

Troy University

Alabama

Effective January 1, 2018

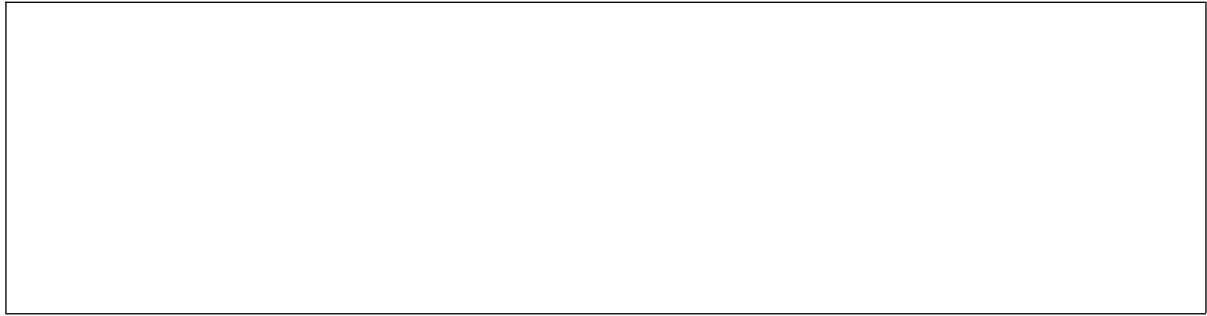
Table of Contents

OVERVIEW OF THE PLAN	1
Purpose of the Plan	1
Using myBlueCross to Get More Information	1
BlueCare Health Advocate	1
Definitions	2
Receipt of Medical Care	2
Beginning of Coverage	2
Limitations and Exclusions	2
Medical Necessity and Precertification	2
In-Network Benefits	3
Relationship Between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association	4
Claims and Appeals	5
Changes in the Plan	5
Termination of Coverage	5
Your Rights	5
Your Responsibilities	5
ELIGIBILITY	6
Eligibility for the Plan	6
Enrollment Waiting Periods	6
Applying for Plan Coverage	6
Eligible Dependents	6
Beginning of Coverage	7
Qualified Medical Child Support Orders	7
Relationship to Medicare	8
Termination of Coverage	9
Leaves of Absence	10
COST SHARING	10
Calendar Year Deductible	10
.....16.....	16

.....16..... 4 -12 Td [(Calend256-275(and)-275)improve(Per)Tds (Cap)pp)2-10.T.d.(3).Tj.

Table of Contents

Organ and Bone Marrow Transplants	24
Women's Health and Cancer Rights Act Information	25
COORDINATION OF BENEFITS (COB)	25
Order of Benefit Determination	26
Determination of Amount of Payment	27
COB Terms	28
Right to Receive and Release Needed Information	29
Facility of Payment	29
Right of Recovery	29
Special Rules for Coordination with Medicare	29
SUBROGATION	29
Right of Subrogation	29



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.

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
-

- 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

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 _____

- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ELIGIBILITY

Eligibility for the Plan

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

- You are an employee and are treated as such by your group. Examples of persons who are not employees include independent contractors, board members, and consultants;
- Your group has determined that you work on average 30 or more hours per week (including vacation and certain leaves of absence that are discussed in the section dealing with termination of coverage) in accordance with the Affordable Care Act;
- You are in a category or classification of employees that is covered by the plan;
- You meet any additional eligibility or participation rules established by your group; and,
- You satisfy any applicable waiting period, as explained below.

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

Enrollment Waiting Periods

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

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

Applying for Plan Coverage

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

Eligible Dependents

Your eligible dependents are:

- Your spouse;
- 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 himself; and (3) depends on you for support, if the incapacity occurred before age 26.

The child may be the employee's natural child; stepchild; legally adopted child; child placed for adoption; or eligible foster child. An eligible foster child is a child that is placed with you by an authorized placement agency or by court order.

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

Beginning of Coverage

Annual Open Enrollment Period

If you do not enroll during a regular enrollment or a special open enrollment period described below, you may enroll only during your group's annual open enrollment period, if any. Your coverage will begin on the date specified by your group following your enrollment.

Regular Enrollment Period

If you apply within 30 days after the date on which you meet the plan's eligibility requirements (including any applicable waiting periods established by your group), your coverage will begin as of the date

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

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

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

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

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

Relationship to Medicare

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

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

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,

- On 30-days advance written notice from your group to us.

Calendar Year Out-of-

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,
- Intensive outpatient services and partial hospitalization.

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



--	--	--



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 \$125 outpatient facility copayment	80% of the allowed amount, subject to the calendar year deductible
Emergency room – medical emergency	100% of the allowed amount, subject to a \$125 outpatient facility copayment	100% of the allowed amount, subject to a \$125 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, no deductible or copayment	100% of the allowed amount, no deductible or copayment when services are rendered within 72 hours of the accident; after 72 hours 80% of the allowed amount, subject to the calendar year deductible 80% 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, no deductible or copayment	80% 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	80% 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	80% 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	80% of the allowed amount, subject to the calendar year deductible
Intensive outpatient services and partial hospitalization for mental health disorders and substance abuse	100% of the allowed amount, subject to a \$60 copayment	80% 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

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.



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

1. Go to www.AlabamaBlue.com.
2. Click "Find a Doctor."
3. Enter a search location by using the zip code for the area you would like to search or by selecting a state.
4. In the "Category" section, select "Pharmacy."
5. In the "Network or Plan" section, use the drop down menu to select "Vaccine Network" and select "Prime Participating Pharmacy Network" as your retail network.

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

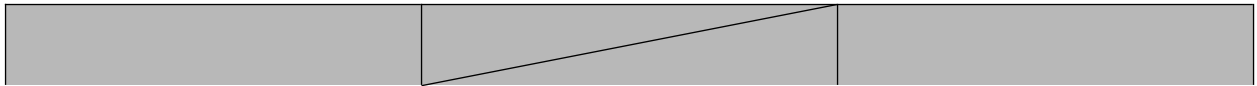
Other Covered Services

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	80% of the allowed amount, subject to the calendar year deductible
Ambulance services	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible
Chiropractic services Limited to 12 visits per person each calendar year	80% of the allowed amount, subject to the calendar year deductible	Non-participating chiropractors in Alabama: 50% of the allowed amount, subject to the calendar year deductible Non-participating chiropractors outside Alabama: 80% 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	80% 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	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	80% of the allowed amount, subject to the calendar year deductible



SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>Prescription Drug Card</p> <p>The pharmacy network for the plan is the Prime Participating Pharmacy Network</p> <p>Some drugs require precertification</p> <p>Prescription drugs can be dispensed for up to a 90 day supply; the copayment is applicable for 30 days.</p> <p>Some copays combined for diabetic supplies</p> <p>Specialty drugs can be dispensed for up to a 30-</p>		



Provider-administered drugs are drugs that must typically be administered or directly supervised by a

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

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 "healthcare expenses or healthcare coverage" Not Separated or Divorced: although the provisions of that nt;

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,

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

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

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

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

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.

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 _____

T

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

Services provided through **teleconsultation**.

Dental treatment for or related to 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

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.

or

- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy:

Blue Cross and Blue Shield of Alabama

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

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

Medicare and COBRA Coverage

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.

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

amount may be based on the negotiated rate payable to in-network providers or may be based on the average charge for the care in the area. In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

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

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

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

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

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

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

BlueCard Program: An arrangement among Blue Cross 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

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

- 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

Specialist: A physician who is not a primary care physician.

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

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

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

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

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

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.

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 group and the employee in relative amounts as determined by the group from time to time. While the group may change its level of contribution at any time, the group 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 group in writing and will constitute a part of this plan. Your contribution is determined by the group 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:

Attention: Employee Benefits (COBRA)
Troy University
107 Wright Hall
Troy University
Troy, Alabama 36082-0001

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

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

54395/000
Health Plan

04/2018

