the investigational setting.

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

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

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

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;

- Provided for the diagnosis or direct care and treatment of your medical condition;

- In accordance with standards of good medical practice accepted by the organized medical community;

- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;

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

Outside Alabama: A term used to describe services received by a member from an In-Network Provider outside the state of Alabama.

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.

Partial Hospitalization: Mental health disorders and substance abuse services provided in a licensed facility by a licensed provider for a minimum of six hours per day, five days per week with active psychosocial treatment and medication management as needed.

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

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

Precertification: The procedures used to determine the medial necessity of the treatment prior to the service.

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, 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.

Rehabilitative services: Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

Residential treatment: Continuous 24 hour per day care provided at a live-in facility for mental health or substance abuse disorders.

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 provides outpatient substance abuse 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.

NOTICE OF NONDISCRIMINATION

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FOREIGN LANGUAGE ASSISTANCE

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüístic
Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: 1-855-216-3144 تباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل الهاتف النصي: 711). بـ

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachlich
Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposé gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Re 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855 216-3144 પર કોલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong s wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່ ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń po numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。

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