SUMMARY PLAN DESCRIPTION FOR ELIGIBLE Post-65 RETIREES (AND THEIR ELIGIBLE DEPENDENTS) IN THE EVONIK CORPORATION CONSOLIDATED RETIREE WELFARE BENEFITS PROGRAM

Effective January 1, 2021

This document is the Summary Plan Description (SPD) for the Evonik Corporation medical benefits for retirees (the Plan) for non-union and certain union Retirees of Evonik Corporation who meet certain age and service requirements (described in the Base Retiree SPD) (together "Covered Persons"). This SPD outlines the rights and benefits of Covered Persons and their Dependents and describes the major provisions of the Plan as in effect on January 1, 2021. This booklet, together with the Retiree Base SPD will constitute the entire SPD for the Blue Cross Blue Shield of Alabama (BCBS AL) Traditional Choice Plan. Eligibility for the BCBS AL Traditional Choice, as well as important legal information is located in the Evonik Retiree Base SPD. The BCBS of AL option benefit details are in this booklet.

Note: This SPD is not intended for Cyro, Lockland Union, Oil Additive retirees hired prior to January 1, 2017, and Piscataway Union retirees. SPDs for each of these groups are provided separately.

The Plan is a participating Plan under the Evonik Corporation Consolidated Retiree Welfare Benefits Program (the Program). The Plan provides medical benefits to eligible Covered Persons of the Company and its participating Employer affiliates. You may check with Mercer Marketplace to verify that your employer is a participating Employer at 1-855-684-6628, Monday through Friday, 7:00 am to 9:00 pm, ET.

This SPD is intended to explain the terms of the Plan in non-technical, everyday language, but capitalized terms and phrases have specific meanings within the context of the Plan. These special capitalized terms are defined in the Defined Terms section at the end of this SPD. The Defined Terms section acts like a glossary.

The complete terms and conditions of the Plan are described in a complex legal Program document. Plan benefits are paid only if provided for in the official Program document. If there are any differences between this SPD and the official Program document, the Program document will govern.

The terms "you" and "your" as used in this Summary Plan Description refer to a Covered Person of the Company or a participating Employer who meets all the eligibility and participation requirements under the Plan (and, with respect to certain benefits rights and participant obligations under the Plan, the Covered Person's Dependents. Receipt of this SPD does not guarantee that the recipient is a Covered Person under the Plan and/or otherwise eligible for benefits under the Plan.

GENERAL PLAN INFORMATION

Introduction

Participation in the Plan will take effect once you enroll in accordance with the Company's procedures. Enrollment is not automatic. Retirees who do not enroll when initially eligible cannot enroll ever again. Once enrolled, Retirees may change elections during the next annual enrollment period or change your coverage if you have a qualifying status change. These Election Changes During the Year may be found in the Retiree Base SPD. No benefits are payable for expenses incurred before the Plan began or after the Plan is terminated. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

All benefits described in this SPD are subject to the exclusions and limitations in this Plan including, but not limited to, the Claims Administrator's determination that care and treatment is necessary according to generally accepted medical standards of care as defined by the Claims Administrator.

The coverage and benefit levels described in this document are subject to change. Please contact the Mercer Retiree Service center to confirm cost and coverage information. Benefits under this Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This Plan provides minimum essential coverage.

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). Each coverage option offered under the Plan meets the minimum value standard for the benefits it provides.

The Plan is administered by third party Claims Administrators on behalf of the Plan Administrator.

BCBS OF AL COVERAGE OPTION

The Plan provides comprehensive coverage for many medical procedures and is offered to help Retirees and their covered Dependents pay for medical care. The Plan offers the following choice of medical coverage option:

- BCBS of AL Traditional Choice

Prescription Drug Coverage

If you are enrolled in the BCBS of AL Traditional Choice option, your Prescription Drug benefits are provided under the Prescription Drug Program administered by Express Scripts, Inc. (formerly Express Scripts). Refer to the *Prescription Drug Program Administered by Express Scripts* SPD.

CONTACT INFORMATION

Group Number: 90620
BCBS of AL Customer Service: 1- 800-219-6305
BCBS of AL Website: www.alabamablue.com
BCBS of AL Claim Address:

BCBS of AL
450 Riverchase Parkway
East, Birmingham, Alabama 35244-2858.

Evonik Corporation

Traditional
Choice /90620

Effective January 1, 2021

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OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact our Customer Service Department at 1-833-994-0014. If needed, simply request a translator and one will be provided to assist you in understanding your benefits.

Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-833-994- 0014. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.

Purpose of the Plan

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

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

Using *my*BlueCross to Get More Information

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

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

BlueCare Health Advocate

By being a member of the plan, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to

you, and much more. To find out more or to contact your BlueCare Health Advocate, call our Customer Service Department at the number on the back of your ID card.

Definitions

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

Required Changes to Plan Coverage Upon Becoming Eligible for Medicare

For Covered Persons who are eligible for Medicare, coverage is available only under the BCBS of AL Traditional Choice coverage option for Medicare eligible individuals. Upon becoming eligible for Medicare, you will be required to switch to the BCBS of AL Traditional Choice coverage option for Medicare eligible individuals as of the first month starting on or after the date you become eligible for Medicare.

If you do not move to the BCBS of AL Traditional Choice coverage option for Medicare eligible individuals once you become Medicare-eligible, you will be deemed to have waived coverage, and you will no longer be a Covered Person under the Plan.

Only Covered Persons who are eligible for Medicare will change to the BCBS of AL Traditional Choice coverage option for Medicare eligible individuals. Family members who are not Medicare-eligible may remain in their pre-age 65 BCBS of AL coverage option.

Enrollment in Medicare Parts A and B

If you are eligible for Medicare, it is your responsibility to enroll (and ensure your covered Medicare-eligible Dependents enroll) for Medicare with your local social security office. To remain in the Plan once you become eligible for Medicare, you must be enrolled in both Medicare Parts A and B on the date you reach age 65 or otherwise become eligible for Medicare. For more information about Medicare, see the *Medicare & You* handbook (generally available from your local social security office), call 800-MEDICARE (800-633-4227), or visit the government's website at http://www.medicare.gov.

If you and/or your covered Dependent is Medicare eligible and chose to continue Plan coverage under the BCBS of AL Traditional Choice medical option for Medicare eligible individuals, Medicare Parts A and B will be considered the primary insurance and the Plan will only pay as a secondary insurer. The Plan will reduce its benefits by the amount Medicare paid or would have paid as the primary payer for the same expenses. As the secondary plan, the Plan may pay the difference between the amount the Plan would normally pay (in absence of Coordination of Benefits) and the amount paid by the primary plan. In no event will you receive more than 100% of your Usual and Reasonable or Allowable Amount charge from the two plans combined. To determine benefits payable as the secondary plan, the Plan first calculates what it would have paid if it were the primary plan. Refer to the Coordination of Benefits Medicare example under the *Medicare Coverage BCBS of AL Traditional Choice* section.

Enrollment in Medicare Part D

The BCBS of AL medical option is "non-creditable" prescription drug coverage because, on average, it is not as good as the standard Medicare drug plan coverage. The Plan is non-creditable because the Plan has an annual maximum of $2,500 for prescription drug coverage. This means that if you or your covered Dependent does enroll in a Part D plan when first eligible and then decides to enroll in a Part D plan later, you will be assessed a 1% per month penalty for each

month you did not take the Part D plan when first eligible (unless you had other creditable prescription drug coverage through another plan).

When you become eligible for Medicare Part A and/or Part B, you have the option of enrolling in a Medicare Part D plan. If you enroll in a Medicare D plan, you may continue your medical and prescription drug coverage through the Plan, or you may drop your Plan coverage. If you drop coverage in the Plan, you will not be permitted to re-enroll in the future with no opportunity to re-enroll in the future. You may enroll in a Medicare D plan and continue the Plan coverage, but the two plans will not coordinate. You will need to decide which benefit plan to use when you fill a prescription.

Under a Medicare D plan, you will pay a monthly premium, which varies by plan and be subject to an annual Deductible. You will also pay a part of the cost of your prescriptions, including a copayment or coinsurance.

If you don't join a Medicare drug plan when you are first eligible, and you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a Medicare Part D plan later. The Medicare drug plan will let you know what the penalty amount is, and it will be added to your monthly Medicare premium. This penalty amount changes every year, and in most cases, you have to pay it as long as you have Medicare prescription drug coverage.

Important Information for Covered Persons Eligible For Medicare

Medicare is the federal government's health insurance program that covers people age 65 or older, some disabled people under age 65, and certain people with end-stage renal disease. Medicare has four parts:

Medicare Part A (Hospital Insurance) helps pay for the costs of Hospitals, certain Skilled Nursing Facilities, Hospice Care and certain home health care. After you meet the Medicare deductible, Medicare pays 100% of expenses covered by Medicare for a specified period. For most people, there is no cost for Medicare Part A coverage.

Medicare Part B (Medicare Insurance) covers doctors' fees, most Outpatient hospital services and medical supplies. After you meet the annual Medicare Part B deductible, Medicare pays for services based on a fee schedule set by Medicare. You and the federal government share the cost of Medicare Part B coverage.

Medicare Part C (also known as Medicare Advantage) are health plan options that are part of the Medicare program. If you join one of these plans, you generally get all your Medicare-covered health care through that plan. This coverage can include prescription drug coverage. Medicare Advantage Plans include:

- Medicare Health Maintenance Organization (HMOs)
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service Plans
- Medicare Special Needs Plans

To join a Medicare Advantage Plan, you must have Medicare Part A and Part B. You will have to pay your monthly Medicare Part B premium to Medicare. In addition, you might have to pay a monthly premium to your Medicare Advantage Plan for the extra benefits that they offer.

Medicare Part D is a voluntary Outpatient prescription drug benefit insurance program created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that covers both Brand Name Drugs and Generic Drugs at designated pharmacies. The coverage is provided through insurance companies and other private companies that have been approved by Medicare to offer these plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The BCBS of AL Traditional Choice medical option for Medicare eligible individuals is the only medical Plan option available if you and/or your covered Dependent is Medicare eligible and elects the BCBS of AL Traditional Choice coverage option. For information on what medical plan options are available for your non-Medicare Dependents, please refer to the *Mixed Family Coverage Options* under the *Plan Coverage Option section*.

With the BCBS of AL Traditional Choice medical option, you can go to any Physician or specialist you wish, and the Plan reimburses a portion of the cost after you meet the Deductible. Certain Covered Medical Expenses require Precertification. If Medicare is primary, you need to Precertify shortly before Medicare benefits are exhausted. Please refer to the *Precertification* section to find out what Covered Medical Expenses require Precertification.

If you or your covered Dependent is Medicare eligible and chooses to continue Plan coverage under the BCBS Traditional Choice medical option for Medicare eligible individuals, Medicare Parts A and B will be considered the primary insurance and the Plan will only pay as a secondary insurer. The Plan will reduce its benefits by the amount Medicare paid or would have paid as the primary payer for the same expenses. As the secondary plan, the Plan may pay the difference between the amount the Plan would normally pay (in absence of Coordination of Benefits) and the amount paid by the primary plan. In no event will you receive more than 100% of your Usual and Reasonable or Allowable Amount charge from the two plans combined. To determine benefits payable as the secondary plan, the Plan first calculates what it would have paid if it were the primary plan.

You should enroll in Medicare Parts A and B once you are eligible. The Plan pays benefits assuming that you have enrolled in Medicare Parts A and B (even if you have not enrolled). The following example shows how Coordination of Benefits works when Medicare is the primary payer:

Example: This example assumes that both the Medicare Part B deductible and the BCBS of AL Traditional Indemnity Deductible have already been satisfied. For an Outpatient surgery charge:

Primary Plan	Medicare
Secondary Plan	BCBS Traditional Choice Plan
Charge (for an Outpatient surgeon's service)	$100 (Medicare Allowable Amount)
Medicare Benefit	$80 (80% x $100 = $80) Medicare pays 80% of the Medicare Allowable Amount after the Part B Deductible.
Evonik Medical Plan Benefit if it Were the Primary Plan	$80 (80% of the Recognized Amount of $100)
Evonik Medical Plan Benefit after Coordination of Benefits	$0 The amount the Plan would have paid as the primary payer is reduced by the amount Medicare paid. The Plan would pay $0 because Medicare paid what the BCBS of AL Traditional Choice option would have paid.

Receipt of Medical Care

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

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

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

Having a primary care physician is a good decision:

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

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

Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics. Find a physician in your area by visiting AlabamaBlue.com/FindADoctor. Click "Find a Doctor," enter a location, and enter contract prefix "DHC" in the pop-up window or select the "BlueCard PPO Network" under "Select All Networks" to locate providers.

Seeing a specialist or behavior health provider is easy:

If you need to see a specialist or behavioral health provider, you can contact their office directly to make an appointment. If you choose to see a specialist or Blue Choice Behavioral Health provider, you will have the maximum benefits available for services covered under the plan. If you choose to see an out-of- network specialist or non-Blue Choice behavioral health provider, your benefits could be lower.

Beginning of Coverage, Change in Coverage, End of Coverage

Refer to the Evonik Corporation Consolidated Retiree Welfare Benefits Program (the Program) and the Retiree Base SPD for Post-65.

Limitations and Exclusions

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

Medical Necessity and Precertification

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

requires that you or your treating physician precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered. The section called Medical Necessity and Precertification later in this booklet tells you when precertification is required and how to obtain precertification.

Your plan is considered a passive PPO which means you are responsible for the same deductible, out of pocket maximum and coinsurance. However, if you use a non-network provider you will be responsible for amounts above reasonable and customary.

In-Network Benefits

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

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

Find a provider in your area by visiting AlabamaBlue.com/FindADoctor. Click “Find a Doctor,” enter a location, and enter contract prefix “DHC” in the pop-up window or select the “BlueCard PPO Network” under “Select All Networks” to locate providers.

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

- BlueCard PPO
- Participating Hospitals
- Hospital Choice Network
- Preferred Outpatient Facilities
- Participating Ambulatory Surgical Centers
- Participating Renal Dialysis Providers
- Preferred Medical Doctors (PMD)
- Preferred Medical Laboratories
- Bariatric Surgery Network
- Select Lab Network
- Blue Choice Behavioral Health Network

- Participating Chiropractors
- Participating Physician Assistants
- Participating Nurse Practitioners
- Preferred Occupational Therapists
- Preferred Physical Therapists
- Preferred Speech Therapists
- Blue Achievement-Knees and Hips Network
- Participating CRNA
- Participating Ground Ambulance
- Participating Licensed Registered Dietitian Network
- Preferred DME Supplier

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

1. In the search box, you can select the category you would like to search under (doctor, hospital, dentist, pharmacy, etc.) or keep on All Categories to search all. Type in the provider's name to search or leave blank to see all results.

2. In the "Network or Plan" section, use the drop down menu to select a specific provider network (as noted above).

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

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

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

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

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

Claims and Appeals

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

Changes in the Plan

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

Your Rights

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

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

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

Your Responsibilities

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

- Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.

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

ELIGIBILITY

Eligibility for the Plan

Eligibility provisions are detailed in the under the Evonik Corporation Consolidated Welfare Benefits Program (the Program) Retiree Base SPD for retirees. This information is under the Evonik Corporation Consolidated Retiree Welfare Benefits Program (the Program) if you are an eligible Retiree.

COST SHARING

Calendar Year Deductible	Individual $600 2 Persons: $1,200 Family: $1,800
Calendar Year Out-of-Pocket Maximum	Individual: $2,400 2 Persons: $4,800 Family: $7,200

Calendar Year Deductible

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

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

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

Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is specified in the table above. All cost-sharing amounts (deductible and coinsurance) for covered in-network services and out-of-network mental health disorders and substance abuse services for medical emergencies that you or your family are required to pay under the plan apply to the calendar year out-of-pocket maximum. Once the out-of-pocket maximum has been reached, you will no longer be subject to cost sharing for covered

expenses that count toward the calendar year out-of-pocket maximum for the remainder of the calendar year.

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

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

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

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

Other Cost Sharing Provisions

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

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

Out-of-Area Services

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

those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

A. BlueCard® Program

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

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

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

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

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

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, we may process your claims for covered healthcare services through Negotiated Arrangements for National Accounts. The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

C. Special Cases: Value Based Programs BlueCard Program

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

Negotiated Arrangements

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

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

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

E. Nonparticipating Providers (Out-of-Network) Outside Our Service Area

1. Member Liability Calculation

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

2. Exceptions

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

F. Blue Cross Blue Shield Global® Core

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

MEDICAL NECESSITY AND PRECERTIFICATION

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

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

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

Examples of services that require precertification include:

- Gender Reassignment Services
- Home Health Care
- Hospice - Inpatient Stay
- In-Patient Hospital Stays
- In-Patient Facility Stays including Residential Treatment Facilities for Mental Health and Substance Abuse Treatment
- In-Patient Surgery
- Intensive Outpatient Programs and Partial Hospitalization Programs
- Private Duty Nursing
- Oral Surgery
- Skilled Nursing Facility
- Transplants

You can find a list of any additional inpatient hospital benefits, physician benefits and other covered services that require precertification at **www.AlabamaBlue.com/precert.** This list will be updated quarterly. You should check this list prior to obtaining any inpatient hospital services, physician services and other covered services.

Inpatient Hospital Benefits

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

For medical emergency services, BCBS must receive notification within 48 hours of the admission.

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

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

For precertification call 1-800-248-2342 (toll-free).

Generally, if precertification is not obtained, a $500 penalty will be assessed.

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

Outpatient Hospital Benefits, Physician Benefits, Other Covered Services

Precertification is required for the following outpatient hospital benefits, physician benefits and other covered services.

- Intensive outpatient services and partial hospitalization;
- **The following durable medical equipment; motorized/power wheelchair.**

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

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

If precertification is not obtained, there will be at $500 reduction in benefits.

Provider-Administered Drugs

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

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

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

If precertification is not obtained, there will be at $500 reduction in benefits.

HEALTH BENEFITS

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

Inpatient Hospital Benefits

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

SERVICE OR SUPPLY	PLAN PAYS
Confinement in a general hospital, psychiatric specialty hospital, or residential treatment facility	80% of the allowed amount, subject to the calendar year deductible
$5 per day allowance for the difference between private and semi-private room rate	80% of the allowed amount, subject to the calendar year deductible
Birthing Centers	80% of the allowed amount, subject to the calendar year deductible

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

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

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

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

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

Inpatient Rehabilitation Benefits

These inpatient hospital benefits consist of:

- General nursing care;
- Physical therapy and hydrotherapy;
- Speech and hearing therapy;
- Functional occupational therapy. The patient's condition must require:
- A rehabilitation trained physician available 24 hours a day;
- A rehabilitation trained nurse present 24 hours a day;
- Four hours of therapy provided by a licensed therapist a day;
- Continued progress toward goals requiring you to remain in the hospital. Your record must show conferences with your physician, therapists, and nurses at least weekly about your progress, any problems and their solutions, and review of the goals set for you.

Inpatient care for rehabilitation is excluded:

- If it maintains or is mainly to keep you clean or fed, or to help you take care of yourself;
- If just to make sure you keep to a therapy schedule or take your prescribed medicine;
- If only repeating services that don't require a skilled therapist, e.g., walking, conditioning, or maintenance;
- If your condition warrants that your rehab services could be provided on an outpatient basis;
- If you can't improve further.

BCBS's standards for inpatient stays for rehabilitation are based on physician referral, how weak you are, how many services you need, how often you need them, how skilled the providers must be, and whether these services will improve your condition.

Outpatient Hospital Benefits

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

SERVICE OR SUPPLY	PLAN PAYS
Outpatient surgery (including ambulatory surgical centers)	80% of the allowed amount, subject to the calendar year deductible
Emergency room – medical emergency	80% of the allowed amount, subject to the calendar year deductible Mental Health and Substance Abuse: 80% of the allowed amount, subject to the calendar year deductible
Emergency Room (Non-Medical Emergency)	50% of the allowed amount, subject to the calendar year deductible
Emergency room – accident	80% of the allowed amount, subject to the calendar year deductible
Outpatient diagnostic lab, X-ray, and pathology	80% of the allowed amount, subject to the calendar year deductible
Outpatient dialysis, IV therapy, chemotherapy, and radiation therapy	80% of the allowed amount, subject to the calendar year deductible
Services billed by the facility for an emergency room visit when the patient's condition does not meet the definition of a medical emergency (including any lab and X-ray exams and other diagnostic tests associated with the emergency room fee)	80% of the allowed amount, subject to the calendar year deductible
Outpatient hospital services or supplies not listed above and not listed in the section of this booklet called Other Covered Services	80% of the allowed amount, subject to the calendar year deductible
Intensive outpatient services and partial hospitalization for mental health disorders and substance abuse	80% of the allowed amount, subject to the calendar year deductible

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

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

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

Physician Benefits

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

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

SERVICE OR SUPPLY	PLAN PAYS
Office visits, in-person consultations, and psychotherapy	80% of the allowed amount, subject to the calendar year deductible
Emergency room physician	80% of the allowed amount, subject to the calendar year deductible Mental Health and Substance Abuse: 80% of the allowed amount, subject to the in network calendar year deductible
Second Surgical Opinions	80% of the allowed amount, subject to the calendar year deductible
Surgery and anesthesia for a covered service	80% of the allowed amount, subject to the calendar year deductible
Maternity care	80% of the allowed amount, subject to the calendar year deductible
Acupuncture Covered for pain therapy when both of the following are true: -Another method of pain management has failed -If services are performed by a M.D or a D.O.	80% of the allowed amount, subject to the calendar year deductible
Bariatric Surgery (Surgeon, Assistant Surgeon Limited to one per lifetime	80% of the allowed amount, subject to the calendar year deductible
Applied Behavioral Analysis (ABA) Therapy	80% of the allowed amount, subject to the calendar year deductible
Inpatient visits	80% of the allowed amount, subject to the calendar year deductible
Inpatient consultations by a specialty provider (limited to one consult per specialist per stay)	80% of the allowed amount, subject to the calendar year deductible
Diagnostic lab, X-rays, and pathology Note: radiologists, anesthesiologists and pathologists are covered	80% of the allowed amount, subject to the calendar year deductible
Chemotherapy and radiation therapy	80% of the allowed amount, subject to the calendar year deductible
Psychological testing	80% of the allowed amount, subject to the calendar year deductible
Allergy testing and treatment	80% of the allowed amount, subject to the calendar year deductible

SERVICE OR SUPPLY	PLAN PAYS
Telephone and online video consultations program To enroll in the telephone and online video consultations program, go to Teladoc.com/Alabama or call 1-855-477- 4549. **General Medical:** Telephone and online video consultations are available through Teladoc to diagnose, treat and prescribe medication (when necessary) for certain general medical issues (flu, allergies, sinus infection, sore throat, etc.) Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations (where available) are offered 7 days a week, 7 a.m. to 9 p.m.	80% of the allowed amount, subject to the calendar year deductible
Telephone and online video consultations program To enroll in the telephone and online video consultations program, go to Teladoc.com/Alabama or call 1-855-477- 4549. **Dermatology:** Log into your Teladoc account to upload images of your skin problem and receive a response through Teladoc's online message center	80% of the allowed amount, subject to the calendar year deductible
Telephone and online video consultations program To enroll in the telephone and online video consultations program, go to Teladoc.com/Alabama or call 1-855-477- 4549 **Behavioral Health:** Telephone and online video consultations are available through Teladoc for certain behavioral health issues, such as anxiety, depression, eating disorder, etc. Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations (where available) are offered 7 days a week, 7 a.m. to 9 p.m.	80% of the allowed amount, subject to the calendar year deductible

TELEHEALTH SERVICES
Benefits are provided for telehealth services subject to 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.
- If you receive other out-of-network physician services (such as out-of-network laboratory services) for a medical emergency in the emergency room of a hospital, those services will also

be paid with the applicable in-network coinsurance - for such physician benefits described in the matrix above, but subject to the calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the applicable requirements of the Patient Protection and Affordable Care Act.

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

Physician Preventive Benefits

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

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

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

SERVICE OR SUPPLY	PLAN PAYS
Routine preventive services and immunizations: (See AlabamaBlue.com/preventiveservices for a listing of specific preventive services and immunizations) The following additional routine services are covered: **Routine Labs and X-rays as part of the medical routine physical exam** **Well Child Care**- (Up to age 18. Includes 7 exams in the first 12 months of life; 3 exams in the second 12 months; 3 exams in the third 12 months; 1 exam per 12 months thereafter) **Adult Physicals**-1 per consecutive 12 month period **OB/Gynecological Exam**- 1 per calendar year **TB Skin Test**-For dependent children **Routine Colonoscopy**- No frequency or age limit **Routine Sigmoidoscopy**- 1 between age 45-55; 1 every three years thereafter **Routine Hearing Exam-**(One per member per calendar year) **Routine Eye Exam-** (One exam per member once every 12 months, including refraction) **Digital Rectal Exam and Prostate Antigen Test** 1 exam in a consecutive 12 month period for males age 40 and older for both tests **Routine Mammography** Routine Mammography Exam includes Digital Breast Tomosythesis (3D Mammogram) 1 baseline mammogram between ages 35-39, and for females age 40 and older, 1 mammogram in a consecutive 12 month period **Human Papillomavirus Test (HPV)** 1 test every 3 years for females ages 30 and older	100% of the allowed amount, no deductible

Other Covered Services

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

SERVICE OR SUPPLY	PLAN PAYS
Accident-related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre- authorized and is limited to 18 months from the date of injury	80% of the allowed amount, subject to the calendar year deductible
Ambulance services	80% of the allowed amount, subject to the calendar year deductible
Bereavement Counseling Benefits are provided for immediate family if the patient was receiving hospice care under this plan. Counseling must be received within six months after the patient's death	80% of the allowed amount, subject to the calendar year deductible

SERVICE OR SUPPLY	PLAN PAYS
Cosmetic Surgery excluded except for expenses in a calendar year of and following Accidental Injury and for breast reconstruction	80% of the allowed amount, subject to the calendar year deductible
Chiropractic services Limited to 30 visits per person per calendar year.	80% of the allowed amount, subject to the calendar year deductible
Dialysis services at a renal dialysis facility	80% of the allowed amount, subject to the calendar year deductible
DME: Durable medical equipment and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints **Note:** For DME the allowed amount will generally be the smaller of the rental or purchase price	80% of the allowed amount, subject to the calendar year deductible
Eyeglasses or contact lenses: One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect	80% of the allowed amount, subject to the calendar year deductible
Home health care Home healthcare benefits consist of home IV therapy, intermittent home nursing visits and home phototherapy for newborns ordered by your attending physician. 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 Limited to an annual maximum of 120 visits per member.	80% of the allowed amount, subject to the calendar year deductible
Hospice care Home healthcare benefits consist of home IV therapy, intermittent home nursing visits and home phototherapy for newborns ordered by your attending physician. 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. Limited to a lifetime maximum of 180 days per member	80% of the allowed amount, subject to the calendar year deductible

SERVICE OR SUPPLY	PLAN PAYS
Wigs Wigs are covered when prescribed by a Physician as a prosthetic for hair loss due to injury or disease. Covered injuries and illnesses are: * Burns - 2nd degree full thickness and 3rd degree burns with resulting permanent alopecia * Lupus * Alopecia areata with near complete or complete cranial hair loss * Alopecia totalis * Alopecia universalis * Fungal infections not responsive to an appropriate (typically 6 week) course of antifungal treatment resulting in near complete or complete cranial hair loss. * Chemotherapy * Radiation therapy Wigs are not covered for Androgenetic Alopecia (male pattern baldness). Other related items such as hair transplants, wig styling, wig shampooing and wig stands are not covered	80% of the allowed amount, subject to the calendar year deductible
Gender Identity Disorder/Dysphoria Limited to one per lifetime and a maximum of $75,000 excluding psychotherapy services	80% of the allowed amount, subject to the calendar year deductible
Organ Transplant	80% of the allowed amount, subject to the calendar year deductible
Infertility Services (Diagnostic and Testing) Limited to $17,500 lifetime maximum Includes in vitro fertilization, GIFT, ZIFT, advanced reproductive technologies, artificial insemination, fertility injections/drugs	80% of the allowed amount, subject to the calendar year deductible
Obesity surgery Note: Must be medically necessary (see covered services)	80% of the allowed amount, subject to the calendar year deductible
Oral Surgery Removal of impacted teeth	80% of the allowed amount, subject to the calendar year deductible
TMJ (Temporomandibular Joint Disorder) - Phase I only Medical-in-nature treatment only, including exams, x-rays, injections, anesthetics, physical therapy and oral surgery; excludes appliance therapy and tooth reconstruction	80% of the allowed amount, subject to the calendar year deductible
Tubal Ligation/Vasectomy Note: Reverse sterilization is not covered	80% of the allowed amount, subject to the calendar year deductible
Cardiac Rehabilitation Therapy	80% of the allowed amount, subject to the calendar year deductible
Pulmonary Rehabilitation Therapy Limited to maximum of 36 hours or a six week period.	80% of the allowed amount, subject to the calendar year deductible

SERVICE OR SUPPLY	PLAN PAYS
Habilitative occupational, physical and speech therapy Limited to a combined maximum of 25 visits per person per calendar year Precertification is required after the 25th visit for medical necessity, If pre-cert is not obtained, no benefits are available. Members (no age limit) with an autism spectrum disorder diagnosis are allowed unlimited visits for occupational, physical and speech therapy	80% of the allowed amount, subject to the calendar year deductible
Rehabilitative occupational, physical and speech therapy Limited to a combined maximum of 25 visits per person per calendar year Precertification is required after the 25th visit for medical necessity, If pre-cert is not obtained, no benefits are available. Members (no age limit) with an autism spectrum disorder diagnosis are allowed unlimited visits for occupational, physical and speech therapy	80% of the allowed amount, subject to the calendar year deductible
Hearing Aids Limited to a maximum of $1500 per 24 consecutive month period Includes electronic hearing aids (monaural and binaural) in accordance with prescription during covered hearing exam. No coverage for bone anchored hearing aids	80% of the allowed amount, subject to the calendar year deductible
Private duty nursing Limited to 70 shifts per member per calendar year	80% of the allowed amount, subject to the calendar year deductible
Skilled nursing facility: 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; 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 him 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 Limited to an annual maximum of 120 visits per person	80% of the allowed amount, subject to the calendar year deductible

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 other home healthcare setting. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

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

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

ADDITIONAL BENEFIT INFORMATION

Individual Case Management

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

Chronic Condition Management

You may also qualify to participate in the chronic condition management program. The chronic condition management program is available for members with heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD), asthma, and other specialized conditions. This program offers personalized care designed to meet your lifestyle and health concerns. Our staff of healthcare professionals will help you cope with your illness and serve as a source of information and education.

Participation in the program is completely voluntary. If you would like to enroll in the program or obtain more information, call 1-888-841-5741 (Monday – Friday, 8 a.m. to 4:45 p.m. CST), or e-mail membermanagement@bcbsal.org.

Assisted Reproductive Technology Cycle Benefits

Assisted reproductive technology cycle "ART" benefits are covered, when precertified by Blue Cross, subject to the following conditions, limitations, and exclusions:

- The retiree and retiree spouse (“male,” “female,” and together “the couple”) are the only members eligible for these benefits. The couple must have previously been tested for infertility with the results the male produces sperm and the female has a functional uterus and one ovary accessible to oocyte retrieval. BCBS must have on file the infertility evaluation, and it must show a history of infertility of at least 24 continuous months. All other conventional means of correcting infertility must have been exhausted. The female may have no medical reason why she cannot undergo ovulation induction, anesthesia, pregnancy or delivery. The female must be ovulating with normal follicle-stimulating hormone.

- The physician providing services must be board certified or eligible in reproductive endocrinology.
- The facility must have our written approval before providing services.
- Maximum benefits include everything furnished during a cycle. If a cycle begins but is only partially completed, payment will be prorated upon those services actually rendered. A cycle begins seven days prior to the female's menstrual period and lasts for 37 days during which the following services are rendered.
- ovulation induction;
- laparoscopic or transvaginal ultrasound aspiration of the oocytes;
- fertilization of the oocyte and development of preembryo or preparation of the gametes prior to transfer to the fallopian tube;
- transfer of the preembryo into the uterus, or transfer of the gametes and/or preembryo to the fallopian tube.

Exclusions for ART:

- Donor sperm or ova, other than those from the retiree and his or her spouse;
- Use of a surrogate mother;
- Sperm, ova or embryos, including the couple's, which have been preserved;
- When either or both of the couple were previously sterilized;
- Expenses for any services, care, treatment or supplies other than those specifically named under your Other Covered Services benefits.

There are no other benefits for assisted reproductive technology cycles under any other portion of this contract.

Mastectomy

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; prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedema.

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

Colorectal Cancer Screening

Benefits for colorectal cancer screening vary depending upon the reason the procedure is performed, the outcome of the procedure (i.e. discovery of a medical condition as a result of the procedure), and the way in which the provider files the claim. If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition (even if the medical condition was unsuspected or unknown prior to the procedure), and if the provider properly files the claim with this information, Blue Cross Blue Shield of AL will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with Diagnostic or surgical procedures.

If you are at high risk of developing colon cancer or you have a family history of colon cancer– within the meaning of Blue Cross Blue Shield of AL medical guidelines – and if the provider properly files the claim with this information, Blue Cross Blue Shield of AL will process the claim as a

Diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures. In all other cases the claim will be subject to the provisions and limitations described under Preventive Benefits.

In all other cases the claim will be subject to the provisions and limitations described under Preventive Benefits.

Benefits for Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim. If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the Physician properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays. If you are at high risk of developing breast cancer or you have a family history of breast cancer– within the meaning of Blue Cross Blue Shield of AL medical guidelines – and if the Physician properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.

In all other cases the claim will be subject to the provisions and limitations described under Preventive Benefits.

Telemedicine

BCBS of AL offers telemedicine services by using a network of licensed, board-certified primary care physicians. Telemedicine provides you and your eligible dependents with quick access to a doctor by a mobile device and/or video call and is available 24/7, and no appointment is needed. Telemedicine is not available internationally. When appropriate, the consulting doctor can usually prescribe a medication and send the prescription to your preferred pharmacy. This program can often eliminate visits to a primary care doctor, urgent care center, or emergency room and the high costs associated with those visits.

All virtual visits will be subject to your elected medical plan's coinsurance and deductible, if applicable. You can use telemedicine for minor medical needs such as:

- Bronchitis/Cold/Cough/Flu/Fever/Sinusitis/Sore Throat
- Pinkeye/Rash/Poison Ivy/Bug Bites
- Stomach Ache
- Upper Respiratory Infection

To access BCBS of AL Telemedicine Services, download the Teladoc app from your smartphone or go to Teleadcom.com/Alabama to set up your account. You can also contact Teladoc by calling 1-855- 466-4548. Your Teladoc ID number is the same ID numbers as on your BCBS of AL Medical ID card.

Weight Reduction Benefits

Services or expenses for treatment of obesity or for any condition which is based upon weight reduction or dietary control, including but not limited to, obesity, diabetes, or heart disease, is not covered except as described in the Prescription Drug Program Administered by Express Scripts section of this SPD. This exclusion does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines established by BCBS of AL. Benefits will only be provided for one surgical procedure for morbid obesity per Covered Person. Benefits will be provided for a subsequent surgery for complications related to a covered surgical procedure for

obesity only if medically necessary and in compliance with the guidelines established by BCBS of AL. However, no benefits will be provided for subsequent surgery for complications related to a covered surgical procedure for morbid obesity (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 noncompliance with medical recommendations applies even if the subsequent surgery would otherwise be medically necessary and would otherwise be in compliance with the guidelines established by BCBS of AL.

Hospice Care

Hospice care is covered when provided by a hospice care program to a Covered Person who is expected by his physician to live no more than six months. Covered services include:

- Board and room;
- general nursing care;
- services of hospice employed physicians;
- physical therapy, occupational therapy, respiratory therapy and speech language pathology services provided by licensed providers;
- medical social services provided by licensed social workers;
- home health and visits by hospice employees;
- medical appliances and drugs and biologicals to relieve pain and control symptoms of the Covered Person related to his terminal Illness; and
- skilled nursing visits by a licensed R.N. or L.P.N.

Other Covered Services

Physical therapy and hydrotherapy given by a licensed physical therapist. Physical therapists who are Preferred Care Providers may be required to Precertify services during the course of your treatment. If so, the physical therapist will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial in accordance with the Plan's appeals procedures (described below).

- Treatment of natural teeth injured by a force outside your mouth or body if service is received within 90 days of the Injury.
- Removal of teeth that will not erupt through the gum.
- Removal of teeth that cannot be removed without cutting into the bone.
- Removal of the roots of a tooth without removing the entire tooth.
- Removal of cysts, tumors or other diseased tissues.
- Cut into gums and tissues of the mouth. Benefits are provided only when not related to the removal, replacement or repair of teeth.
- Chiropractic services except Maintenance Care.

Care provided by a Home Health Care Agency is covered when it is performed by or under the direct supervision of a licensed, registered, or practical Nurse and reviewed by a Physician. Covered services include:

- nursing service by either an R.N. or L.P.N.,
- physical, occupational, speech and respiratory therapy,
- medical social service,
- home health aide service,
- nutritional guidance,
- Diagnostic services,
- oxygen and its administration, and
- hemodialysis.

Hospice Care is covered when provided by a Hospice Care program to a Covered Person who is expected by his Physician to live no more than six months. Covered services include:

- Board and Room,
- general nursing care,
- services of hospice employed Physicians,
- physical therapy, occupational therapy, respiratory therapy and speech language pathology services provided by licensed providers,
- medical social services provided by licensed social workers,
- home health and visits by hospice employees,
- medical appliances and drugs and biologicals to relieve pain and control symptoms of the Covered Person related to his terminal Illness, and
- skilled nursing visits by a licensed R.N. or L.P.N.
- sleep studies performed outside of a healthcare facility, such as home sleep studies, whether or not supervised or attended.
- Speech Therapy given by a qualified speech therapist or Physician
- Reconstructive surgery needed to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects.

Foreign medical claims are covered under the out-of-network benefit level. Benefits are based upon the rate of exchange at the time of service.

Gender Identity Disorder/Dysphoria

Precertification is required. If preadmission certification is not obtained, no benefits will be payable. Call 1-800-821-7231 to precertify. Refer to the Precertification Section for information on how to precertify.

Covered Medical Expenses are subject to the below conditions, limitations, and exclusions. You must precertify prior to receiving services. Keep in mind that certification by BCBS of AL that a hospital admission is medically necessary does not mean the plan has decided to pay any hospital benefits.

The claims administrator has specific guidelines regarding covered medical expenses for treatment of gender identity disorder. Contact the claims administrator at the telephone number on your ID card for information about these guidelines.

Gender Identity Disorder/Dysphoria is limited to a lifetime maximum of $75,000, subject to deductible and coinsurance. Any combination of network and non-network benefits for treatment of Gender Identity Disorder/Dysphoria is limited to $75,000 during the entire period of time you are enrolled under the plan. The following services provided under this benefit apply to this maximum including hormone replacement, related testing and transgender surgery; however, psychotherapy does not apply to this maximum. All of the following must be met:

Treatment must conform to the most recent edition of the *World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*;

- Must be at least 18 years of age;
- Must demonstrate capacity to make fully informed decisions and consent for treatment;
- Must be diagnosed with Gender Identity Disorder (GID) of transsexualism;
- Must have undergone a minimum of 12 months of continuous hormonal therapy months under the direct supervision of a Physician,
- There is documentation that you have completed a minimum of 12 months of successful continuous full time real-life experience in your new gender, across a wide range of life experiences;
- You regularly participated in psychotherapy throughout the real-life experience as recommended by a health care provider;
- You must demonstrate knowledge of the required length of hospitalizations, likely complications, and post-surgical rehabilitation requirements of various surgical procedures;
- If you have a significant medical or mental health issues present, these issues must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy prior to surgery; and
- Two referrals from qualified mental health professionals who have independently assessed the individual. One referral should be from a person who has only had an evaluative roll with the individual. Both referring providers must submit letters of their evaluation. At least one of the evaluating professionals must have a doctoral degree [PhD, MD, Ed.B, D. Sc, D.S.W., or Psy.D] and be capable of adequately evaluating co-morbid psychiatric conditions.

Gender Identity Disorder/Dysphoria Covered Medical Expenses:

Charges made by a Physician for: (1) performing the surgical procedure; and (2) preoperative and post-operative hospital and office visits;

- Administration of anesthetics;
- Breast cancer screening for female to male who have not undergone a mastectomy;
- Prostate cancer screening for male to female who have retained their prostate;
- Outpatient diagnostic laboratory and x-rays;
- Psychological/Psychological Counseling;

- Surgical: Male to Female:
- Orchiectomy
- Penectomy
- Vaginoplasty
- Clitoroplasty
- Labioplasty
- Surgical: Female to Male:
- Hysterectomy
- Salpingo-oophorectomy
- Vaginectomy
- Metoidioplasty
- Scrotoplasty
- Urethroplasty
- Placement of testicular prostheses
- Phalloplasty

Gender Identity Disorder/Dysphoria Exclusions.

Blepharoplasty, Breast Augmentation, chin implants, cryopreservation of fertilized embryos, facial bone reconstruction, face lift, liposuction, hair removal/hairplasty, laryngoplasty or shortening of the vocal cords, lip enhancement/reduction, liposuction of the waist (body contouring), nose implants, prosthetic devices, rhinoplasty, skin resurfacing, reduction thyroid chondroplasty (removal of adam's apple), reversal of genital surgery o reversal of surgery to revise secondary sex characteristics.

Note: Certain Covered Persons will be required to complete continuous hormone therapy prior to surgery. In consultation with the Covered Person's Physician, this will be determined on a case-by-case basis through the Prior Authorization process.

Baby Yourself Program

Baby Yourself offers individual care by a registered nurse. Please call our nurses at 1-800-222-4379 (or 1-205-733-7065 in Birmingham) or visit AlabamaBlue.com/BabyYourself as soon as you find out you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant.

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

Organ and Bone Marrow Transplants

The organs for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney; and (6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval.

When we approve a facility for transplant services it is limited to the specific types of transplants stated. Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma.

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

Transplant benefits for living donor expenses are limited to:

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

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

There are no transplant benefits for: (1) any investigational/experimental artificial or mechanical devices;

(2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) donor costs if the recipient is not covered by this plan; (7) recipient or donor lodging, food, or transportation costs, unless otherwise specifically stated in the plan; (8) a condition or disease for which a transplant is considered investigational; (9) transplants (excluding kidney) performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

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

COORDINATION OF BENEFITS

Medicare

Upon becoming eligible for Medicare, the Covered Person who is Medicare-eligible should enroll in both Parts A and B of Medicare. Medicare becomes the primary payor of your medical benefits, and your benefits under the Plan coordinate with your Medicare benefits. The Plan will calculate your benefits assuming that you have enrolled in Medicare Parts A and B once you are eligible. This Plan has a non duplication of benefits provision. The Plan will reduce its benefits by the

amount Medicare paid or would have paid as the primary payer for the same expenses. As the secondary plan, the Plan may pay the difference between the amount the Plan would normally pay (in absence of Coordination of Benefits) and the amount paid by the primary plan. In no event will you receive more than 100% of your Usual and Reasonable or Allowable Amount charge from the two plans combined. To determine benefits payable as the secondary plan, the Plan first calculates what it would have paid if it were the primary plan.

If You Have Other Coverage (Not Including Medicare)

The Plan coordinates benefits from all group plans and certain other insurance arrangements covering a Covered Person to prevent duplication of medical benefit payments. The Plan's coordination of benefits rules set out the order for payment of covered charges when two or more plans are potentially responsible for Covered Medical Expenses. When a Covered Person is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the coordination of benefits rules will pay as if there were no other plan involved. This Plan has a non-duplication of benefits provision. Under coordination of benefits, the total benefits paid by all plans combined will not exceed 100% of your Reasonable and Customary charge. When the other plan does not have a non-duplication or coordination of benefits provision, it will be the primary plan. If both plans have non-duplication or coordination of benefits provisions, the payment order will be decided in the order described below.

Other Plans

This Plan coordinates payment of medical benefits with certain other plans of a Covered Person. For purposes of coordination of benefits, the term "plan" means this Plan and any one of the following plans or insurance arrangements:

- group or group-type plans, including franchise or blanket benefit plans;
- group practice and other group prepayment plans;
- other plans required or provided by law (this does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination); and
- No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Order of Benefit Determination

For purposes of coordination of benefits, the rules establishing the order of benefit determination are as follows:

- A plan that covers a person other than as a dependent will be primary to a plan that covers such person as a dependent.
- A plan that covers a person as a dependent of an employee or Retiree whose date of birth occurs earlier in a Calendar Year will be primary to a plan that covers such person as a dependent of an employee or Retiree whose date of birth occurs later in a Calendar Year (only month and day of birth, not year, will be reviewed in this case).
- In the case of dependent child whose parents are separated or divorced:
- When the parent with custody of the child has not remarried, the plan that covers the child as a dependent of the parent with custody will be primary to the plan that covers the child as a dependent of the parent without custody; and
- When the parent with custody of the child has remarried, the plan that covers the child as a dependent of the parent with custody will be primary to the plan that covers the child as a

stepparent, and the plan that covers the child as a dependent of the stepparent will be primary to the plan that covers the child as a dependent of the parent without custody.

- However, if there is a court decree which establishes financial responsibility for the medical expenses of the child, the plan that covers the child as a dependent of the parent with such responsibility will be primary to any other plan that covers the child as a dependent.
- The plan that has covered a person for the longer period of time will be primary, provided that the plan that covers the person as a laid-off or retired employee, or as a dependent of such an employee, will be secondary to any plan that covers such person as an active employee or as a dependent of such an active employee.
- When the rules stated above do not determine an order of benefit determination, the plan that has covered a person for the longer period of time will be primary.

Payment to Other Organizations

Whenever payments that should have been made under this Plan in accordance with these coordination of benefits provisions have been made under any other plans, this Plan may pay to the other plan (or any entity making such other payments) any amounts the Claims Administrator determines to be warranted in order to satisfy the intent of these provisions. Amounts paid to the other plan will be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan will be fully discharged from liability.

Other Limitations. This Plan will always be considered the secondary carrier with respect to fault or personal Injury protection, catastrophic funds mandated by motor vehicle or other state law, uninsured motorist, motor vehicle medical reimbursement, (regardless whether it is purchased by the Covered Person), homeowner's insurance, premises insurance, or other similar coverage.

Right to Receive and Release Necessary Information

In order to decide if the Plan's coordination of benefits rules (or any other benefit plan's coordination of benefits rules) applies to a claim, the Plan Administrator or the Claims Administrator (without the consent of or notice to any person) has the right to:

- release to any person, insurance company, or organization, the necessary claim information; and
- receive from any person, insurance company, or organization, the necessary claim information.

You must cooperate with the Claims Administrator and Plan Administrator to comply with the Plan's coordination of benefits rules. This includes, but is not limited to, supplying any information needed to coordinate benefits and/or executing any necessary forms and/or documents.

COBRA or State Continuation Coverage

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the "COBRA plan") and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the "COBRA plan") and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

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

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

Determination of Amount of Payment

1. If this plan is secondary to Medicare, it shall pay benefits as if the secondary plan did not exist.

2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

3. 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 and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term "allowable expense" does not include the following:

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

Birthday: The term "birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial Parent: The term "custodial parent" means:

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

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

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

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

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

The term "plan" does not include non-group or individual health or medical reimbursement insurance contracts. The term "plan" also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term "primary plan" means a plan whose benefits for a person's 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. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We are not required to tell or get the consent of any person to do this. Each person claiming benefits

under this plan must give us any facts we need to apply these COB rules and to determine benefits payable as a result of these rules.

Facility of Payment

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

Right of Recovery

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

Special Rules for Coordination with Medicare

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

Members that go on LTD (Long Term Disability) become eligible for Medicare after 24 months and Medicare becomes primary.

HEALTH BENEFIT EXCLUSIONS

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

A

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

C

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

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

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

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

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

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

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

D

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

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

Services for or related to a Dependent child's Pregnancy, including the six-week period after delivery.

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

E

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

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

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

F

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

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

Foreign travel – care, treatment, or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

G

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

H

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

Services or expenses of a Hospital Stay, except one for an Emergency, unless BCBS of AL certifies it before your admission. Services or expenses of a Hospital Stay for an Emergency if BCBS of AL Is not notified within 48 hours, or on the next business day after your admission, or if BCBS of AL determines that the admission was not Medically Necessary. Services or expenses for which a claim is not properly submitted to BCBS of AL.

I

Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including investigational services that are part of a clinical trial. Under federal law, the plan cannot deny a member participation in an approved clinical trial, is prohibited from dropping coverage because member chooses to participate in an approved clinical trial, and from denying coverage for routine care that the plan would otherwise provide just because a member is enrolled in an approved clinical trial. This applies to all approved clinical trials that treat cancer or other life-threatening diseases.

Implantable devices (and services, supplies, equipment and accessories ancillary to implantation of same), unless provided in and billed by an In-Network Hospital, In-Network Outpatient facility, or In- Network ambulatory surgery center, and covered by Plan.

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.

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.

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

N

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

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

O

Except as may be otherwise expressly covered in the booklet, services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion 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 provided by an **out-of-network provider** for any benefits under this plan, unless otherwise specifically stated in the plan.

P

Hot and cold **packs**, including circulating devices and pumps. Expenses for **prescription drugs**.

Private duty nursing unless previously stated as a covered service.

Services, care, treatment, or supplies furnished by a provider that is not recognized by BCBS of AL as an approved provider for the type of service or supply being furnished. For example, BCBS of AL reserves the right not to pay for some or all services or supplies furnished by certain persons who are not medical doctors (M.D.s), even if the services or supplies are within the scope of the provider's license.

R

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

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

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

Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical therapist.

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

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

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

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

S

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

Services or expenses for, or related to **sex therapy** programs or treatment for **sex offenders**. Services or expenses of any kind for or related to reverse **sterilizations**.

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

- Hot and cold packs;
- Standard batteries used to power medical or durable medical equipment;
- Solutions used to clean or prepare skin or minor wounds including alcohol solution or wipes, povidone-iodine solution or wipes, hydrogen peroxide, and adhesive remover;
- Standard dressing supplies and bandages used to protect minor wounds such as band aids, 4 x 4 gauze pads, tape, compression bandages, eye patches;
- Elimination and incontinence supplies such as urinals, diapers, and bed pans; and
- Blood pressure cuffs, sphygmometers, stethoscopes and thermometers.
- Services or expensed for learning or vocational rehabilitation.
- Services or supplies received relating to bodily Injury sustained or Sickness contracted while in the military, naval, or air forces of any country or any civilian noncombatant unit serving with such forces engaged in war or other armed conflict.

- 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 your Employer's liability laws, state or federal. This applies even if 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.
- Travel, even if prescribed by your Physician (not including ambulance services otherwise covered under the Plan).
- 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.

T

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

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

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

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

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

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

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

W

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

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

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

CLAIMS AND APPEALS

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

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

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

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

Post-Service Claims

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

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

complete it, attach an itemized bill, and send it to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

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

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

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

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

Pre-Service Claims

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

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

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

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

benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Our notification may be oral, unless you ask for it in writing. We will provide this notification to you only if

(1) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters, and (2), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

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

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

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

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

Concurrent Care Determinations

Determinations by Us to Limit or Reduce Previously Approved Care: If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of

treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

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

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

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

Your Right To Information

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

Appeals

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

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

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

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

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

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

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

You must send your appeal to the following address:

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

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

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

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

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

If in writing, you should send your letter to the appropriate address listed below:

- For inpatient hospital care and admissions:

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

or

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

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

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

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

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

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

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

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

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

If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), we will make a decision on your appeal

within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

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

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

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

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

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

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

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

External Reviews

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

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

Expedited External Reviews for Urgent Pre-Service Claims

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

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

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

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

ARBITRATION

THIS ARBITRATION PROVISION DOES NOT APPLY TO CLAIMS FOR BENEFITS UNDER SECTION 502(a) OF ERISA.

IN CONSIDERATION OF COVERAGE UNDER THE PLAN AND PAYMENT OF PREMIUMS, YOU (AND WE) AGREE THAT ANY ONE OR MORE OF THE FOLLOWING CLAIMS THAT ARE NOT RESOLVED BY FINAL AND BINDING EXTERNAL REVIEW DESCRIBED ABOVE SHALL BE RESOLVED BY FINAL AND BINDING ARBITRATION:

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

THIS ARBITRATION AGREEMENT IS INTENDED TO HAVE THE BROADEST SCOPE PERMISSIBLE BY LAW, AND INCLUDES ANY AND ALL CLAIMS, WHETHER IN PLAN, TORT, OR OTHERWISE, WHETHER ARISING BEFORE, ON, OR AFTER THE

DATE OF COVERAGE UNDER THE PLAN, AND INCLUDING WITHOUT LIMITATION ANY STATUTORY, COMMON LAW, INTENTIONAL TORT, OR EQUITABLE CLAIMS.

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

THE CLAIMANT IS RESPONSIBLE FOR STARTING THE ARBITRATION PROCEEDINGS BY NOTIFYING THE OTHER PARTY IN WRITING OF THE ARBITRATION DEMAND. IF THE CONTRACT HOLDER OR MEMBER IS THE CLAIMANT, THE WRITTEN ARBITRATION DEMAND SHOULD BE SENT TO THE FOLLOWING ADDRESS:

BLUE CROSS AND BLUE SHIELD OF ALABAMA
LEGAL DEPARTMENT
450 RIVERCHASE PARKWAY EAST
BIRMINGHAM, ALABAMA 35242

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

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

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

THE ARBITRATOR SHALL BE EMPOWERED TO GRANT WHATEVER RELIEF WOULD BE AVAILABLE IN COURT UNDER LAW OR EQUITY, EXCEPT AS

EXPRESSLY LIMITED BY THE PLAN. THE ARBITRATOR'S DECISION SHALL BE IN WRITING, SHALL CONTAIN FINDINGS OF FACT AND CONCLUSIONS OF LAW, AND SHALL SPECIFY THE TYPE OF ANY DAMAGES OR RELIEF AWARDED.

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

THIS PLAN IS MADE PURSUANT TO A TRANSACTION INVOLVING INTERSTATE COMMERCE, AND IS GOVERNED BY THE FAA. IF ANY PORTION OF THIS ARBITRATION PROVISION IS DEEMED INVALID OR UNENFORCEABLE, THE REMAINING PORTIONS SHALL CONTINUE IN FULL FORCE AND EFFECT.

Notice

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

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

Correcting Payments

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

Responsibility for Providers

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

Misrepresentation

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

Governing Law

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

Termination of Benefits and Termination of the Plan

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

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

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

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

Changes in the Plan

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

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

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

No Assignment

As discussed in more detail in the Claims and Appeals section of this booklet, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your

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

DEFINITIONS

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

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

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

In-Network Providers: Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable - 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 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.

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

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

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

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

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

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

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

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

Covered Person: means a Retiree or a Dependent of those who is covered under this Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

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

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

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

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

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not “investigational”; and,
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask

your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

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

Medicare means the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member: You or your eligible dependent who has coverage under the plan.

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

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

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

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

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

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

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

If there is any conflict between any of the foregoing documents, we will resolve that conflict in a manner that best reflects the intent of the group and us as of the date on which claims were

incurred. Unless the context requires otherwise, the terms "plan" and "contract" have the same meaning.

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

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

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

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

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

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

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

Retiree: A former Employee as defined under the Eligibility section of the Summary Plan Description for the Evonik Corporation Consolidated Retiree Welfare Benefits Program

Residential Treatment: Continuous 24 hour per day care provided at 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.

Spouse means the Retiree’s legal partner in marriage to whom the Retiree is not legally separated or divorced. Spouse includes a same-sex spouse to whom the Retiree is legally married. Spouse does not include a Retiree’s registered domestic partner, civil union partner, or other similar relationships recognized under state law.

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

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

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

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

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

NOTICE OF NONDISCRIMINATION

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

Blue Cross and Blue Shield of Alabama

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

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

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

FOREIGN LANGUAGE ASSISTANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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