
# BENEFIT BOOKLET

Effective October 1, 2024

BLUE CROSS AND BLUE SHIELD OF ALABAMA

# Table of Contents

# OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact Customer Service at 1-800-760-6851. If needed, simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

***Atención por favor - Spanish***

***Este folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-800-760-6851. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.***

## Purpose of the Plan

The plan is intended to help members pay for the costs of medical care. The plan does not pay for all of a member's medical care. For example, ~~you or~~ members may be required to pay a copayment for some services. A copayment is a fixed dollar amount ~~you or~~ members must pay on receipt of care. The most common example is the office visit copayment that must be paid when members go to a doctor's office. 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.

## 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. Please take the time to familiarize yourself with these definitions so that you will understand benefits.

## Receipt of Medical Care

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

Generally, after-hours care is provided by a member's physician. They may have a variety of ways of addressing member's needs. You should call the 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 in severe pain or experiencing a condition that is life endangering their, emergency care may be obtained by calling 911 or visiting an emergency room.

Having a primary care physician is a good decision.

Although members 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 members and understands their medical history.
- Having someone you can count on as a key resource for members healthcare questions.
- Receiving 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 a member needs to see a specialist or behavioral health provider, contact their office directly to make an appointment. If an in-network specialist or Blue Choice behavioral health provider is chosen, members will have the maximum benefits available for services covered under the plan. If an out-of-network specialist or non-Blue Choice behavioral health provider is chosen, members benefits could be lower.

## Beginning of Coverage

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

## Medical Necessity and Precertification

The plan will only pay for care that is medically necessary, as determined by Blue Cross and Blue Shield of Alabama (BCBS). BCBS develops medical necessity standards to aid BCBS when making medical necessity determinations. BCBS publishes these standards on the Internet at www.AlabamaBlue.com/providers/policies. The definition of medical necessity is found in the Definitions section of this booklet.

In some cases, such as inpatient hospital admissions in non-emergency situations, the plan requires that members precertify the medical necessity of your care. The provisions later in this booklet will tell you when precertification is required. **Look on the back of member's ID card for the phone number that you or the provider should call.** In some cases, our contracts with providers require the provider to initiate the precertification process for members. The provider should tell you when these requirements apply. Members are responsible for making sure that the provider initiates and complies with any precertification requirements under the plan. Please note that precertification relates only to the medical necessity of care; it does not mean that member's care will be covered under the plan.

## In-Network Benefits

One way in which the plan tries to manage health care costs and provide enhanced benefits is through negotiated discounts with medical providers. In-network providers are hospitals, physicians, and other health care providers that contract with Blue Cross and/or Blue Shield plans for furnishing health care services at a reduced price.

Examples of in-network providers include PMD, Preferred Care, BlueCard PPO, and Blue Choice Behavioral Health Network. 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.

A special feature of this plan gives access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll- free access line at 1- 800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder web site at www.AlabamaBlue.com/FindADoctor and log into your *my*BlueCross. Search for a specific provider by typing their name in the Search Term box or click Search to see all in-network providers for the plan.

PPO providers will file claims on a member's behalf with the local Blue Cross plan where services are rendered. The local Blue Cross plan will then forward the claims for verification of eligibility and determination of benefits. Assuming the services are covered, members will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance.

Sometimes a network provider may furnish a service that is either not covered under the plan or is not covered under the contract between the provider and the local Blue Cross plan where services are rendered. When this happens, benefits may be denied.

If a network provider is terminated ***without*** cause from our network while a member is a continuing care patient, a request may be made to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates under the plan. After the provider's contract is terminated, the provider cannot bill the member for amounts in excess of the in-network allowed amounts under the plan. For this purpose of requesting this continuity of care, a continuing care patient is defined as an individual who:

- Is or was determined to be terminally ill and is receiving treatment for such illness;
- Is undergoing a course of treatment for a serious and complex condition;
- Is pregnant and undergoing a course of treatment for the pregnancy;
- Is undergoing a course of institutional or inpatient care; or
- Is scheduled to undergo non-elective surgery, including receipt of post-operative care, with respect to such a surgery.

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

## Out-of-Network Services

There are no benefits available for services or supplies rendered by an out-of-network provider, except for treatment of an accidental injury or treatment of a true medical emergency. Services or supplies rendered by an out-of-network provider, when the services are to treat an accidental injury or true medical emergency, may be considered as in-network services. A good "rule of thumb" to remember when selecting providers for members, is to always select an in-network provider (PPO provider) when available. In order to locate a PPO provider in your area, go to bcbsal.org or call the BCBS Customer Service number on the back of the member's card. If in need of a provider while traveling outside the state of Alabama, call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder web site at www.AlabamaBlue.com/FindADoctor.

There are times when there is no network available in the geographical area in which a particular service or supply is rendered. When there is no network available for a particular service or supply, the service or supply may be considered as in-network.

## 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 ALL Kids 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.

## Limitations and Exclusions

The plan contains a number of provisions that limit or exclude benefits for certain services and supplies, even if medically necessary. Members need to be aware of these limits and exclusions in order to take maximum advantage of this plan.

## Claims and Appeals

When members receive services from an in-network provider, the provider will generally file claims on behalf of members. If a claim is denied in whole or in part, an appeal may be filed with BCBS. Members will be given a full and fair review. The provisions of the plan dealing with claims or appeals are found in the Claims and Appeals section of this booklet.

# ELIGIBILITY

## Eligibility and Application for the Plan

Eligibility information can be found on the ALL Kids website. One can apply on-line, over the phone, or print out an application from the ALL Kids web site at www.alabamapublichealth.gov/allkids/.
One may also contact ALL Kids Customer Service at 1-888-373-5437.

## Beginning of Coverage

*Effective Date of Coverage*

Coverage is effective on the date specified by ALL Kids. The effective date is usually the first day of the month following receipt of the application. In no event is there coverage for health services rendered or delivered before the effective date of coverage.

The effective date of ALL Babies coverage is the date of application.

*Effective Date of Coverage for Hospitalization*

If a member is hospitalized on his or her effective date of coverage, health services related to the hospitalization are covered as long as: (a) Blue Cross Blue Shield of Alabama is notified of the hospitalization within 48 hours of the effective date or as soon as reasonably possible; and (b) health services are received in accordance with the terms, conditions, exclusions, and limitations of the policy.

If a member is hospitalized on his or her effective date of coverage and the hospitalization is covered under a prior plan, health services related to that hospitalization are not covered under ALL Kids. All other health services are covered as of the effective date.

If a member has prior coverage which has been required by state law to extend benefits for a particular condition or a disability as defined by state law, health services for the condition of disability will not be covered under the policy until the prior coverage is exhausted.

## Termination of Coverage

Member's coverage shall automatically terminate on the earliest of the date specified below.

- The last day of the month of member's annual enrollment period unless member's application for renewal is approved for coverage.
- The date member moves out of Alabama.
- The last day of the month that member turns 19.
- The date the policy is terminated, as specified by ALL Kids. (ALL Kids will instruct BCBSAL to terminate coverage of members. ALL Kids is responsible for notifying member of the termination of the policy.)
- The date specified by ALL Kids that coverage will terminate due to fraud or misrepresentation or because false material information was knowingly provided. ALL Kids has the right to rescind coverage back to the effective date.
- The date specified by ALL Kids that all coverage will terminate because of the use of the member's ID card by any unauthorized person or use of another person's card.

If ALL Kids member becomes pregnant, notify ALL Kids. The current ALL Kids coverage will be extended to provide 12 months of continuous postpartum coverage even if the member reaches the age of 19 as long as member is living and a resident of the state.

The postpartum period for ALL Babies is from delivery through the end of the month in which the 60th day of postpartum falls counting from the date the pregnancy ends either as a full term or as a miscarriage.

# COST SHARING

| COST SHARING | | | |
|---|---|---|---|
| | **NO FEE** | **LOW FEE** | **FEE** |
| **Calendar Year Deductible** | No deductible | No deductible | No deductible |
| **Members Plan Year Out-of-Pocket Maximum** | Not Applicable | Not to exceed 5% of the annual family income used for determining eligibility per benefit year | Not to exceed 5% of the annual family income used for determining eligibility per benefit year |
| **Lifetime Dollar Maximum on Essential Health Benefits** | Unlimited | Unlimited | Unlimited |

## Fee Categories:

ALL KIDS:

- **No Fee:** Children who have been excluded from cost sharing by federal regulation will not have any premiums or copayments when receiving health care services through ALL Kids.
- **Low Fee:** Children whose family incomes are between 142 and 151% of the Federal Poverty Level will pay an annual premium of $52 per child per year (up to a maximum of $156 per family per year). These children will have copayments ranging from $3 to $200 when receiving medical and dental services through ALL Kids providers. There will be no copayment for preventive services.

  There is a $1 copayment for Generic prescription drugs. Copayment for Preferred brands will be $5. Non-Preferred brands are not covered. (A list of Preferred brands can be obtained from the Blue Cross and Blue Shield of Alabama website at AlabamaBlue.com/GenericPlusDrugList/StandardDrugList.)
- **Fee:** Children whose family incomes are between 151 and 312% of the Federal Poverty Level will pay an annual premium of $104 per child per year (up to a maximum of $312 per family per year). These children will have copayments ranging from $6 to $200 when receiving medical and dental services through ALL Kids providers. There will be no copayment for preventive services.

  There is a $5 copayment for Generic prescription drugs. Copayment for Preferred brands will be $25. Non-Preferred brands are not covered. (A list of Preferred brands can be obtained from the Blue

Cross and Blue Shield of Alabama website at AlabamaBlue.com/GenericPlusDrugList/StandardDrugList.)

ALL BABIES:

- ALL Babies has the same co-payment cost sharing as ALL Kids. There is no premium assessed for ALL Babies.

## Calendar Year Deductible

There is no calendar year deductible for ALL Kids.

## Members Plan Year Out-of-Pocket Maximum

The maximum out-of-pocket expense (premiums and copayments) any family should pay, shall not exceed 5% of the annual family income (used for determining eligibility) per benefit year. Should a family's annual out-of-pocket expenses (premiums and copayments) approach this maximum, the family should notify ALL Kids in order to eliminate cost-sharing during the remainder of benefit period.

## Lifetime Maximum

There is no lifetime dollar maximum on essential health benefits under the plan.

## Other Cost Sharing Provisions

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

- **Amounts in excess of the allowed amount:** As a general rule, and as explained in more detail in Definitions, the allowed amount may often be significantly less than the provider's actual charges.

## Out-of-Area Services

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

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

### A. BlueCard® Program

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

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

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

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the member’s healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the member’s healthcare provider or provider group that may include types

of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

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

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

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

**C. 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 the member.

**D. Non-Participating Healthcare Providers Outside Our Service Area**

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

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

**E. Blue Cross Blue Shield Global Core**

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

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

- **Inpatient Services**
  In most cases, if the member contacts 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 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 health care services.

- **Outpatient Services**
  Physicians, urgent care centers, and other outpatient providers located outside the Blue Card service area will typically require payment 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 Blue Card 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.

# 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 the member's 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 the member's 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, the member's provider will initiate the precertification process. Members should be sure to check with the provider to confirm whether precertification has been obtained. It is the member's responsibility to ensure that their provider obtains precertification.

## Inpatient Hospital Benefits

Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency and maternity admissions.
For emergency hospital admissions, we must receive notification within 48 hours of the admission.

**For preadmission certification call 1-800-248-2342 (toll-free).**

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

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

## Outpatient Hospital Benefits, Physician Benefits, Other Covered Services

Precertification is required for certain outpatient hospital benefits, physician benefits, and major medical benefits. More information about the specific services that require precertification can be found at AlabamaBlue.com/Precert. This list will be updated no more than twice a calendar year. Check this list prior to obtaining any outpatient hospital services, physician services, and other covered services for members.

The general categories or descriptions of outpatient hospital benefits, physician benefits, and other covered services that require precertification at the time of the filing of this booklet are set forth below. Examples are for illustrative purposes only.

- ABA therapy;
  - For precertification, call 1-877-563-9347 (toll-free).
- Intensive outpatient services and partial hospitalization;
  - For precertification, call 1-800-548-9859 (toll-free).
- Home health and hospice when services are rendered outside the state of Alabama;
  - For precertification, call 1-800-821-7231 (toll-free).
- Certain advanced imaging (such as, for example, MRA, MRI, PET, CT and CTA);
  - For precertification, call 1-866-803-8002 (toll-free).
- Certain select procedures (such as, for example, implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, and surgery for obstructive sleep apnea);
- Certain reconstructive procedures: (such as, for example, blepharoplasty, rhinoplasty, and surgery for varicose veins);
- Certain durable medical equipment.
  - For precertification, call 1-800-248-2342 (toll free).
- Certain radiation therapy management services (such as, for example, proton beam therapy, cyber knife and stereotactic radiosurgery);
- Certain genetic laboratory testing (such as, for example, breast cancer (BRCA) testing and genetic carrier screening):
  - For precertification, call 1-866-803-8002 (toll free).

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

## 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, physician's office, or home healthcare setting. Provider-administered drugs also include gene therapy and cellular immunotherapy. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

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

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

# HEALTH, MENTAL HEALTH, AND SUBSTANCE ABUSE BENEFITS

### Mental Health and Substance Abuse Benefits

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

### Inpatient Hospital and Residential Treatment Facility Benefits

**Attention:** Preadmission Certification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions.

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

Preadmission certification does not mean that a member's admission is covered. It only means that BCBS has approved the medical necessity of the admission.

In many cases the member's provider will initiate the preadmission certification process for you. You should be sure to check with the admitting physician or the hospital admitting office to confirm whether preadmission certification has been obtained. It is the member's responsibility to ensure that their provider obtains preadmission certification.

**For preadmission certification call 1-800-248-2342 (toll-free).**

Generally, if preadmission certification 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.

| INPATIENT HOSPITAL AND RESIDENTIAL TREATMENT FACILITY BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| 365 days of care during each confinement | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $200 copayment per admission<br><br>Note: The hospital copay will be waived, on the maternity inpatient delivery | 100% of the allowed amount, subject to a $200 copayment per admission<br><br>Note: The hospital copay will be waived, on the maternity inpatient delivery |

**Attention:** If your child receives 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 a medical emergency or an accidental injury.

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

- Bed, board, and general nursing care in a semi-private 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 members 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.

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

| OUTPATIENT HOSPITAL FACILITY SERVICES | |
|---|---|
| Surgery | **No Fee:** No copayment, then covered at 100% of the allowance<br>**Low Fee:** $6 copayment, then covered at 100% of the allowance<br>**Fee:** $100 copayment, then covered at 100% of the allowance |
| Medical Emergency/ Accidental Injury | **No Fee:** No copayment, then covered at 100% of the allowance<br>**Low Fee:** $6 copayment, then covered at 100% of the allowance<br>**Fee:** $60 copayment, then covered at 100% of the allowance |
| Diagnostic X-ray | **No Fee:** No copayment, then covered at 100% of the allowance<br>**Low Fee:** $6 copayment, then covered at 100% of the allowance<br>**Fee:** $65 copayment, then covered at 100% of the allowance |
| Diagnostic lab, hemodialysis, IV therapy, chemotherapy, radiation therapy, and treatment of non-emergency services in the emergency room | **No Fee:** No copayment, then covered at 100% of the allowance<br>**Low Fee:** No copayment, then covered at 100% of the allowance<br>**Fee:** No copayment, then covered at 100% of the allowance |
| Intensive outpatient services and partial hospitalization for mental health disorders and substance abuse<br>**Precertification is required** | **No Fee:** No copayment, then covered at 100% of the allowance<br>**Low Fee:** No copayment, then covered at 100% of the allowance<br>**Fee:** No copayment, then covered at 100% of the allowance |

**Attention:** If your child receives 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 a medical emergency or an accidental injury .

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

Precertification is required for the following outpatient hospital benefits, physician benefits and major medical benefits. You can find more information about the specific services that require precertification at AlabamaBlue.com/Precert. This list will be updated no more than twice a calendar year. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services for members.

The general categories or descriptions of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the filing of this booklet include:

- ABA therapy;
  - For precertification, call 1-877-563-9347 (toll-free).
- Intensive outpatient services and partial hospitalization;
  - For precertification, call 1-800-548-9859 (toll-free).
- Home health and hospice when services are rendered outside the state of Alabama;

- For precertification, call 1-800-821-7231 (toll-free).

- Certain advanced imaging (such as, for example: MRA, MRI, PET, CT and CTA);
  - For precertification, call 1-866-803-8002 (toll-free).
- Certain select procedures (such as, for example, implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, and surgery for obstructive sleep apnea);
- Certain reconstructive procedures: (such as, for example, reduction mammoplasty, rhinoplasty, and surgery for varicose veins);
- Certain durable medical equipment (such as, for example, motorized/power wheelchair);
  - For precertification, call 1-800-248-2342 (toll free).
- Certain radiation therapy management services (such as, for example, proton beam therapy, cyber knife and stereotactic radiosurgery);
- Certain genetic laboratory testing (such as, for example, breast cancer (BRCA) testing and genetic carrier screening):
  - For precertification, call 1-866-803-8002 (toll free)

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

## Physician Benefits

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

| PHYSICIAN BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Office visits and consultations<br>Note: Office visits for Obesity are limited to 4 visits per member each calendar year. Office visits for Medical Nutritional Therapy by a Nutritionist or PMD for Obesity are limited to 2 visits per member each calendar year. (These services are subject to meeting medical criteria) | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment<br><br>Note: Office visits for mental health and substance abuse are subject to one copay, per member, per day | 100% of the allowed amount, subject to a $13 copayment<br><br>Note: Office visits for mental health and substance abuse are subject to one copay, per member, per day |
| Physician fees in the emergency room | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Surgery and anesthesia for a covered service | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |

| | | | |
|---|---|---|---|
| Maternity care | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Inpatient visits | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Inpatient consultations by a specialty provider (limited to one consult per specialist per day) | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Diagnostic lab, X-rays, and pathology | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Chemotherapy and radiation therapy | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Allergy testing | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $6 copayment | 100% of the allowed amount, subject to a $17 copayment |
| Allergy treatment | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $12 copayment |
| Temporomandibularjoint disorder (TMJ) | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Applied behavioral analysis (ABA)<br><br>Limited to ages 0-18, for autism spectrum disorders | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $13 copayment |
| Vaccine Counseling | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $13 copayment |

| **TELEHEALTH SERVICES** |
|---|
| Benefits are provided for telehealth services subject to the applicable cost sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care provider's license and deemed medically necessary |

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, and heart catheterization.
- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.

## Physician Preventive Benefits

**Attention:** 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 child's outpatient hospital benefits and subject to any applicable outpatient copayments. Examples may include 1) laboratory testing performed in the physician's office but sent to an outpatient hospital facility for processing; 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

| PHYSICIAN PREVENTIVE BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Routine preventive services and immunizations: (See www.AlabamaBlue.com/preventiveservices for a listing of specific preventive services | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment |
| Routine developmental testing Limited to 5 visits between ages 8 months and 36 months | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment |
| Complete Blood Count (CBC) | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment |
| Urinalysis | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment |

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

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

1. Go to www.AlabamaBlue.com.
2. Select Pharmacy.
3. Select Find a Pharmacy.
4. Enter a zip code or city and state in the Location setting.
5. Select Vaccine Network in the drop-down menu labeled All Networks/Plans.

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

## Other Covered Services

| OTHER COVERED SERVICES | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| 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. May be received concurrent with treatment. | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Chiropractic: Professional services of a licensed chiropractor practicing within the scope of his license | 100% of the allowed amount; no copayment; limited to the lesser of 12 visits or $400 per member each calendar year | 100% of the allowed amount, subject to a $2 copayment; limited to the lesser of 12 visits or $400 per member each calendar year | 100% of the allowed amount, subject to a $5 copayment; limited to the lesser of 12 visits or $400 per member each calendar year |
| Dialysis services at a renal dialysis facility | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| 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 | 100% of the allowed amount; no copayment (for DME the allowed amount will generally be the smaller of the rental or purchase price) | 100% of the allowed amount; no copayment (for DME the allowed amount will generally be the smaller of the rental or purchase price) | 100% of the allowed amount; no copayment (for DME the allowed amount will generally be the smaller of the rental or purchase price) |
| Eyeglasses or contact lenses:<br>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 | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Rehabilitative occupational therapy<br>**Precertification is required for Rehabilitative occupational therapy after 15 visits. If no precertification is received, then no additional benefits beyond the initial 15 visits are available** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $13 copayment |

| SERVICE OR SUPPLY | NO FEE | LOW FEE | FEE |
|---|---|---|---|
| Habilitative occupational therapy **Precertification is required for Habilitative occupational therapy after 15 visits. If no precertification is received, then no additional benefits beyond the initial 15 visits are available** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $13 copayment |
| Rehabilitative physical therapy **Precertification is required for Rehabilitative physical therapy after 15 visits. If no precertification is received, then no additional benefits beyond the initial 15 visits are available** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $13 copayment |
| Habilitative physical therapy **Precertification is required for Habilitative physical therapy after 15 visits. If no precertification is received, then no additional benefits are available beyond the initial 15 visits are available.** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $13 copayment |
| Rehabilitative speech therapy **Precertification is required for Rehabilitative speech therapy after 15 visits. If no precertification is received, then no additional benefits beyond the initial 15 visits are available.** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $13 copayment |
| Habilitative speech therapy **Precertification is required for Habilitative speech therapy after 15 visits. If no precertification is received, then no additional benefits beyond the initial 15 visits are available** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $3 copayment | 100% of the allowed amount, subject to a $13 copayment |
| Occupational, physical and speech therapy for autism spectrum disorders ages 0-18<br><br>Benefits for occupational, physical, and speech therapy for the treatment of all autism spectrum disorder diagnoses for members birth through eighteen years old are not limited and are not included in any visit maximums | 100% of the allowed amount, no copayment<br><br>**Note: Precertification is required** | 100% of the allowed amount, subject to a $3 copayment<br><br>**Note: Precertification is required** | 100% of the allowed amount, subject to a $13 copayment<br><br>**Note: Precertification is required** |

| SERVICE OR SUPPLY | NO FEE | LOW FEE | FEE |
|---|---|---|---|
| Home Health care<br>In-Network home healthcare benefits consist of intermittent home nursing visits and home phototherapy for newborns ordered by the attending physician<br><br>**Precertification is required for the nursing visits when services are rendered outside of Alabama – call 1-800-821-7231** | 100% of the allowed amount, no copayment; limited to 60 visits per member each calendar year | 100% of the allowed amount, no copayment; limited to 60 visits per member each calendar year | 100% of the allowed amount, no copayment; limited to 60 visits per member each calendar year |
| Hospice care<br>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<br>**Precertification is required for the hospice visits when services are rendered outside of Alabama – call 1-800-821-7231** | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |
| Home Infusion benefits<br>Home infusion benefits include coverage of certain provider-administered drugs ordered by the attending physician and administered by a home infusion service provider in the home or in an infusion suite associated with the home infusion service provider. In-Network benefits include coverage of the provider-administered drug and drug infusion related administration services. | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |

## Orthodontia Services

| ORTHODONTIA SERVICES | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Benefits for orthodontia services are only provided for the following conditions:<br>⌋ Cleft palate or cleft lip deformities;<br>⌋ Cleft lip and alveolar process involvement;<br>⌋ Velopharyngeal incompetence;<br>⌋ Short palate;<br>⌋ Submucous cleft;<br>⌋ Alveolar notch; or<br>⌋ Trauma, diseases or dysplasia resulting in significant facial growth impact or jaw deformity | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment | 100% of the allowed amount, no deductible or copayment |
| Craniofacial anomalies, including, but not limited to:<br>⌋ Hemifacial microsomia;<br>⌋ Craniosynostosis syndrome;<br>⌋ Marfan's syndrome;<br>⌋ Apert's syndrome;<br>⌋ Crouzon's syndrome;<br>or<br>⌋ Other syndromes by review | 100% of the allowed amount, no deductible or no copayment | 100% of the allowed amount, no deductible or no copayment | 100% of the allowed amount, no deductible or no copayment |

## Skilled Nursing Facility Benefits

| SKILLED NURSING FACILITY BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Includes facility charges for room, board, and routine nursing care when the patient is recovering from a serious illness or injury, confined to a bed with a long-term illness or injury, or has a terminal condition | 100% of the allowed amount, no copayment; limited to a lifetime maximum of 100 days per member | 100% of the allowed amount, no copayment; limited to a lifetime maximum of 100 days per member | 100% of the allowed amount, no copayment; limited to a lifetime maximum of 100 days per member |

The following terms and conditions apply to skilled nursing facilities:

- The admission must take place within 14 days after the patient leaves the hospital and that hospital stay must have lasted at least three days in a row for the same illness or injury.
- The patient's doctor must visit the patient at least once every 30 days and these visits must be written in the patient's medical records.
- The facility must be an approved skilled nursing facility as defined by the Social Security Act.

## Ambulance Services

| AMBULANCE SERVICES | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Ambulance | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $6 copayment per trip | 100% of the allowed amount, subject to a $100 copayment per trip |

## Routine Vision Services

| ROUTINE VISION SERVICES | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Routine vision examinations | 100% of the allowed amount, no copayment; limited to one examination per member every calendar year<br>Limited to $48 for a new patient; $37 for an established patient | 100% of the allowed amount, subject to a $3 copayment; limited to one examination per member every calendar year<br>Limited to one copayment per day for the exam and one copay for frames and lenses<br>Limited to $48 for a new patient; $37 for an established patient | 100% of the allowed amount, subject to a $13 copayment; limited to one examination per member every calendar year<br>Limited to one copayment per day for the exam and one copay for frames and lenses<br>Limited to $48 for a new patient; $37 for an established patient |

| SERVICE OR SUPPLY | NO FEE | LOW FEE | FEE |
|---|---|---|---|
| Lenses and frames | 100% of the allowed amount, no copayment; limited to one pair of eyeglasses every calendar year<br>Limited to $180 for single vision; $230 for bifocal; $250 for trifocal or progressive<br>**No coverage for contact lenses** | 100% of the allowed amount, subject to a $3 copayment; limited to one pair of eyeglasses every calendar year<br>Limited to one copayment per day for the exam and one copay for frames and lenses<br>Limited to $180 for single vision; $230 for bifocal; $250 for trifocal or progressive<br>**No coverage for contact lenses** | 100% of the allowed amount, subject to a $13 copayment; limited to one pair of eyeglasses every calendar year<br>Limited to one copayment per day for the exam and one copay for frames and lenses<br>Limited to $180 for single vision; $230 for bifocal; $250 for trifocal or progressive<br>**No coverage for contact lenses** |
| Low visual aids | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |

The following terms and conditions apply to routine vision services:

Routine service benefits are provided at a fee schedule and include the following services:

- Vision exam
- Glasses
- Frames
- Low visual aids

Exclusions for vision care benefits:

- Diagnostic services;
- Benefits provided after the member's coverage under this contract ends, except covered lenses or frames prescribed and ordered before and delivered within 60 days from then;
- Orthoptics and vision training;
- Replacement of lost or broken lenses or frames, unless at the time of the replacement the member is eligible for benefits;
- Services or supplies required by the group as a condition of employment or rendered by a medical department or health clinic maintained by or on behalf of the group, a mutual benefit association, labor union, trustee, or similar person or entity; and,
- All services related to the fitting and supply of contact lenses.

## Hearing Services

| HEARING SERVICES | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Hearing aids and examinations | 100% of the allowed amount, no copayment; hearing aids limited to $750 each ear, every two calendar years | 100% of the allowed amount, no copayment; hearing aids limited to $750 each ear, every two calendar years | 100% of the allowed amount, no copayment; hearing aids limited to $750 each ear, every two calendar years |

## Prescription Drug Benefits

| PRESCRIPTION DRUG BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| Prescription drugs<br>No benefits are available for drugs purchased at a non-participating pharmacy<br><br>Benefits are provided for oral, injectable, and transdermal contraceptives<br><br>**Brand name drugs for which a generic equivalent is available: Not covered**<br>Generic drugs may be classified at any Tier. Generic drug is one that the FDA has approved under an Abbreviated New Drug Application (ANDA) and no New Drug Application (NDA) is on file. A generic drug is also one that is manufactured by more than one manufacturer and is designated as a multi-source product by the major drug database providers, Medispan and First DataBank.<br><br>Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network.<br>• A list of eligible vaccines these pharmacies may provide can be found at AlabamaBlue.com/VaccineNetworkDrugList | No copayment for Tier 1 and Tier 2 drugs. Tier 3 drugs are not covered | **Tier 1 drugs:**<br>$1 copayment<br><br>**Tier 2 drugs:**<br>$5 copayment<br><br>**Tier 3 drugs:**<br>Not covered | **Tier 1 drugs:**<br>$5 copayment<br><br>**Tier 2 drugs:**<br>$25 copayment<br><br>**Tier 3 drugs:**<br>Not covered |

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

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

> **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. Only the member (or guardian) and the member's prescribing physician can make that determination.

- To be eligible for benefits, drugs must be legend drugs prescribed by a physician and dispensed by a licensed participating 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 3 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 "My Blue Cross" section of the BCBS web site. Even though a member's physician has written a prescription for a drug, the drug may not be covered or a clinical edit(s) may apply (i.e. prior authorization, step therapy, quantity limitation). The guidelines in some instances also require ~~you to obtain~~ prior authorization as to the medical necessity of the drug. You may call the customer service number on member's card for more information. The member's in-network pharmacist should help you comply with the Drug Coverage Guidelines.
- Compound drugs are defined as drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded drugs may be subject to additional coverage criteria and utilization management edits. Compounds are covered only when medically necessary. Compound drugs are always classified as the highest cost-sharing, non-specialty drug tier.
- Drugs can be dispensed up to a maximum 34-day supply. Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used (e.g., 23 days in a 30-day supply). Your pharmacist may be able to synchronize the refill date for member's prescriptions. Ask the pharmacist if prescription drug medication synchronization is available.
- Insulin, needles, and syringes purchased on the same day in the same quantity will have one copayment; otherwise, each has a separate copayment. Separate copays apply for blood glucose strips and lancets. These are the only diabetic supplies available as prescription drug benefits under the plan.

## Provider-Administered Drug Benefits

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

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

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

Provider-administered drug coverage is subject to Drug Coverage Guidelines and medical necessity policies found in the pharmacy section of our website. A drug may not be covered under the plan because, for example, there are safety and/or efficacy concerns. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. The guidelines in some instances also require the drug be administered by a provider and/or facility approved by the drug manufacturer. You can find a list of the provider-administered drugs that require precertification at AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList.

### Health Management Benefits

| HEALTH MANAGEMENT BENEFITS | |
|---|---|
| Individual Case Management | Coordinates care in event of catastrophic or lengthy illness or injury |
| Chronic Condition Management | Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease |

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

Members may also qualify to participate in the chronic condition management program. Chronic condition management is designed for individuals whose long-term medical needs require disciplined compliance with a variety of medical and lifestyle requirements. If the manager of the chronic condition management program determines from members claims data that the member is a good candidate for chronic condition management, the manager will contact the member and ask if he/she would like to participate. Participation in the program is completely voluntary. For more information about the program, call BCBS's customer service department at 1-800-760-6851.

# Additional Benefit Information

### ALL Babies

ALL Babies is an ALL Kids program and recipients receive the same health benefits as ALL Kids recipients. The eligibility criteria and coverage period may be different.

### Baby Yourself Program

If a member is pregnant, Baby Yourself offers individual care by a registered nurse. Please call the BCBS nurses at 1-800-222-4379 (or 205-733-7065 in Birmingham) as soon as pregnancy is indicated. Begin care for the baby and the expectant mother as early as possible and continue throughout the pregnancy. A baby has the best chance for a healthy start by early, thorough care while the member is pregnant. If a pregnant member falls into one of the following risk categories, please tell the doctor and the Baby Yourself nurse:

- High blood pressure;
- Diabetes;
- History of previous premature births;
- Multiple births (twins, triplets, etc.)

### Women's Health and Cancer Rights 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.

### 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/multivesicular. 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 the BCBS list of approved facilities for that type of transplant and it must have BCBS's advance written approval. When BCBS approves 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 services, 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 transport of 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, pre-existing condition exclusions, and other plan limitations. For example, if the members 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, and; (9) transplants (excluding kidney) performed in a facility not on the BCBS approved list for that type or for which BCBS did not give 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.

# COORDINATION OF BENEFITS (COB)

If a member becomes covered under any other individual or group health plan or program, such other plan shall pay primary and this plan shall pay secondary to such other plan or program. If this plan is required to make a secondary payment according to these rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

## Order of Benefit Determination

ALL Kids will always be the secondary payer or the payer of last resort.

## 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 BCBS's records indicate this plan is secondary, we will not process member's claims until filed with the primary plan and the primary plan has made its benefit determination.

If this plan is required to make a secondary payment according to the above rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

## COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term "allowable expense" means any health care 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 cosmetic surgery, acupuncture, orthodontia for cosmetic purposes, 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.

Primary Plan: The term "primary plan" means a plan whose benefits for a person's health care 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 health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. BCBS may get the facts BCBS needs 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. BCBS is not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give BCBS any facts BCBS needs 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, BCBS 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. BCBS 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 BCBS is more than BCBS should have paid under this COB provision, BCBS may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

## SUBROGATION

### Right of Subrogation

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

### Right of Reimbursement

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

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

### Right to Recovery

Members agree to furnish BCBS promptly all information which the members, have concerning rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with BCBS in protecting and obtaining our reimbursement and subrogation rights in accordance with this section. Members, or the representing attorney, will notify BCBS before filing any suit or settling any claim so as to enable BCBS to participate in the suit or settlement to protect and enforce BCBS's rights under this section. If a member does notify BCBS so that BCBS is able to and does recover the amount of BCBS's benefit payments for the member, BCBS will share proportionately with the member in any attorney's fees charged the member by the representing attorney for obtaining the recovery. If the members does not give BCBS that notice, BCBS reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for the attorney representing member.

Members further agree not to allow BCBS reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on member's part. It is understood and agreed that if members do, BCBS may suspend or terminate payment or provision of any further benefits for members under the plan.

# HEALTH, MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT EXCLUSIONS

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

## A

Services or expenses for elective **abortions**. An elective abortion is defined as an abortion performed for reasons other than the compromised physical health of the mother, or conception due to incest or rape.

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 BCBS **certifies** it before member's admission, services or expenses of a hospital stay for an emergency if BCBS is not notified within 48 hours or on our next business day after member's admission, or if BCBS determines 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 12 months after services were rendered or expenses incurred.

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

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

Services or expenses related to the fitting and supply of **contact lenses**.

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. Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

- You must contact BCBS prior to surgery to find out whether a procedure will be reconstructive or cosmetic. The member’s physician must prove to the satisfaction of BCBS that surgery is reconstructive and not cosmetic. Physician must show BCBS history and physical exams, visual field measures, photographs, and medical records before and after surgery. BCBS may not be able to determine prior to member’s 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 member’s appearance, but reconstructive if done because member’s eyelids kept members 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.

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

# E

Services, care, or treatment members receive after the **ending date** of member’s coverage. This means, for example, that if a member is in the hospital when his or her coverage ends, BCBS will not pay for any more hospital days. BCBS not insure against any condition such as pregnancy or injury. BCBS provides benefits only for services and expenses furnished while this plan is in effect.

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

Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with

contact lenses, or any surgery on the eye to improve vision including radial keratotomy. This exclusion does not apply to benefits stated in Routine Vision Services benefits.

# 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.

# I

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

# 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.

# N

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

Services, care, or treatment members receive during any period of time with respect to which BCBS has not been paid for member’s coverage and that **nonpayment** results in termination.

Services or expenses rendered by out-of-network **Certified Registered Nurse Practitioners** (CRNP) or out-of-network **Certified Nurse Midwives** (CNM).

# O

Except as may be expressly covered in 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 does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines of Blue Cross. Benefits will only be provided for one surgical procedure for obesity (morbid) per member under this plan. Benefits will be provided for a subsequent surgery for complications related to a

covered surgical procedure for obesity (morbid) only if medically necessary and in compliance with the guidelines of Blue Cross. However, no benefits will be provided for subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) (including revisions or adjustments to a covered surgical procedure or conversion to another covered bariatric procedure and weight gain or failure to lose weight) if the complications arise from non-compliance with medical recommendations regarding patient activity and lifestyle following the procedure. This exclusion for subsequent surgery for complications that arise from non-compliance with medical recommendations applies even if the subsequent surgery would otherwise be medically necessary and would otherwise be in compliance with the guidelines of Blue Cross. (This exclusion does not apply to cardiac or pulmonary rehabilitation, diabetes self-management programs, or plan approved programs for pediatric obesity.)

Services or expenses for **occupational therapy** (except as previously stated covered).

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

# P

**Private** duty nursing.

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

# R

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

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

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

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

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

# S

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

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

Services or expenses for **speech therapy** (except as previously stated covered).

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

# 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.

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 **third party vendor** that are used in surgery or any operative setting unless otherwise required by law. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.

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

Services or expenses for or related to organ, **tissue or cell transplants** except specifically as allowed by this 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 ALL Kids has insurance coverage for benefits under the law.

# DENTAL BENEFITS

All services must be rendered by a Preferred Dentist. To locate a Preferred Dentist, go to www.AlabamaBlue.com/FindADoctor. Orthodontic services are covered for some conditions as stated previously in the medical sections of this booklet. For services exceeding $1,500 maximum per person per year, approval from the plan must be sought by the provider. Basic diagnostic and preventive services, and wisdom teeth removal and related services are excluded from this benefit amount.

Benefits are paid toward the lesser of the Preferred Dentist Fee Schedule or the dentist's actual charge for services. All Preferred Dentists agree that the BCBS payment is payment in full except for member's copayments.

No coverage is available for non-preferred dentists. Preferred dentists may not collect their fee for plan benefits except for applicable copayments. They must bill BCBS first, except for services not covered by the plan, such as implant and non-covered orthodontia services.

| BASIC DIAGNOSTIC AND PREVENTIVE BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| **Basic diagnostic and preventive services, consisting of:**<br>• **Dental exams, up to twice per calendar year**<br>• **Dental X-ray exams:**<br>1. **Full mouth X-rays, one set during any 36 months in a row;**<br>2. **Bitewing X-rays, up to twice per calendar year; and**<br>3. **Other dental X-rays, used to diagnose a specific condition**<br>• **Tooth sealants on teeth numbers 2, 3, 14, 15, 18, 19, 30, and 31, limited to one application per tooth each calendar year**<br>• **Fluoride treatment for children through age 18, twice per calendar year**<br>• **Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18**<br>• **Routine cleanings, twice per calendar year** | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment | 100% of the allowed amount, no copayment |

| BASIC RESTORATIVE BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| **Basic restorative services consisting of:**<br>• **Filings made of silver amalgam and tooth color materials**<br>• **Posterior composite filings**<br>• **Simple tooth extractions**<br>• **Direct pulp capping, removal of pulp, and root canal treatment**<br>• **Repairs to removable dentures**<br>• **Emergency treatment for pain** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $5 copayment per visit | 100% of the allowed amount, subject to a $20 copayment per visit |

| SUPPLEMENTAL BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| **Supplemental services consisting of:**<br>**Oral surgery, i.e., to treat fractures and dislocations of the jaw, to diagnose and treat mouth cysts and abscesses and for tooth extraction and impacted teeth**<br>**General anesthesia when given for oral or dental surgery. This means drugs injected or inhaled to relax the patient or lessen the pain, or make the patient unconscious, but not analgesics or drugs administered by local infiltration**<br>**Administration of nitrous oxide**<br>**Treatment of the root tip of the tooth including its removal** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $5 copayment per visit | 100% of the allowed amount, subject to a $20 copayment per visit |

| PROSTHETIC BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| **Prosthetic services consisting of:**<br>**Full or partial dentures**<br>**Fixed or removable bridges**<br>**Inlays, onlays, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not correct the dental problem** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $5 copayment per visit | 100% of the allowed amount, subject to a $20 copayment per visit |

Limits on prosthetic services:

- Partial Dentures - If a removable partial denture can restore the upper or lower dental arch satisfactorily, BCBS will pay as though it were supplied even if you chose a more expensive means.
- Precision Attachments - There are no benefits for precision attachments.
- Dentures - BCBS pays only toward standard dentures.
- Replacement of Existing Dentures, Fixed Bridgework, Veneers, or Crowns - BCBS pays toward replacing an existing denture, fixed bridgework, veneer, or crown only if the old one can't be fixed. If one can be fixed, BCBS will pay toward fixing it (this includes repairs to fixed dentures). BCBS will only pay to replace these items every five years.
- There are no benefits to replace lost or stolen items.

| PERIODONTIC BENEFITS | | | |
|---|---|---|---|
| **SERVICE OR SUPPLY** | **NO FEE** | **LOW FEE** | **FEE** |
| **Periodontic services consisting of:**<br>**Periodontic exams twice each 12 months**<br>**Removal of diseased gum tissue and reconstructing gums**<br>**Removal of diseased bone**<br>**Reconstruction of gums and mucous membranes by surgery**<br>**Removing plaque and calculus below the gum line for periodontal disease** | 100% of the allowed amount, no copayment | 100% of the allowed amount, subject to a $5 copayment per visit | 100% of the allowed amount, subject to a $20 copayment per visit |

## Payment of Benefits

Preferred Dentists are paid directly by Blue Cross and Blue Shield of Alabama. Services are covered only if rendered by a Preferred Dentist who participates with Blue Cross and Blue Shield of Alabama. Orthodontia services are covered under the health plan, (not a part of the dental plan). See Orthodontia Services under Health Benefits for more information.

# DENTAL BENEFIT LIMITATIONS

Limits to all benefits:

- Examination and diagnosis no more than twice during any benefit period.
- Full mouth X-rays will be provided once each 36 months; two bitewings no more than twice during any calendar year.
- Routine cleaning will be provided no more than twice during any benefit period.
- Fluoride treatment will be provided to members through age 18 no more than twice during any benefit period.
- Tooth sealants on teeth numbers 2, 3, 14, 15, 18, 19, 30 and 31, limited to not more than one application per tooth each calendar year.
- If members changes dentists while being treated, or if two or more dentists do one procedure, BCBS will pay no more than if one dentist did all the work.
- When there are two ways to provide treatment and both are services covered under the plan, BCBS will pay toward the less expensive one. The dentist may bill you for any excess charges.
- Prosthetic – Gold, baked porcelain restorations, veneers, crowns and jackets – If a tooth can be restored with a material such as amalgam, BCBS will pay toward that method of treatment even if a more expensive means is used. Payment will be made toward eliminating oral disease and replacing missing teeth.
- Orthodontics – Orthodontia services are covered under the health plan, (not a part of the dental plan). See Orthodontia Services under the Health Benefits section of this booklet for more information.

# DENTAL BENEFIT EXCLUSIONS

We will not provide benefits for the following:

## A

**Anesthetic** services performed by and billed for by a dentist other than the attending dentist or his assistant.

**Appliances** or restorations to alter vertical dimensions from its present state or restoring the occlusion. Such procedures include but are not limited to equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from the grinding of teeth or the wearing down of the teeth and restoration from the malalignment of teeth.

## B

Dental services to the extent coverage is available to the member under any other **Blue Cross and Blue Shield contract.**

## C

Dental services for which you are not **charged.**

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

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

Services or expenses of any kind either (a) for which a **claim** submitted for a member in the form prescribed by BCBS has not been received by BCBS, or (b) for which a claim is received by BCBS later than 12 months after the date services were performed.

Services or expenses of any kind for **complications** resulting from services received that are not covered as benefits under this contract.

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.

# D

**Dental** care or treatment not specifically identified as a covered dental expense.

# E

Dental services you receive before members **effective date of coverage**, or after member's effective date of termination.

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

# F

Charges to use any **facility** such as a hospital in which dental services are rendered, unless approved as dentally necessary.

Charges for **failure** to keep a scheduled visit with the dentist.

# G

**Gold** foil restorations.

# I

Charges for **implants**.

Charges for **infection** control.

Any dental treatment or procedure, drugs, drug usage, equipment, or supplies which are **investigational**, including services that are part of a clinical trial.

# L

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 provide or pay for care, through insurance or any other means. This applies even if the law does not cover all members expenses.

# M

Dental services with respect to **malformations** from birth or primarily for appearance.

# N

Services or expenses of any kind, if not required by a dentist, or if **not dentally necessary**.

Services or expenses rendered by a **non-preferred** dentist.

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

# O

Charges for **oral** hygiene and dietary information.

Charges for **orthodontia** services, except as indicated under Orthodontia Services in the Health Benefits section of this booklet.

## P

Charges for dental care or treatment by a **person** other than the attending dentist unless the treatment is rendered under the direct supervision of the attending dentist.

Charges for **plaque control program**.

## R

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

## W

Dental services or expenses in cases covered in whole or in part by **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 employer. It applies whether the law provides for dental services as such. Finally, it applies whether your employer has insurance coverage for benefits under the law.

# ALL KIDS PLUS

**ALL Kids PLUS** is a service delivery mechanism that has been developed between the Alabama Department of Public Health and some state agencies to provide services for children with special health care needs (CSHCN). **ALL Kids PLUS** supplements the basic ALL Kids plan by offering children (CSHCN) access to a wider and more in-depth range of services.

To use PLUS services, children with special health care needs must be enrolled in ALL Kids and meet the eligibility criteria of the participating state agencies. Services are individualized and may include care coordination, family support services, special instruction/ training, nutrition services, transportation services, social services, durable medical equipment and supplies, and related rehabilitative services.

Service availability is dependent on the service and the funding capacity of the participating agencies.

**PARTICIPATING AGENCIES: Because of financial considerations, ALL Kids PLUS services can only be arranged by or provided by participating state agencies. You must establish eligibility with one of these ALL Kids PLUS state agencies in order to be considered for ALL Kids PLUS services (Participating Agencies may change).**

| PARTICIPATING STATE AGENCIES/CONTACT | DESCRIPTION OF SERVICES PROVIDED |
|---|---|
| **Alabama Department of Rehabilitation Services**<br>**Division of Children's Rehabilitation Services (CRS)**<br>**1-800-441-7607** | Provides comprehensive services through its clinics and private providers to children with special health care needs/conditions, including developmental delay. |
| **Alabama Department of Rehabilitation Services Division of Early Intervention (EI)**<br>**1-800-441-7607** | Provides and coordinates statewide Early Intervention Services to children from birth to age three (3) who are developmentally delayed or have the potential for physical or developmental delay. |

***** You may contact a participating state agency for more information about services provided. *****

(The list of services is subject to change over time and is based on the availability of funds.)

# CLAIMS AND APPEALS

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

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

## Claims and Appeals Process for Blue Cross and Blue Shield of Alabama

Claims for benefits under the ALL Kids plan can be pre-service, post-service, or concurrent. This section of the booklet explains how BCBS will process these different types of claims and how members can appeal a partial or complete denial of a claim.

It may become necessary to act on a member's behalf through an authorized representative to exercise a member's rights under this section of this booklet. An authorized representative is someone designated in writing to act on the member's behalf. BCBS has developed a form that must used to designate an authorized representative. The form can be obtained by calling the BCBS Customer Service Department or by going to the Internet web site at www.bcbsal.com to request copy of the form. If a person is not properly designated as a member's authorized representative, BCBS will not be able to deal with him or her in connection with the exercise of member's rights under this section of this booklet.

For urgent pre-service claims, BCBS will presume that the member's provider is the member's authorized representative unless told otherwise in writing.

## Pre-Service Claims

A pre-service claim is one in which the member is required to obtain approval from BCBS before services or supplies are rendered. For example, the member may be required to obtain preadmission certification of inpatient hospital benefits. Or the member 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, the member or the member's provider must call the BCBS Health Management Department at 205-988-2245 or 1-800-248-2342 (toll-free). The member or member's provider must tell BCBS the contract number, the name of the facility in which the member is being admitted (if applicable), the name of a person BCBS can call back, and a phone number to reach that person. Pre-service claims may also be submitted in writing. Written pre-service claims should be sent to BCBS 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 BCBS during regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require a pre-service claim so long as BCBS is provided notice within 48 hours of the admission and BCBS certifies the admission as both medically necessary and as an emergency admission. Precertification for an inpatient hospital admission if member is admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical

Doctor (PMD Physician) is not required. CURP is a program implemented by BCBS and in- network hospitals in the Alabama service area to simplify the administration of preadmission certifications and concurrent utilization review. If the member's plan provides chiropractic, physical therapy, or occupational therapy benefits and members receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, the member's provider is responsible for initiating the precertification process for the member. For home health care and hospice benefits (if covered by members plan), see the previous sections of this booklet for instructions on how to precertify treatment.

## Post-Service Claims

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

In order for BCBS to treat a submission by member or member's 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 BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS claim filing requirements and will file claims for members. If member's provider does not file the claim, call the BCBS Customer Service Department and ask for a claim form. Tell the Customer Service representative the type of service or supply for claim (for example, hospital, physician, or pharmacy), and they will send the proper type of claim form. When the form is received, complete it, attach an itemized bill, and send it to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by BCBS within 12 months after the service takes place to be eligible for benefits.

If BCBS receives a submission that does not qualify as a claim, the member or member's provider will be notified of the additional information needed. Once that information is received, the submission will be processed as a claim.

Processing of Claims: Even if BCBS has received all of the information that is needed in order to treat a submission as a claim, from time-to-time additional information may be needed in order to determine whether the claim is payable. If additional information is needed, BCBS will ask the member to furnish it to them, and further processing of member's claim will be suspended until the information is received. The member has 90 days to provide the information to BCBS. In order to expedite the receipt of the information, BCBS may request it directly from the member's provider. If this occurs, the member will be sent a copy of the request, however, the member will remain responsible for seeing that BCBS gets the information on time.
Ordinarily, BCBS will notify the member of the decision within 30 days of the date on which member's claim is filed. If it is necessary for BCBS to ask for additional information, you will be notified of the decision within 15 days after receipt of the requested information. If BCBS does not receive the information, the member's claim will be considered denied at the expiration of the 90-day period BCBS gave the member for furnishing the information.

In some cases, BCBS may ask for additional time to process a member's claim. If the member does not wish to give the additional time, BCBS will go ahead, and process member's claim based on the information they have. This may result in a denial of member's claim.

Who Gets Paid: Some of the contracts BCBS has with providers of services, such as hospitals, require BCBS to pay benefits directly to the providers. With other claims, BCBS may choose whether to pay the member or the provider. If the member or the provider owes BCBS money, BCBS may deduct the amount owed from the benefit paid. When BCBS pays or deducts the amount owed from the member or the provider, this completes BCBS's obligation under the plan. BCBS need not honor an assignment of the member's claim to anyone. Upon the member's death or incompetence, or if the member is a minor, BCBS may pay the estate, the guardian, or any relative BCBS believes is due to be paid. This, too, completes BCBS's plan obligation.

If the member attempts to file a pre-service claim but fails to follow the procedures for doing so, BCBS will notify the member of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). BCBS notification may be oral, unless you ask for it in writing. BCBS will provide this notification to the member only if (1) an attempt to submit a pre-service claim was received by a person or organizational unit of BCBS that is customarily responsible for handling benefit matters, and (2), the 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: BCBS will treat a member's claim as urgent if a delay in processing the member's claim could seriously jeopardize the member's life, health, or ability to regain maximum function or, in the opinion of the member's treating physician, a delay would subject member to severe pain that cannot be managed without the care or treatment that is the subject of member's claim. If the member's treating physician tells BCBS that the member's claim is urgent, BCBS will treat it as such.

If the member's claim is urgent, BCBS will notify member of the decision within 72 hours. If more information is needed, BCBS will let member know that within 24 hours of member's claim. Member will then have 48 hours to provide this information to BCBS. BCBS will notify member of the decision within 48 hours after the requested information is received. BCBS's response may be oral; if it is, BCBS will follow it up in writing within three days. If BCBS does not receive the information, the member's claim will be considered denied at the expiration of the 48-hour period given to furnish the information.

Non-Urgent Pre-Service Claims: If member's claim is not urgent, BCBS will notify member of the decision within 15 days. If more information is needed, BCBS will let the member know before the 15-day period expires. BCBS will tell you what further information we need. Member will then have 90 days to provide this information. In order to expedite receipt of the information, BCBS may request it directly from the member's provider. If this occurs, the member will be sent a copy of the request, however, the member will remain responsible for seeing that BCBS gets the information on time. BCBS will notify the member of the decision within 15 days after receipt of the requested information. If BCBS does not receive the information, the member's claim will be considered denied at the expiration of the 90-day period given to furnish the information.

Courtesy Pre-Determinations: For some procedures the member is encouraged, but not required, to contact BCBS before the member has the procedure. For example, if the member's physician thinks a procedure might be excluded as cosmetic, you can ask BCBS to determine beforehand whether the procedure is cosmetic or reconstructive. This type of review is called a courtesy pre-determination. If a courtesy pre-determination is asked for, BCBS will strive to provide a timely response. If it is decided that a courtesy pre-determination cannot be made (for example, we cannot get the information needed to make an informed decision), BCBS will let the member-know. In either case, courtesy pre-determinations are not pre-service claims under the ALL Kids plan. When requests for courtesy pre-determinations are processed, BCBS is not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy predetermination, the member or member's provider should call the BCBS Customer Service Department.

## Concurrent Care Determinations

Determinations by BCBS to Limit or Reduce Previously Approved Care: If BCBS has previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and then later decides to limit or reduce the previously approved stay or course of treatment, the member will be given enough advance written notice to permit the initiation of an appeal and obtain a decision before the date on which care or treatments are no longer approved. Reasonable rules BCBS establishes for the filing of your appeal must be followed, such as time limits within which the appeal must be filed.

Requests to Extend Previously Approved Care: If a previously approved hospital stay or course of treatment is about to expire, the member may submit a request to extend previously approved care. This request may be made in writing or orally, either directly to BCBS or through the member's treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 205-988-2245 or 1-800-248-2342 (toll-free).

- For in-network physical therapy or occupational therapy (if covered by members plan), call 205-220-7202.
- For care from an in-network chiropractor (if covered by members plan), call 205-220-7202.

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

## Your Right To Information

The member has the right, upon request, to receive copies of any documents that BCBS relied on in reaching the decision and any documents that were submitted, considered, or generated by BCBS in the course of reaching the decision. The member also has the right to receive copies of any internal rules, guidelines, or protocols that BCBS may have relied upon in reaching the decision. If the decision was based on a medical or scientific determination (such as medical necessity), the member may also request that BCBS provide you with a statement explaining the application of those medical and scientific principles to the member. If BCBS obtained advice from a health care professional (regardless of whether BCBS relied on that advice), the member may request that BCBS give the name of that person. Any request that the member makes for information under this paragraph must be in writing. BCBS will not charge for any information that the member requests under this paragraph.

## Appeals

If the member is dissatisfied with BCBS's adverse benefit determination of a claim, the member may file an appeal with BCBS. The member cannot file a claim for benefits under the plan in federal or state court (or in arbitration if provided by your plan) unless the member has exhausted these administrative remedies.

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

- Any determination BCBS makes with respect to a post-service claim that results in the member owing any money to a provider other than copayments the member makes, or are required to make, to a provider;
- BCBS's denial of a pre-service claim; or,
- An adverse concurrent care determination (for example, BCBS denies the member's request to extend previously approved care).

In all cases other than determinations by BCBS to limit or reduce previously approved care, the member has 180 days following an adverse benefit determination within which to submit an appeal.

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 BCBS recommends that the member uses a form that BCBS has developed for this purpose. The form will help the member provide BCBS with the information that BCBS needs to consider the appeal. To get the form, call BCBS's customer service department. The member may also go to BCBS's Internet web site at www.bcbsal.com. Once there, a copy of the form may be requested.

If the member chooses not to use BCBS's appeal form, the member may send BCBS a letter. The 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 members claims report with the appeal.); and,

- A statement that an appeal is being filed.

The member must send the appeal to the following address:

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

Please note that if the member calls or writes BCBS without following the rules just described for filing an appeal, BCBS will not treat the inquiry as an appeal. BCBS will, of course, do everything possible to resolve questions or concerns.

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

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

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

If in writing, members should send letters to the appropriate address listed below:

- For inpatient hospital care and admissions:

Blue Cross and Blue Shield of Alabama
Attention: Health Management – Appeals
P.O. Box 2504
Birmingham, Alabama 35201-2–504

or

- For in-network physical therapy, occupational therapy, or care from an in-network chiropractor (when covered by members plan):

Blue Cross and Blue Shield of Alabama
Attention: Health Management – Appeals
P.O. Box 362025
Birmingham, Alabama 35236

The member's written appeal should provide BCBS with member's name, contract number, the name of the facility or provider involved, and the date or dates of service.

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

If BCBS needs more information, the member will be asked to provide it. In some cases, BCBS may ask the member's provider to furnish that information directly to us. If this occurs, the member will be sent a copy of the request. However, the member will remain responsible for seeing that BCBS gets the information. If BCBS does not get the information, it may be necessary for BCBS to deny the appeal.

Time Limits for Our Consideration of Member's Appeal: If the appeal arises from BCBS's denial of a

post-service claim, BCBS will notify the member of the decision within 60 days of the date on which the appeal was filed.

If the appeal arises from BCBS's denial of a pre-service claim, and if member's claim is urgent, BCBS will consider the appeal and notify the member of the decision within 72 hours. If the pre-service claim is not urgent, BCBS will give a response within 30 days.

If the appeal arises out of a determination by BCBS 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), BCBS will make a decision on the appeal as soon as possible, but in any event before BCBS imposes the limit or reduction.

If the appeal relates to the decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), BCBS will make a decision on the 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, BCBS may ask for additional time to process the appeal. If the member does not wish to give BCBS additional time, BCBS will go ahead and decide on the appeal based on the information BCBS has. This may result in a denial of the appeal.

If the Member Is Dissatisfied After Exhausting Mandatory Plan Administrative Remedies: If the member has filed an appeal and is dissatisfied with the BCBS response, the member may do one or more of the following:

- Ask the BCBS customer service department for further help;
- File a voluntary appeal (discussed below); or,
- File a lawsuit in federal court under Section 502(a) of Employment Retirement Income Security Act of 1974 (ERISA) or in the forum specified in the ALL Kids plan if member's claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If BCBS has given the member the appeal decision and the member is still dissatisfied, the member may file a second appeal (called a voluntary appeal). If the voluntary appeal relates to a pre-service adverse benefit determination, the member may file the appeal in writing or over the phone. If over the phone, the member should call the phone number called to submit the first appeal. If in writing, the member should send letters to the same address used when submitting the first appeal.

The member's written appeal must state that you are filing a voluntary appeal.

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

The member may ask BCBS to provide more information about voluntary appeals. This additional information will allow the member to make an informed judgment about whether to request a voluntary appeal.

# RESPECTING YOUR PRIVACY

The confidentiality of member's personal health information is important to BCBS. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as ALL Kids are generally required to limit the use and disclosure of member's protected health information to treatment, payment, and health care operations and to put in place appropriate safeguards to protect member's 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 Blue Cross and Blue Shield of Alabama.

Disclosures of Protected Health Information to the Plan Sponsor:

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

- The plan may inform the plan sponsor whether you are enrolled in the plan.
- Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying members. 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.
- The plan may disclose member's protected health information to the plan sponsor for plan administrative purposes due to employees of ALL Kids performing 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 members protected health information:

- The plan sponsor will only use or disclose member's 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 member's protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep members protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose member's 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 member's protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow member or the plan to inspect and copy any protected health information about members that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that members 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 the member's 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). Members 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 health care operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of the member's 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 the member's 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 members protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy the member's 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 member's protected health information in accordance with the HIPAA regulations that have just been explained:

- Administrative Director

If any of the foregoing employees or workforce members of the plan sponsor use or disclose member's 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 members.

Security of Members 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 member's 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 member's electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of member's 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 Member's Personal Health Information:

As a business associate of the plan, we (Blue Cross and Blue Shield of Alabama/BCBS) have an agreement with the plan that allows BCBS to use member's personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that BCBS may obtain, use and release all records about members that BCBS needs to administer the plan or to perform any function authorized or permitted by law. The member further directs all persons to release all records to us about members that BCBS needs in order to administer the plan.

# GENERAL INFORMATION

## Delegation of Discretionary Authority to Blue Cross

ALL Kids has delegated to BCBS, 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 BCBS makes reasonable determinations that are neither arbitrary nor capricious in BCBS's administration of the plan, those determinations will be final and binding on the member, subject only to the member's 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).

## Notice

BCBS gives you notice when you are sent information by mail or electronically to the latest address BCBS has on file, or notice is sent to ALL Kids. You and ALL Kids are assumed to receive notice three days after it is mailed.

If you are required to provide notice to BCBS, unless otherwise specified in this booklet, you should do so in writing, including member's full name and contract number.

## Correcting Payments

BCBS tries to pay all claims quickly and correctly, however, mistakes are sometimes made. If a member or a provider receives a payment in error, the payee must repay BCBS. If he does not, the amount paid in error may be deducted from any future amount paid to the member or the provider. If BCBS deducts it from an amount paid to the member, it will be reflected in the member's claims report.

## Responsibility for Providers

BCBS is not responsible for what providers do or fail to do. If they refuse to treat members or give members poor or dangerous care, BCBS is not responsible. BCBS need not do anything to enable them to treat members.

## Misrepresentation

If ALL Kids learns of any material misrepresentation in applying for coverage, when BCBS learns of this BCBS may terminate member's coverage back to the effective date on which member's coverage began as listed in our records. BCBS need not refund any payment for the coverage.

## Multiple Coverage

If members become covered by a second plan during their 12 months of enrollment with ALL Kids, the other plan will pay benefits primary and ALL Kids will pay secondary.

## 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

BCBS's obligation to provide or administer benefits under the plan may be terminated at any time by either ALL Kids or BCBS 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 ALL Kids, not to BCBS. If ALL Kids fails to pay BCBS the amounts due under the contract within the time period specified therein, the obligation to provide or administer benefits under the plan will terminate automatically and without notice to the member or ALL Kids as of the date due for payment. The fiduciary obligation, if any, to notify the member of this termination belongs to ALL Kids, not to BCBS.

Subject to any conditions or restrictions in BCBS's contract with ALL Kids, ALL Kids 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 BCBS will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to the member by ALL Kids or BCBS. The fiduciary obligation, if any, to notify member of this termination belongs to ALL Kids, not to BCBS.

If, for any reason, BCBS services are terminated under the contract, members will cease to receive any benefits by BCBS for any and all claims incurred after the effective date of termination. In some cases, this may mean retroactive cancellation of member's plan benefits. Any fiduciary obligation to notify the member of the termination belongs to ALL Kids, not to BCBS.

### Changes in the Plan

Any and all of the provisions of the ALL Kids plan may be amended by ALL Kids at any time by an instrument in writing, subject to any conditions or restrictions in contract with the group.

In many cases, this instrument will consist of a new booklet (including any riders or supplements to the booklet) that has been prepared and sent to ALL Kids in draft format. This means that from time to time the benefit booklet in the member's possession may not be the most current. If the member has any question whether their booklet is up to date, they should contact ALL Kids. Any fiduciary obligation to notify the member of changes in the plan belongs to ALL Kids, not to BCBS.

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 members 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.

# DEFINITIONS

**ABA Therapy:** Applied Behavioral Analysis (ABA) therapy is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

**Allowed Amount:** Benefit payments for covered services are based on the amount of the provider's charge that BCBS recognizes 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 BCBS 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:** In accordance with Blue Cross and Blue Shield of Alabama's applicable provider payment policies in effect at the same time the service is rendered, the allowed amount for care rendered by out-of-network providers may be based on the negotiated rate payable to in-network providers for the care in the area, may be based on the average charge for the care in the area, or may be based on a percentage of what Medicare would typically pay for the care in the area (or. If no Medicare rates are available, an approximation of what Medicare would pay for care using various sources). In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;
- The relative complexity of the service;

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

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

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

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

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

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

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

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

**Concurrent Utilization Review Program (CURP):** A program implemented by BCBS 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 BCBS's 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 BCBS has approved 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 members are sick or injured, and be related to members condition and prescribed by members physician to use in members home.

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

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

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

**Hospital:** Any institution that is classified by BCBS as a "general" hospital.

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

**In-Network Provider:** A provider is considered to be an in-network provider if, and only to the extent that, the provider is furnishing a service or supply that is specified as an in-network benefit under the terms of the contract between the provider and the Blue Cross and/or Blue Shield plan (or its affiliates). Examples include BlueCard PPO providers, Preferred Medical Doctors (PMD physicians), Blue Choice Behavioral Health Network providers, and Participating Pharmacies. A provider will be considered an in-network provider only if the local Blue Cross and/or Blue Shield plan designates the provider as an In-Network provider for the service or supply being furnished. This means that if members receives a service or supply from a provider that has a contractual relationship with a Blue Cross and/or Blue Shield plan but is not designated by the local Blue Cross and/or Blue Shield plan as a BlueCard PPO provider, the service will be considered as out-of-network.

**Inpatient:** A registered bed patient in a hospital; provided that BCBS reserves 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 BCBS has not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, BCBS develops written criteria (called medical criteria) concerning services or supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and BCBS's members. This is done so that members and providers will know in advance, when possible, what BCBS will pay for. If a service or supply is considered investigational according to one of the published medical criteria policies, BCBS will not pay for it. If the investigational nature of a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS 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 to remember that when BCBS makes 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 member's treatment must be made solely by the attending physician and other medical providers.

**Medical Emergency:** A medical condition that occurs suddenly and without warning with symptoms

which are so acute and severe as to require immediate medical attention to prevent permanent damage to the health, other serious medical results, serious impairment to bodily function, or serious and permanent lack of function of any bodily organ or part.

**Medically Necessary or Medical Necessity:** BCBS uses these terms to help BCBS determine whether a particular service or supply will be covered. When possible, BCBS develops a written criterion (called medical criteria) that is used to determine medical necessity. This criteria is based on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and BCBS members. This is done so that members and providers will know in advance, when possible, what BCBS will pay for. If a service or supply is not medically necessary according to one of BCBS's published medical criteria policies, BCBS will not pay for it. If a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be medically necessary only if BCBS determines that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of members medical condition;
- Provided for the diagnosis or direct care and treatment of members medical condition;
- In accordance with standards of good medical practice accepted byte organized medical community;
- Not primarily for the convenience and/or comfort of you, members, your family, members 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 members medical condition. A "setting" may be member’s home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital where the member is an inpatient, or another type of facility providing a lesser level of care. Only member’s medical condition is considered in deciding which setting is medically necessary. Financial or family situation, the distance the member lives from a hospital or other facility, or any other non-medical factor is not considered. As member’s medical condition changes, the setting a member needs may also change. Ask member’s physician if any of member’s services can be performed on an outpatient basis or in a less costly setting.

It is important to remember that when BCBS makes medical necessity determinations, they are solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning member’s treatment must be made solely by the attending physician and other medical providers.

**Member:** ALL Babies expectant mother or ALL Kids enrolled child or adolescent.

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

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

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

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

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

- Psychologists who are licensed by the state in which they practice (Ph.D., Psy.D. or Ed.D.), as defined in Section 27-1-18 of the Alabama Code or other applicable state law.
- In-network Certified Registered Nurse Practitioners who are practicing within the scope of their license and in collaboration with an in-network M.D. or D.O.
- In-network Certified Nurse Midwives who are practicing within the scope of their license and in collaboration with an in-network M.D. or D.O.
- Physician Assistants (P.A.s) (including P.A.s who assist in surgery) when (1) the P.A. is employed by and acting under the direct supervision of a M.D. or D.O. who is an in-network provider; (2) the
  P.A. is acting within the scope of his or her license and is in compliance with the rules, regulations, and parameters applicable under local law to the P.A.; and (3), the services of the P.A. would have been covered if provided directly by the M.D. or D.O.

**Plan:** The plan is the group health benefit plan of ALL Kids Children's Health Insurance, as amended from time to time. The plan documents consist of the following:

- This benefit booklet, as amended;
- The BCBS contract with the group, as amended;
- Any benefit matrices upon which BCBS have relied with respect to the administration of the plan; and,
- Any draft benefit booklets that BCBS is treating as operative. “Operative,” means that a draft of the booklet has been provided to ALL Kids that will serve as the primary, but not the sole, instrument upon which the 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, BCBS will resolve that conflict in a manner that best reflects the intent of ALL Kids and BCBS, 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:** ALL Kids.

**Preadmission Certification:** The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member’s admission, or within 48 hours or the next business day after the admission in the case of an emergency admission, based upon medically recognized criteria.

**Preferred Medical Doctor:** A physician who has an agreement with Blue Cross and Blue Shield of Alabama to provide surgical and medical services to members entitled to benefits under the PMD program.

**Pregnancy:** The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body – usually, but not always, in the uterus – and lasting from the time of conception to the time of childbirth, 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 members alone.

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

**Rehabilitative services:** Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.
**Residential treatment:** Continuous 24 hour per day care provided at a live-in facility for mental health or substance abuse disorders.

**Skilled Nursing Facility:** Any Medicare participating skilled nursing facility which provides non-acute care for patients needing skilled nursing services 24 hours a day. This facility must be staffed and equipped to perform skilled nursing care and other related health services. A skilled nursing facility does not provide custodial or part-time care.

**Subrogation:** The Plan's right to recover money it has paid for health care benefits when another party is legally responsible for payment.

**Subscriber:** ALL Babies expectant mother or ALL Kids enrolled child or adolescent.

**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 BCBS 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 health care provider. Teleconsultations include consultations by e-mail or other electronic means.

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

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Health Plan

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