ELIGIBILITY FOR BENEFITS

IBEW-NECA Local 505 Health Plan

Employer Identification Number 63-0366157 – Blue Cross Blue Shield Group Number 26256

("Health Plan" or the "Plan")

ELIGIBILITY INSERT

This **Eligibility Insert** describes the eligibility rules of the Health Plan including how you become covered for benefits, maintain coverage and provide coverage for dependents under the Health Plan.

This Eligibility Insert is a part of and integral to the Summary Plan Description (SPD) booklet provided by Blue Cross Blue Shield of Alabama which explains the Health Plan benefits, provisions, limitations, exclusions and participant rights under the Health Plan.

The SPD booklet does not include the eligibility rules. The eligibility rules are stated in this Eligibility Insert which is provided to you with the SPD booklet. If the SPD booklet does not include this Eligibility Insert, call the Plan Manager.

Questions concerning eligibility under the Plan should be directed to the Plan Manager –

Alabama Administrators
1717 Old Shell Road
Mobile, AL 36604

(251) 478-5412

Questions concerning benefits and claims should be directed to the Claims Administrator –

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, AL

1-800-292-8868

ELIGIBILITY RULES

IBEW-NECA Local 505 Health Plan

("Health Plan" or the "Plan")

Eligible Employee

An employee is an Eligible Employee if employed by or seeking employment with a participating employer in a job classification covered under the terms of the Collective Bargaining Agreement or other written agreement approved by the Board of Trustees which requires the employer to make contributions to the Health Plan.

Non-Bargaining employee participation as an Eligible Employee is contingent on a written agreement between the employer and the Board of Trustees.

An Eligible Employee can achieve initial eligibility and maintain continuing eligibility only while remaining an Eligible Employee. Failure to remain an Eligible Employee will result in termination of eligibility for coverage under the Plan effective the last day of the month in which the employee ceases to be an Eligible Employee regardless of hours worked or reserve hours.

Eligibility Based on Hours Worked

The Collective Bargaining Agreement or other written agreement approved by the Trustees requires employers to pay into the Health Plan a negotiated contribution rate for each hour worked. Overtime hours are also paid at the rate per hour worked. The monthly report of employee hours worked and the employer contribution payment are sent to the Health Plan after the employer confirms the payroll records for each month. The Plan is due to receive the monthly report in the month following the report period. Eligibility for coverage under the Plan is based on the information provided in the employer reports.

The employer monthly report is based on the employer's weekly payroll periods which may or may not correspond to the calendar month. The employer's payroll period report for the month is used to determine initial and continuing eligibility. Hours worked for a calendar month are not available and not used for determining eligibility.

Transfer of Hours When You Work Out of Town – Reciprocity

The Health Plan participates in reciprocal agreements with other health and welfare plans. Reciprocal contributions received by this Health Plan on behalf of an employee are credited based on hours worked and reported regardless of the contribution rate received. The reciprocal contribution rate will not increase or decrease the number of hours credited towards an employee's eligibility.

It is the responsibility of the employee, when working outside the jurisdiction of the Home Local, to ensure that reciprocal hours and contributions are transferred to this Health Plan, referred to as the Home Plan. This may require the employee to register in the reciprocal transfer system listing the Home Plan. Hours worked for which reciprocal contributions are due cannot be credited to an employee's record until the contribution is paid and received by this Health Plan. It is not the responsibility of the Trustees or the Health Plan to procure a reciprocal transfer on behalf of an employee.

Additional information about reciprocity may be found in the national reciprocal agreement or by contacting your Local Union office. Late reciprocal transfers can affect eligibility, see COBRA Continuation of Coverage.

Initial Eligibility

An Eligible Employee will become initially eligible for coverage under the Health Plan by working at least **450** hours during a six (6) consecutive month period. The coverage will become effective on the first day of the month following the month in which this requirement is completed and coverage will remain in effect until the first day of the next Coverage Quarter.

Initial Eligibility - Continued

The Plan Manager will notify the Eligible Employee when coverage starts under the Health Plan. This notice will be sent some time **after** the employee has become eligible due to the fact that employer records do not reach the Health Plan immediately. The notice of coverage will include this Eligibility Insert, a Summary of Benefits and Coverage, a Summary Plan Description and an enrollment form for applying for coverage for the employee and dependents. Information concerning when coverage will start can be obtained from the Plan Manager.

To finalize eligibility, the Eligible Employee must complete and file an enrollment form with the Plan Manager's office listing all individuals for which the employee requests coverage. Dependents will not be covered until the Plan Manager receives a completed enrollment form listing the dependent(s) and all required information to evidence Eligible Dependent status.

Continuing Coverage

After obtaining initial eligibility, an Eligible Employee will continue coverage under the Health Plan by working at least **450** hours in each Eligibility Quarter. Working **450** hours in an Eligibility Quarter entitles the Eligible Employee to continue coverage for the corresponding Coverage Quarter. Eligibility Quarters and Coverage Quarters are as follows:

Work in This Period **ELIGIBILITY QUARTER**			***Provides Coverage in This Period*** **COVERAGE QUARTER**		
January	February	March	June	July	August
April	May	June	September	October	November
July	August	September	December	January	February
October	November	December	March	April	May

The Eligibility Quarter and Coverage Quarter are separated by two (2) months. These "lag months" allow time for the employer report to be received and processed by the Plan.

EXAMPLE 1: If the Eligible Employee worked **450** hours in the Eligibility Quarter – January, February, and March – the Eligible Employee is covered for June, July, and August.

Credit for hours less than **450** will be at the rate of one month of coverage for every **150** hours worked. After credit for hours worked, the Eligible Employee may use Reserve Hours or the Disability Credit and when all hours are exhausted elect COBRA continuation of coverage.

EXAMPLE 2: If the Eligible Employee worked **300** hours in the Eligibility Quarter – January, February, and March – the Eligible Employee is covered for June and July. In this example, the employee has no Reserve Hours and will need to pay the COBRA premium for the month of August to complete the Coverage Quarter. The Eligible Employee receives an eligibility notice and COBRA continuation of coverage election form.

The examples are based on hours worked. In addition to hours worked, the Eligible Employee may accumulate and use Reserve Hours to continue coverage under the Health Plan.

Reserve Hours – Hour Bank

Reserve Hours can assist an Eligible Employee in retaining coverage during periods of illness or periods of low employment. After the employee has obtained coverage under the Health Plan, any hours worked in excess of **450** during an Eligibility Quarter will be credited to the Eligible Employee's Reserve Hour Bank. The maximum number of Reserve Hours that can be accumulated is **450** hours. Reserve Hours will only extend coverage when the individual is an Eligible Employee. Reserve Hours are forfeited when the individual no longer meets the definition of an Eligible Employee.

Disability Credit

An Eligible Employee who becomes disabled while covered under the Health Plan based on hours worked will have up to three months of coverage (maximum **450** hours) paid for by the Health Plan. The member must show medical proof of disability using the Health Plan's disability claim form which requires a doctor's certification and signature. No more than three (3) months of coverage may be credited for any one disability or during any twelve-month period. **The member must apply in writing within six (6) months of the date the disability started or the disability credit will be forfeited.** Any disability credit will not extend a COBRA continuation of coverage period but rather runs concurrent with the COBRA maximum period.

Reinstatement of Eligibility for Benefits

Eligible Employees who have been covered under the Health Plan and have had their coverage terminate for one of the reasons listed in the section of this Eligibility Insert titled "Termination of Coverage" will be eligible for reinstatement of coverage based on hours worked. Eligibility for coverage may be reinstated under the same terms as required for initial eligibility, except that in no case shall coverage reinstate earlier than the first day of the Coverage Quarter following the date of termination.

NOTE: The Eligible Employee must complete an enrollment form each time coverage starts under the Plan. Only those listed on the enrollment form will be covered by the Health Plan. Eligible Dependents must be listed by name, date of birth and Social Security number.

Termination of Coverage

Eligible Employees, Retirees, and/or Dependents will no longer be eligible for coverage on the earlier of:

1. The last day of the month during which the employee is no longer an Eligible Employee regardless of Reserve Hours.
2. The first day of a Coverage Quarter corresponding to the Eligibility Quarter during which the employee has fewer than **150** hours worked plus Reserve Hours or the first day of the month during the Coverage Quarter following the pro-rating of coverage at the rate of **150** hours per month.
3. The first day of the month in which the member fails to make payment of the required COBRA premium within 30 days of the due date or within another specifically stated grace period.
4. The last day of the month in which the individual reaches the maximum allowed period for COBRA continuation of coverage.
5. The last day of the month during which there is a divorce or other termination of marriage for the dependent spouse.
6. In the case of a dependent, the last day of the month in which the dependent no longer meets the definition of an Eligible Dependent or the Eligible Employee fails to provide information to verify dependent status when requested or the date the Eligible Employee's eligibility for coverage terminates.
7. In the case of a Retiree and dependent, the first day of the month in which the Retiree or dependent fails to make timely payment of the required COBRA premium or the date on which the Retiree or dependent becomes eligible for Medicare or other employer-sponsored group coverage or the dependent is no longer an Eligible Dependent.
8. Dependent coverage terminates the last day of the month in which the employee dies.
9. The date the Trustees amend the Plan to exclude coverage for any class of members or the date the Health Plan is terminated.
10. The date a member submits a false claim or is involved in any other fraudulent act related to this Plan.

In all cases, the termination occurs automatically and without notice. Termination of coverage occurs on the last day of the month in which the participant has a termination event except for failure to make timely payment of a required premium in which case coverage terminates on the first day of the month for which the premium is due. Some termination events will qualify the individual for COBRA continuation of coverage and that is explained in the Summary Plan Description booklet.

COBRA Continuation of Coverage

Should coverage terminate due to insufficient hours or failure to remain an Eligible Employee or Eligible Dependent, the employee/dependent may elect to continue coverage under the temporary continuation of coverage provision, commonly called COBRA. This continuation of coverage is available to the employee and dependents. Additional information on the member's rights under this law can be found in the section titled "COBRA" of the SPD booklet. You may also contact: 1-866-444-3272 or www.dol.gov/ebsa.

The member is responsible for notifying the Plan Manager when there is a Change-In-Status Event that results in a termination of coverage for a dependent, such as a divorce or child reaching age 26. The member must file the notice with the Plan Manager within thirty (30) days of the Event and the Plan will provide a notice of COBRA eligibility. If the member elects COBRA continuation of coverage, there is a required monthly premium payment to maintain coverage. The required monthly premium payment is made in accordance with the rules and regulations established by the Trustees and allowed under COBRA.

Eligibility is determined on a prospective basis and work performed today may not affect the requirement that the employee pay a COBRA premium for coverage in the current Coverage Quarter. Payments must be made even if the employee has returned to work. Any COBRA premium the employee pays that is later determined to be unnecessary will be refunded to the employee. Example, hours not timely reported by a reciprocal health plan may result in the employee having to pay a COBRA premium to maintain coverage. In such case, the Plan may refund the COBRA premium when the reciprocal contributions are received. Failure to pay the COBRA premium will result in termination and coverage will not reinstate until the Initial Eligibility requirement is met.

In addition, the Plan offers two special extensions: Retiree Extension and Survivor Dependent Extension.

Retiree Extension

An Eligible Employee who is at least age sixty (**60**) or disabled under Social Security and eligible for the Local's Retirement Plan may continue coverage after the standard COBRA continuation period by paying the required monthly premium. Retirees may continue coverage for themselves and for their Eligible Dependent(s) who were covered under the Plan at the time of the member's retirement. The retiree may not add any dependent that was not covered at the time of retirement after the first eighteen (18) months of COBRA coverage.

Coverage may be continued until the Retiree is eligible for Medicare; Eligible Dependents who are not eligible for Medicare may continue coverage under the Plan through payment of the required monthly premium after the Retiree's coverage terminates. Coverage for an Eligible Dependent will terminate when the dependent becomes eligible for Medicare or when the individual ceases to be an Eligible Dependent under the Plan. Please see the section of this Eligibility Insert titled "Termination of Coverage" for additional information. In general, coverage will always terminate when the individual becomes eligible for Medicare. The Retiree and Eligible Dependent(s) are covered under the same benefit schedule as employees.

The required premium amount for Retirees is established by the Board of Trustees and Retirees receive a notice of the premium amount due at the time of retirement and within thirty days of the date of a change in the amount due. The Plan does not send a monthly notice of the required premium due to Retirees. It is the Retiree's responsibility to ensure that payments are made in a timely manner to avoid termination of coverage. The required premium is due the first day of each month for coverage that month and there is a 30-day grace period for payment. The required premium payments must be made in accordance with the rules and regulations established by the Board of Trustees. This benefit is not guaranteed and may be terminated.

Failure to make timely payment of the required premium will result in a termination of coverage which may not be reinstated for any reason other than hours worked. The Retiree is **required** to notify the Plan Manager if there is a return to work after the retirement date.

A Medicare eligible retiree who returns to work may become eligible based on hours worked and in such case the Health Plan will pay first, before Medicare, as the primary plan. The Medicare eligible retiree who elects COBRA continuation of coverage, may continue under the Health Plan but the Health Plan will pay after Medicare pays and only for expenses paid by Medicare. In that case, because the Health Plan is secondary to Medicare, the retiree should be enrolled in Part B Medicare and this will ensure that the retiree does not have to pay a Medicare premium penalty or incur an extended waiting period for Part B Medicare coverage to take effect if there is a late enrollment. Medicare does not consider a Retiree Plan or COBRA as an employment plan for the purpose of delaying enrollment in Part B Medicare.

Survivor Dependent Extension

Should the employee decease while covered under the Health Plan, the Eligible Dependent(s) may elect COBRA coverage and have the first three **(3)** months of coverage from the date of the employee's death at no cost and may then continue coverage through the remainder of the COBRA maximum coverage period allowed by paying the required monthly premium. After the first thirty six (36) months of COBRA, the surviving dependent(s) may continue coverage by paying the monthly premium until the dependent no longer meets the definition of an Eligible Dependent, the date the spouse remarries, becomes eligible for other employer-group coverage, or Medicare.

The Eligible Dependent of a Retiree who dies while covered Plan may continue coverage by making the required monthly premium. **The surviving dependent of a Retiree will not qualify for the three (3) months of paid coverage.**

Dependent Coverage

An Eligible Employee's Eligible Dependent(s) will become covered under the Health Plan when the Eligible Employee becomes covered under the Plan **if** the employee completes an enrollment form naming each dependent and files that form with the Plan Manager within thirty (30) days of notification by the Plan of initial eligibility. Late enrollment, after thirty (30) days of the notification, will postpone the effective date of coverage for that dependent to the first day of the month following receipt of the enrollment form and any information required by the Plan to evidence dependent status. Only Eligible Dependents who are listed on the enrollment form may be eligible for benefits under the Health Plan.

A new Eligible Dependent will be covered on the date they become a dependent (date of marriage, date of birth or adoption). Dependent eligibility is not automatic; the Eligible Employee must complete and file an enrollment form with the Plan Manager within thirty (30) days of the event in order to add an Eligible Dependent.

Failure to notify the Plan Manager's office of the addition of a new dependent within thirty (30) days of the event will result in the dependent becoming eligible for coverage on the first day of the month following the month in which the Eligible Employee files an enrollment form listing the dependent with the Plan Manager. The Eligible Employee must be able to provide the dependent's date of birth, Social Security number and other written documentation if requested by the Plan to evidence any requirement necessary for Eligible Dependent status.

An Eligible Dependent is defined in the Summary Plan Description booklet.

SPECIAL LIMITATION FOR DEPENDENT COVERAGE

CONSTRUCTION ELECTRICIAN (CE) AND CONSTRUCTION WIREMAN (CW)

A Construction Electrician (CE) or Construction Wireman (CW) must pay a monthly premium to the Health Plan to cover Eligible Dependent(s). This premium is required by members in the CE and CW classification because the collectively bargained employer contribution rate is less than that of the journeyman classification. Should for any reason the employer report hours based on the journeyman rate, this will not affect the CE and CW classification for the purposes of coverage and said coverage will remain limited to that provided for the CE and CW classification (no dependent coverage without payment). A CE or CW classified employee must contact the Plan Manager immediately upon becoming eligible under the Plan, if not before, to obtain information on how to enroll for the dependent coverage and make monthly premium payments to provide Eligible Dependent coverage.

Coverage for Eligible Dependents will terminate on the first day of the month in which the employee fails to pay the required monthly premium within the **30** day grace period or within another specifically stated grace period.

Member Responsibility for Failure to Timely Notify

It is the responsibility of the employee and/or dependent (the member) to read the Eligibility Insert, Summary Plan Description booklet, share it with all dependents, and submit when requested any information necessary to protect the member's coverage and rights under the Health Plan. It is the employee's responsibility to obtain and distribute ID cards (identification cards indicating coverage under the Health Plan) to any Eligible Dependents that do not reside with the employee.

The employee and/or dependent (the member) is **required** to notify the Plan Manager in the case of:

- **Divorce**
- Marriage
- Child reaching age 26 years, the maximum age
- Birth, adoption, or placement of a child by guardian or custody status
- When the employee or any eligible dependent becomes eligible for Medicare

It is the member's responsibility to notify the Plan Manager when a Change-in-Status event occurs. Failure to provide notice within thirty (30) days of the event will result in the employee becoming liable for claims paid by the Health Plan on behalf of an ineligible individual.

Even in the case of a divorce when the member is court ordered to provide health insurance for the divorced spouse, the member is **required** to notify the Plan Manager of the divorce so that the ex-spouse is removed from the Health Plan coverage and the Health Plan will then offer the ex-spouse the opportunity to keep the coverage through COBRA continuation of coverage. Failure to timely notify the Plan of an event may result in the employee being billed for any claims paid after the event, a termination of the employee's coverage under the Health Plan or a reduction in hours worked to compensate the Heath Plan for the overpayment.

Eligibility Rules Final and Binding

The Eligibility Rules as stated are final and binding and take precedent over any other statements concerning eligibility. No oral representation, confirmation, description or explanation of eligibility given by any person is binding. Eligibility is solely determined based on these eligibility rules.

Board of Trustees

The Health Plan is governed by the Board of Trustees which is made up of representatives of the Union and Employer Association elected to manage the Health Plan. The Board of Trustees is the Health Plan administrator and each Trustee is a fiduciary to the Trust and Plan. The Trustees are responsible for designing and managing the Plan and maintaining the financial integrity of the Health Plan. The Trustees have full discretionary authority to make determinations with respect to eligibility, benefits, policies, procedures and all matters concerning and related to the Health Plan and Trust. All questions, controversies, appeals or other matters concerning the Health Plan are under the authority of and will be decided by the Board of Trustees. Any decision by the Board of Trustees shall be final and binding. The eligibility rules and benefits may be changed by majority vote of the Trustees. The Trustees have the power and authority to make additional rules and regulations as may be required.

The benefits described are continued on a month-to-month basis. There is no guarantee that the eligibility provisions or benefits will be maintained indefinitely. The Trustees reserve the right to change, modify, reduce and terminate any and all benefits for any class of employees, dependents, or retired employees at their sole discretion. The member will be notified by the Trustees within 60 days of any reduction in benefits or change in eligibility rules that affects the coverage under the Health Plan. Benefits are subject to and contingent upon the financial ability of the Trust Fund to make payment.

Summary Plan Description

This **Eligibility Insert** taken with the Blue Cross Blue Shield benefits booklet comprises the Summary Plan Description. Please read this information carefully and share it with your family.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of some documents, records and other information relevant to the Health Plan or any claim you may make under the Health Plan. The Health Plan's Summary Plan Description booklet describes the eligibility rules, benefits, limitations, exclusions, provisions and your right to appeal as a participant. No action at law or in equity shall be brought by any participant or beneficiary after the expiration of twelve (12) months from the date of a decision issued by the claims administrator (Blue Cross Blue Shield of Alabama) or the Board of Trustees. Failure to bring an action within this 12-month period shall forever bar such action.

Additional information and assistance may be obtained from the Plan Manager –

Alabama Administrators
1717 Old Shell Road
Mobile, AL 36604

(251) 478-5412
1-800-221-7025

IBEW-NECA Local 505 Health Plan

BlueCard PPO

Effective January 1, 2018
Revised March 1, 2018

Table of Contents

Table of Contents

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OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact our Customer Service Department at 1-800-292-8868. 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 usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-800-292-8868. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.

Purpose of the Plan

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

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

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 www.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:

- 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.

BlueCare Health Advocate

By being a member of the plan, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you, and much more. To find out more or to contact your BlueCare Health Advocate, call our Customer Service Department at the number on the back of your ID card.

Definitions

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

Receipt of Medical Care

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

Generally, after-hours care is provided by your physician. They may have a variety of ways of addressing your needs. You should call your physician for instructions on how to receive medical care after the physician's normal business hours, on weekends and holidays, or to receive non-emergency care for a condition that is not life threatening, but requires medical attention.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room.

Having a primary care physician is a good decision:

Although you are not required to have a primary care physician, it is a good idea to establish a relationship with one. Having a primary care physician has many benefits, including:

- Seeing a physician who knows you and understands your medical history.
- Having someone you can count on as a key resource for your healthcare questions.
- Help when you need to coordinate care with specialists and other providers.

Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics. Find a physician in your area by visiting AlabamaBlue.com and choosing Find a Doctor.

Seeing a specialist or behavior health provider is easy:

If you need to see a specialist, you can contact their office directly to make an appointment. If you choose to see a specialist in our BlueCard PPO network, you will have in-network benefits for services covered under the plan. If you choose to see an out-of-network specialist not in the BlueCard PPO network, your benefits could be lower.

Beginning of Coverage

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

Limitations and Exclusions

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

Medical Necessity and Precertification

The plan will only pay for care that is medically necessary and not investigational, as determined by us. We develop medical necessity standards to aid us when we make medical necessity determinations. We publish these standards at www.AlabamaBlue.com/providers/policies. The definition of medical necessity is found in the Definitions section of this booklet.

In some cases, the plan requires that you or your treating physician 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 precertification.

In-Network Benefits

One way in which the plan tries to manage healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. As one example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the plan. Additionally, out-of-network providers have not contracted with us or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the plan.

In-network providers are hospitals, physicians, pharmacies, and other healthcare providers or suppliers that contract with us or any Blue Cross and/or Blue Shield plans (directly or indirectly through, for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced price.

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

- BlueCard PPO
- Participating Hospitals
- Hospital Choice Network
- Preferred Outpatient Facilities
- Participating Ambulatory Surgical Centers
- Participating Renal Dialysis Providers
- Preferred Medical Doctors (PMD)
- Bariatric Surgery Network
- Select Lab Network
- Blue Choice Behavioral Health Network
- Expanded Psychiatric Services
- Participating Chiropractors
- Participating Physician Assistants
- Participating Nurse Practitioners
- Preferred Occupational Therapists
- Preferred Physical Therapists
- Preferred Speech Therapists
- Participating CRNA
- Pharmacy Vaccine Network

- AccessONE Retail Network
- AccessONE ESN Network
- Prime Participating Pharmacy Network
- ValueONE Network
- PreferredONE Retail Network
- PreferredONE ESN Network
- ChoiceONE Retail Network
- ChoiceONE ESN Network
- Pharmacy Select Network
- Preferred DME Supplier
- Participating Air Ambulance

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

1. Click “Find a Doctor.”
2. Select a healthcare provider type: doctor, hospital, dentist, pharmacy, other healthcare provider, or other facility or supplier.
3. Enter a search location by using the zip code for the area you would like to search or by selecting a state.
4. Use the drop-down menu in the Network and Plans filter to select a specific provider network (as noted above).

Search tip: If your search returns zero results, try expanding the number in the Maximum miles for search 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 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder website at http://provider.bcbs.com. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross 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.

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

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract.

The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

Claims and Appeals

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

Changes in the Plan

From time to time it may be necessary to change the terms of the plan. The rules we follow for changing the terms of the plan are described later in the section called Changes in the Plan.

Termination of Coverage

The section below called Eligibility Insert tells you when coverage will terminate under the plan. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the plan or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your group coverage terminates. COBRA coverage is explained in detail later in this booklet.

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 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

Eligibility Insert

SUMMARY PLAN DESCRIPTION (SPD)

and

ELIGIBILITY FOR BENEFITS

IBEW-NECA Local 505 Health Plan

("Health Plan")

ELIGIBILITY INSERT

This Blue Cross Blue Shield SPD booklet does not include the eligibility rules. The eligibility rules are stated in the Eligibility Insert which is provided to you with the SPD booklet. If your book does not include the Eligibility Insert, call the Plan Manager and one will be sent to you.

The **Eligibility Insert** describes the eligibility rules of the Health Plan including how you become covered for benefits, maintain coverage and provide coverage for dependents under the Health Plan.

The Eligibility Insert is a part of an integral to the Summary Plan Description (SPD) booklet provided by Blue Cross Blue Shield of Alabama which explains the Health Plan benefits, provisions, limitation, exclusions and your rights under the Health Plan.

Questions concerning your eligibility under the Plan should be directed to the Plan Manager-

Alabama Administrators
1717 Old Shell Road
Mobile, AL 36604

(251) 478-5412

Eligible Dependents

Your eligible dependents are:

- Your spouse (does not include common law spouse);
- Your married or unmarried child up to age 26; and
- Your unmarried, incapacitated child who (1) is age 26 and over; (2) is not able to support him/herself; and depends on you for support; and (3) provide the Disability commenced prior to age 26.

The child may be the employee's natural child; stepchild; legally adopted child; child placed for adoption; child for whom you are legally required to provide health insurance coverage during the period specified in a Qualified Medical Child Support Order (QMCSO); a child over whom you have legal guardian status by court appointment because the child's parents are dead or have had their parental rights terminated by court action.

The Eligible Employee must provide written documentation when requesting coverage for a dependent.

Evidence must be submitted with the request or within thirty (30) days of a request for verification from the Plan. Failure to provide timely proof of dependency when requested will result in termination of the dependent's coverage retroactive to the date the Plan requested evidence or dependency and the Eligible Employee will be held liable for any benefits paid on behalf of that individual. You may cover your grandchild if you have legally adopted your grandchild.

Member Responsibility for Notice of a Change-In-Status Event

The Eligible Employee is responsible for notifying the Plan Manager of any Change-In-Status Event that affects the eligibility of a family member. A Change-In-Status Event is deemed to occur upon:

- A change in your marital status (marriage, divorce, legal separation or death of your spouse).
- A change in the number of your dependents (birth or adoption of a child, death of a child, obtaining legal custody or legal guardianship).
- A change in your, or your spouse's, employment status (starting/ending employment, changing from part-time to full-time or vice versa, a strike or lock-out, or taking or returning from an unpaid leave of absence or leave under the Family and Medical Leave Act or USERRA during which your, or your spouse's, coverage terminated or was reinstated).
- A change in the eligibility status of a dependent child (child reaching the maximum age for coverage under the Plan, child becoming eligible under his/her employer's health plan regardless of whether or not the coverage is actually elected .
- An end to the Disability of a Disabled child enrolled as your dependent under the Plan.
- A change required by a court order.
- Your, or a dependent's, entitlement to Medicare or Medicaid.
- You or your dependent(s) loss of coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility. Enrollment request must be made within 60 days of the termination of coverage.
- You or your dependent(s) becomes eligible for the premium assistance under Medicaid or SCHIP. Enrollment request must be made within 60 days of becoming eligible for the premium assistance.

If you incur a Change-In-Status event, or if an Eligible Dependent is also eligible for health coverage under another plan, you must notify the office of the Plan Manager within 30 days (unless otherwise noted) of the event and provide written documentation to verify the change in status.

Failure to report a Change-In-Status Event that would result in a dependent no longer meeting the definition of an Eligible Dependent may result in the Eligible Employee's liability for any benefits paid by the Plan on behalf of that individual.

COBRA Continuation of Coverage

Should coverage terminate due to insufficient hours or failure to remain an Eligible Employee or Dependent, the participant/member may elect to continue coverage under the temporary continuation of coverage provision, commonly called COBRA. This continuation of coverage is available to the employee and dependents. Additional information on your rights under this law can be found in the section titled "COBRA" of this booklet. You may also contact :1-866-444-3272 or www.dol.gov/ebsa.

The member is responsible for notifying the Plan Manager when there is a Change-In-Status Event that results in a termination of coverage for a dependent, such as divorce or child reaching age 26. The member must file the notice with the Plan Manage within thirty (30) days of the event and the Plan will provide a notice of COBRA eligibility. If the participants elects COBRA continuation of coverage, there is a required monthly premium payment to maintain coverage. The required monthly premium payment is made in accordance with the rules and regulations established by the Trustees and allowed under COBRA.

Remember, eligibility is determined on a prospective basis and work performed today may not affect the requirement that you pay a COBRA premium for coverage in the current Coverage Quarter. Payments must be made even if you have returned to work. Any COBRA premium you pay that is later determined to be unnecessary will be refunded to you. Example, hours not timely reported by a reciprocal health plan may result in you having to pay a COBRA premium to maintain coverage. In such case, the Plan may refund the COBRA premium when the reciprocal contributions are received.

COBRA will allow you or an eligible participant to maintain coverage under the Plan for a specific period defined by the situation and COBRA regulation. The extension may be as much as 18 to 36 months based on timely payment of the required premium.

Qualified Medical Child Support Orders (QMSCO)

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

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

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

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

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

Relationship to Medicare

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

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

Individuals Age 65 and Older

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

If both you and your spouse are over age 65, you may elect to enroll in Original Medicare or a Medicare Advantage plan and/or a Medicare Part D prescription drug plan and disenroll completely from the plan. This means that you will have no benefits under the plan. If you enroll in Original Medicare, you may also purchase a Medicare Supplement contract. In addition, the group is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract. If you enroll in a Medicare Advantage plan, you may not purchase a Medicare Supplement contract.

If you are age 65 or older, considering retirement, or have another qualifying event under COBRA, and think you may need to buy COBRA coverage after such qualifying event, you should read the section in this booklet dealing with COBRA coverage – particularly the discussion under the heading Medicare and COBRA Coverage.

Disabled Individuals

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

End-Stage Renal Disease

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

Medicare Part D Prescription Drug Coverage

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

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

Leaves of Absence

If your group is covered by the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to employers who employ 50 or more employees. You should contact your group to determine whether a leave qualifies as FMLA leave.

You may also continue your coverage under the plan for up to 30 days during an employer-approved leave of absence, including sick leave. Contact your group to determine whether such leaves of absence are offered. If your leave of absence also qualifies as FMLA leave, your 30-day leave time runs concurrently with your FMLA leave. This means that you will not be permitted to continue coverage during your 30-day leave time in addition to your FMLA leave.

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

Enrollment is Not a Contract of Employment

Eligibility under the Plan and receipt of benefits does not constitute a contract between the Plan and the Eligible Employee as a condition of nor inducement to employment. Enrollment in the Plan does not give any employee the right to be retained in the employ of a contributing employer, nor does it interfere with the right of an employer to discharge any employee at any time.

Eligibility and enrollment under this Plan does not entitle any member to benefits for illness or injury incurred as a result of employment nor as a result of active or inactive duty, voluntarily or involuntarily, in the Uniformed Services.

COST SHARING

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible The in-network and out-of-network calendar year deductibles are separate and do not apply to each other	$1,000 individual ($2,000 family)	$2,000 individual ($4,000 family)
Calendar Year Out-of-Pocket Maximum	$6,000 individual ($12,000 family)	There is no out-of-pocket maximum for out-of-network services

Calendar Year Deductible

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

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

- The individual calendar year deductible must be satisfied on a per member per calendar year basis, subject to the family calendar year deductible.
- The family calendar year deductible is an aggregate dollar amount. This means that all amounts applied toward the individual calendar year deductible will count toward the family calendar year deductible amount. Once the family calendar year deductible is met, no further family members must satisfy the individual calendar year deductible.
- Only one individual calendar year deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- In all cases, the deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is specified in the table above. All cost-sharing amounts (deductible, copayment and coinsurance) for covered in-network services that you or your family are required to pay under the plan apply to the calendar year out-of-pocket maximum. Once the maximum

has been reached, you will no longer be subject to cost-sharing for covered expenses of the type that count toward the calendar year out-of-pocket maximum for the remainder of the calendar year.

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

- All cost-sharing amounts (deductibles, copayments, coinsurance) paid for any out-of-network services or supplies that may be covered under the plan;
- Amounts paid for non-covered services or supplies;
- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges);
- Amounts paid for services or supplies in excess of any plan limits (for example, a limit on the number of covered visits for a particular type of provider); and,
- Amounts paid as a penalty (for example, failure to precertify).

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

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

Other Cost Sharing Provisions

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

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

Out-of-Area Services

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. 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 to you.

D. Nonparticipating Providers Outside Our 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.

E. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core service 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 BlueCard Worldwide 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. You must contact us to obtain precertification for non-emergency inpatient 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 the following outpatient hospital benefits, physician benefits and other covered services. You can find a list of any additional outpatient hospital benefits, physician benefits and other covered services that require precertification at www.AlabamaBlue.com/precert. This list will be updated quarterly. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services.

Examples of services that require precertification at the time of the printing of this booklet include:

- Certain outpatient diagnostic lab, X-ray, and pathology when services are rendered in the state of Alabama; and,

  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).

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 www.AlabamaBlue.com/web/pharmacy/drugguide.html. 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 or physician's office. 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 www.AlabamaBlue.com/web/pharmacy/drugguide.html. This list will be updated quarterly.

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

Inpatient Hospital Benefits

Attention: Precertification is required for all hospital admissions except for medical emergency and maternity admissions. 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
First 365 days of care during each confinement (combined in-network and out-of-network)	100% of the allowed amount, no deductible, subject to a $250 per day copayment beginning with the 1st through the 5th day	50% of the allowed amount, subject to a $1,200 deductible per admission
Days of confinement extending beyond the 365-day benefit maximum	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
$5 per day allowance for the difference between private and semi-private room rate	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible

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

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

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

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

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to

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

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

Outpatient Hospital Benefits

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)	100% of the allowed amount, subject to a $250 outpatient facility copayment	50% of the allowed amount, subject to the calendar year deductible
Emergency room – medical emergency	100% of the allowed amount, subject to a $250 outpatient facility copayment	100% of the allowed amount, subject to the calendar year deductible and a $250 outpatient facility copayment
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	100% of the allowed amount, subject to a $250 outpatient facility copayment	100% of the allowed amount, subject to the calendar year deductible and a $250 outpatient facility copayment when services are rendered within 72 hours of the accident; after 72 hours 50% of the allowed amount, subject to the calendar year deductible 50% of the allowed amount, subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Outpatient diagnostic lab, X-ray, and pathology	100% of the allowed amount, subject to a $250 outpatient facility copayment	50% of the allowed amount, subject to the calendar year deductible
Outpatient dialysis, IV therapy, chemotherapy, and radiation therapy	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible
Services billed by the facility for an emergency room visit when the patient's condition does not meet the definition of a medical emergency (including any lab and X-ray exams and other diagnostic tests associated with the emergency room fee)	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Outpatient hospital services or supplies not listed above and not listed in the section of this booklet called Other Covered Services	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible

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 copayments. Examples may include 1) laboratory testing performed in the physician's office, but sent to an outpatient hospital facility for processing; 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Office visits and in-person consultations **Primary physicians include the following providers:** General Practice, Family Practice, Internal Medicine, Pediatrics, Geriatrics, OB/GYN, Nurse Practitioner, Physician Assistant (including physician assistants who assist with surgery), Midwife, Licensed Clinical Social Worker, Licensed Professional Counselor, Clinical Nurse Specialist, Mental Health Nurse Practitioner, and Mental Health Clinical Nurse Specialist	100% of the allowed amount, no deductible; subject to a $40 copayment for primary care physicians and a $60 copayment for specialists	50% of the allowed amount, subject to the calendar year deductible
Emergency room physician	100% of the allowed amount, no deductible, subject to a $60 copayment	100% of the allowed amount, subject to the calendar year deductible and a $60 copayment
Second surgical opinion	100% of the allowed amount, subject to a $60 copayment	50% of the allowed amount, subject to the calendar year deductible
Surgery and anesthesia for a covered service **Note: See Special Diagnostic Procedures below for exceptions**	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Maternity care	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Inpatient visits	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Inpatient consultations by a specialty provider (limited to one consult per specialist per stay)	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Diagnostic X-rays **Note: See Special Diagnostic Procedures below for exceptions**	Physician's office: 100% of the allowed amount, subject to a $10 copayment per procedure	50% of the allowed amount, subject to the calendar year deductible
Diagnostic lab and pathology **Note: See Special Diagnostic Procedures below for exceptions**	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible
Special Diagnostic Procedures performed in the physician's office or free-standing diagnostic center • CAT Scan • MRI • PET/SPECT • ERCP • angiography/arteriography • cardiac cath/arteriography • colonoscopy • UGI endoscopy • muga-gated cardiac scan	100% of the allowed amount, no deductible; subject to a $250 copayment per procedure	50% of the allowed amount, subject to the calendar year deductible
Chemotherapy and radiation therapy	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible
Allergy testing and treatment	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Telephone and online video consultations program To enroll in the telephone and online video consultations program, go to www.Teladoc.com/Alabama or call 1-855-477-4549. **General Medical:** Telephone and online video consultations are available through Teladoc to diagnose, treat and prescribe medication (when necessary) for certain general medical issues (flu, allergies, sinus infection, sore throat, etc.) Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations (where available) are offered 7 days a week, 7 a.m. to 9 p.m..	Effective: 01/01/2018 - 02/28/2018 100% of the allowed amount, after a $40 copayment per consultation Effective: 03/01/2018 100% of the allowed amount, after a $20 copayment per consultation	Not covered

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

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of

fractures, endoscopic procedures, and heart catheterization.

- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.
- If you receive other out-of-network physician services (such as out-of-network laboratory services) for a medical emergency in the emergency room of a hospital, those services will also be paid with the applicable in-network coinsurance and/or copayment amounts for such physician benefits described in the matrix above, but subject to the calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the applicable requirements of the Patient Protection and Affordable Care Act.
- 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, and in all cases where the primary purpose for your visit is not routine preventive services and/or routine immunizations, the applicable office visit or outpatient facility copayments under your Physician Benefits or Outpatient Hospital Benefits may apply.

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

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; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Ambulance services	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Chiropractic services Limited to 15 visits per person each calendar year	80% of the allowed amount, subject to the calendar year deductible	Non-participating chiropractors in Alabama: Not covered Non-participating chiropractors outside Alabama: 50% of the allowed amount, subject to the calendar year deductible
Dialysis services at a renal dialysis facility	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
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 **Note:** For DME the allowed amount will generally be the smaller of the rental or purchase price	80% of the allowed amount, subject to the calendar year deductible	Non-preferred DME supplier in Alabama: 50% of the allowed amount, subject to the calendar year deductible Non-preferred DME supplier outside Alabama: 80% of the allowed amount, subject to the calendar year deductible
Eyeglasses or contact lenses: One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect	80% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Home health and hospice care In-network home healthcare benefits consist of home IV therapy, 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	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible **Note:** In Alabama, not covered
Habilitative occupational, physical and speech therapy: Limited to a combined maximum of 30 visits per member each calendar year (combined in-network and out-of-network)	80% of the allowed amount, subject to the calendar year deductible	**In Alabama:** 50% of the allowed amount, subject to the calendar year deductible **Outside Alabama:** 50% of the allowed amount, subject to the calendar year deductible
Rehabilitative occupational, physical and speech therapy: Limited to a combined maximum of 30 visits per member each calendar year (combined in-network and out-of-network)	80% of the allowed amount, subject to the calendar year deductible	**In Alabama:** 50% of the allowed amount, subject to the calendar year deductible **Outside Alabama:** 50% of the allowed amount, subject to the calendar year deductible

Prescription 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
Prescription Drug Card The pharmacy network for the plan is the **ValueONE Retail Network** Some drugs require precertification Prescription drugs can be dispensed for up to a 30-day supply Some copays combined for diabetic supplies Tier 4 (specialty) drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for Tier 4 (specialty) drugs is the **Pharmacy Select Network**. Go to www.AlabamaBlue.com/web/pharmacy/-drugguide.html for a list of these specialty drugs View the **Source Rx 2.0** list that applies to the plan at www.AlabamaBlue.com/web/pharmacy/-drugguide.html	100% of the allowed amount, subject to the following copayments for a 30-day supply for each prescription: **Tier 1 drugs** $15 copayment **Tier 2 drugs** $50 copayment **Tier 3 drugs** $100 copayment **Tier 4 specialty drugs** The lesser of 50% of the allowed amount or $425 copayment per prescription	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 4 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 www.AlabamaBlue.com. Once there, you can search for your drug by clicking the "Find Drugs/Pricing/Mail Order" 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.
- 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 Tier 4 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 Tier 4 specialty drugs. Tier 4 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. Tier 4 specialty drugs often grow out of biotech research and may require refrigeration or special handling.

> **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 in a 30-day supply).
- Maintenance drugs (including certain diabetic supplies) can be dispensed up to a maximum of a 90-day supply. You must satisfy the copayment requirement for each 30-day supply. In-network pharmacies should have a list of maintenance drugs.
- Insulin, needles, and syringes purchased on the same day will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day will have one copayment. Otherwise, each has a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan. Glucose monitors 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 www.AlabamaBlue.com or call 1-800-391-1886 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 Tier 4 (specialty) drugs are not available through this pharmacy service	100% of the allowed amount, subject to the following copayments/coinsurance for up to a 90-day supply for each prescription: **Tier 1 drugs** $37.50 copayment **Tier 2 drugs** $125 copayment **Tier 3 drugs** $250 copayment **Tier 4 (specialty) 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 or physician's office. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

Provider-administered drug coverage is subject to Drug Coverage Guidelines 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.

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 205-733-7067 or 1-800-821-7231 (toll-free).

Disease Management

You may also qualify to participate in the disease management program. The disease management program is available for members with heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD) and asthma. This program offers personalized care designed to meet your lifestyle and health concerns. Our staff of healthcare professionals will help you cope with your illness and serve as a source of information and education. Participation in the program is completely voluntary. If you would like to enroll in the program or obtain more information, call 1-888-841-5741 (Monday–Friday, 8 a.m. to 4:45 p.m. CST), or e-mail 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 1-205-733-7065 in Birmingham) as soon as you find out you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant.

If you fall into one of the following risk categories, please tell your doctor and your Baby Yourself nurse: age 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 transporting the organ and removal team.

Transplant benefits for living donor expenses are limited to:

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

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

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

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

Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema. Benefits for this treatment will be subject to the same calendar year deductible and coinsurance provisions that apply for other medical and surgical benefits.

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 calendar year and does not include the year in which the individual is born.

Custodial Parent: The term "custodial parent" means:

- A parent awarded custody of a child by a court decree; or,
- In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

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

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

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

Plan: The term "plan" includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term "plan" does not include non-group or individual health or medical reimbursement insurance contracts. The term "plan" also does not include hospital indemnity coverage or other fixed indemnity

coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term “primary plan” means a plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or,
- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Special Rules for Coordination with Medicare

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

SUBROGATION

Right of Subrogation

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

Right of Reimbursement

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

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

Right to Recovery

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

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce 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 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 or expenses for **acupuncture**, biofeedback, behavioral modification and other forms of self-care or self-help training.

Anesthesia services or supplies or both by local infiltration.

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

C

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

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

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

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

Compound drugs. 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.

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

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

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

appearance, but reconstructive if done because your eyelids kept you from seeing very well.

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

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

D

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

E

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

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

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

F

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

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

H

Hearing aids or examinations or fittings for them.

I

Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including 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, or would be, entitled to reimbursement under **Medicare**, regardless of whether the member properly and timely applied for, or submitted claims to Medicare, except as otherwise required by federal law.

Care and treatment for **mental health** disorders or disease (including substance abuse).

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

N

Services or expenses of any kind for **nicotine addiction** except as provided under the section of the 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

Unless otherwise expressly covered under the Physician Preventive Benefits section of this 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).

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

P

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

Private duty nursing.

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

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

Residential treatment.

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.

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

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

S

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

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

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

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 booklet, 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

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.

Out-of-network **telephone and video** consultations.

Dental 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. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.

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

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

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

W

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

Services or expenses 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 a partial or complete denial of a claim.

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

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

Post-Service Claims

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

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

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

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

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

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

Pre-Service Claims

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

In order to file a pre-service claim you or your provider must call our Health Management Department at

1-205-988-2245 or 1-800-248-2342 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing.

Written pre-service claims should be sent to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

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

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

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

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

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

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

not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call our Customer Service Department.

Concurrent Care Determinations

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

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

- For inpatient hospital care, call 1-205-988-2245 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 our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a healthcare professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Appeals

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

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

In all cases other than determinations by us to limit or reduce previously approved care and

determinations by your group regarding initial eligibility or retroactive rescission, you have 180 days following our adverse benefit determination within which to submit an appeal.

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

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

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

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

You must send your appeal to the following address:

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

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

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

If over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 1-205-988-2245 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 chiropractic services, physical therapy, speech therapy, or occupational therapy:

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.

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

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

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

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

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

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

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

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

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

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

Voluntary Appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your

letter to the same address you used when you submitted your first appeal.

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

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

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

External Reviews

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

Expedited External Reviews for Urgent Pre-Service Claims

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

COBRA

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to temporarily continue coverage under the plan beyond the point at which coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage may be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. You are not entitled to buy COBRA coverage if you are employed as a nonresident alien who received no U.S. source income, nor may your family members buy COBRA.

Not all group health plans are covered by COBRA. As a general rule, COBRA applies to all employer sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan. You must contact your plan administrator (normally your group) to determine whether this plan is covered by COBRA.

By law, COBRA benefits are required to be the same as those made available to similarly situated active

employees. If the group changes the plan coverage, coverage will also change for you. You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes.

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

COBRA Rights for Covered Employees

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

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

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

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

COBRA Rights for a Covered Spouse and Dependent Children

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

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

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

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

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

as a dependent child of the covered employee.

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

Extensions of COBRA for Disability

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

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

For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under Extensions of COBRA for Second Qualifying Events for more information about this.

For this disability extension of COBRA coverage to apply, you must give the plan administrator timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the plan administrator within 30 days of any revocation of Social Security disability benefits. See the section called Notice Procedures for more information about the notice procedures you must use to give this notice.

Extensions of COBRA for Second Qualifying Events

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

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

For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage

would be lost because of the event, whichever is later. See the section Notice Procedures for more information about the notice procedures you must use to give this notice.

Notice Procedures

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

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

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

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

Adding New Dependents to COBRA

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

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

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

Medicare and COBRA Coverage

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

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

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

Electing COBRA

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

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

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

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

COBRA Premiums

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

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

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

Early Termination of COBRA

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

- The group no longer provides group health coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA coverage, you become covered under another group health plan;
- After electing COBRA coverage, you become enrolled in Medicare; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

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

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

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

RESPECTING YOUR PRIVACY

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

Disclosures of Protected Health Information to the Plan Sponsor:

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

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

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

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information

under HIPAA.

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

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

- Plan Manager
- Gulf State Consultants & Administrators, Inc. d/b/a Alabama Administrators

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

Security of Your Personal Health Information:

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

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

- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

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

Our Use and Disclosure of Your Personal Health Information:

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

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

The group has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of benefits and/or administrative services under the plan.

Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan (including, when applicable, arbitration) and thereafter to judicial review to determine whether our determination was arbitrary or capricious (in the case of claims covered by Section 502(a) of ERISA) or correct using the standard of review set forth in any applicable arbitration provisions of this booklet.

Notice

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

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

Correcting Payments

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

Responsibility for Providers

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

Misrepresentation

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

Governing Law

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

Termination of Benefits and Termination of the Plan

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

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

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

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

Changes in the Plan

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

The new benefit booklet (including any riders or supplements to the booklet) will state the effective date applicable to it. In some cases, this effective date may be retroactive to the first day of the plan year to

which the changes relate. The changes will apply to all benefits for services you receive on or after the stated effective date.

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

No Assignment

As discussed in more detail in the Claims and Appeals section of this 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 Educational Reconciliation Act, and its implementing rules and regulations.

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

> **In-Network Providers:** Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered care. The negotiated price applies only to services that are covered under the plan and also covered under the contract that has been signed with the in-network provider.
>
> Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2), which subset of those providers will be considered BlueCard PPO providers, and (3), the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.
>
> See Out-of-Area Services, earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Alabama.
>
> **Out-of-Network Providers:** The allowed amount for care rendered by out-of-network providers is often determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to in-network providers or may be based on the average charge for the care in the area. In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:
>
> - The charge or average charge for the same or a similar service;
> - Pricing data from the local Blue Cross and/or Blue Shield plan where services are rendered;
> - The relative complexity of the service;

- The in-network allowance in Alabama for the same or a similar service;
- Applicable state healthcare factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

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

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

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

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

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: An arrangement among 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.

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

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

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

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

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

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

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

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

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

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

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

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 the booklet.

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

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

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

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

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

jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

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

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

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

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

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

- This benefit booklet, as amended;

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

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

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

Precertification: The procedures used to determine the medical 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, abortion, miscarriage or other termination.

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

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

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 live-in facility for mental health or substance abuse disorders.

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

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 a Teladoc 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.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation, to the extent applicable to the plan.

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit in a Federal court (unless your plan has a binding arbitration clause). In such a case, the court may require the plan administrator, which is not Blue Cross, to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted your administrative remedies under the plan. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court

may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Administrative Information

The following information is provided pursuant to the requirements of ERISA:

- The Plan's official name is: IBEW-NECA Local 505 Health Plan.
- The Plan Sponsor and Plan Administrator is the Board of Trustees of the IBEW-NECA Local 505 Health Plan. The Trustees are responsible for discharging all obligations that ERISA and its regulations impose upon plan sponsors and plan administrators, such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law.
- The Plan Number assigned by the Plan Sponsor is: 501.
- The IRS Employer Identification Number (EIN) of the Sponsor is: 63-0366157.
- The Plan provides hospital and medical benefits as administered under an administrative services agreement between Blue Cross and Blue Shield of Alabama and the Board of Trustees. Blue Cross has complete discretion to interpret and administer the provisions of the Plan. Blue Cross and Blue Shield of Alabama provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The administrative functions performed by Blue Cross include paying claims, determining medical necessity, etc. The Plan benefits are self-insured.
- The agent for legal process is the Plan Manager.
- The records of the health plan are kept on the basis of a Plan year which begins on October 1st and ends on the following September 30th.
- The Board of Trustees currently intends to continue the Plan as described herein, but reserves the right, in their discretion, to amend, reduce or terminate the Plan and coverage at any time for active employees, retirees, former employees, and all dependents.
- This is an employer-employee shared cost plan. The sources of the contributions to this Plan are currently the employer and the employee in relative amounts as determined by the Collective Bargaining Agreement. While the employer may change its level of contribution at any time, the employer must always contribute at least a portion of the employee's premiums. Any information concerning what is to be paid by the employee in the future will be furnished by the Board of Trustees in writing and will constitute a part of this Plan. Your contribution is determined by the Board of Trustees based on the Plan's experience and other factors.
- Plan Administrator Contact Information:

  Please mail or hand-deliver all COBRA notices to your Plan Administrator at the following address:

IBEW-NECA Local 505 Health Plan
c/o Alabama Administrators
Plan Manager
1717 Old Shell Road
Mobile, Alabama 36604-1323

NOTICE OF NONDISCRIMINATION

Blue Cross and Blue Shield of Alabama 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 Service, 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 lingüística 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: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل 1-855-216-3144 (الهاتف النصي: 711). بـ

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

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés 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. Rele 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 કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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 pod 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。

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

Customer Service Department:

1-800-292-8868 (TTY 711) toll-free

Preadmission Certification:

205-988-2245
or 1-800-248-2342 toll-free

Website:

www.AlabamaBlue.com

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Health Plan

03/2018