All Kids Children's Health Insurance Program

Effective October 1, 2013

Table of Contents

Table of Contents

INSERT

All Kids Children's Health Insurance Program

05000

Effective October 1, 2013

Attention: This insert amends the Group Health Care Summary Plan Description for the employees of **All Kids Children's Health Insurance Program**
Effective **October 1, 2013**
(Print date on back cover **04/2014**)
Effective **October 1, 2013**, the following revisions are applicable:

The following is a correction to the Prescription Drug Benefits:

Prescription Drug Benefits

Insulin, needles, and syringes purchased on the same day in the same quantity will have one copayment; otherwise, each has a separate copayment. Separate copays apply for Blood glucose strips and lancets.
These are the only diabetic supplies available as prescription drug benefits under the plan.

OVERVIEW OF THE PLAN

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

Atención por favor - Spanish

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

Purpose of the Plan

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

Definitions

Near the end of this booklet you or your child will find a section called Definitions, which identifies words and phrases that have specialized or particular meanings. Please take the time to familiarize yourself with these definitions so that you and your child will understand your child's ALL Kids benefits.

Receipt of Medical Care

You and your child's provider may decide that certain care and/or treatment may be necessary even if the plan does not provide coverage for this care or treatment. You and your child's provider are responsible for making this decision.

Beginning of Coverage

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

Medical Necessity and Precertification

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

In some cases, such as inpatient hospital admissions in non-emergency situations, the plan requires that you and your child precertify the medical necessity of your care. The provisions later in this booklet will

tell you and your child when precertification is required. **Look on the back of your child's ID card for the phone number that you or your child's provider should call.** In some cases, our contracts with providers require the provider to initiate the precertification process for your child. Your child's provider should tell you when these requirements apply. You are responsible for making sure that your child's provider initiates and complies with any precertification requirements under the plan. Please note that precertification relates only to the medical necessity of care; it does not mean that your child's care will be covered under the plan.

In-Network Benefits

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

Examples of in-network providers include PMD, Preferred Care, BlueCard PPO, and Blue Choice Behavioral Health Network. In-network pharmacies are pharmacies that have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense prescription drugs.

A special feature of your child's plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit the BlueCard PPO Provider Finder web site at www.provider.bcbs.com. PPO providers will file claims on your child's behalf with the local Blue Cross plan where services are rendered. The local Blue Cross plan will then forward the claims to us for verification of eligibility and determination of benefits. Assuming the services are covered, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance.

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

Out-of-Network Services

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

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

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

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

Blue Cross and Blue Shield of Alabama and 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.

Limitations and Exclusions

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

Claims and Appeals

When your child receives services from an in-network provider, your child's provider will generally file claims on behalf of your child. If a claim is denied in whole or in part, you may file an appeal with BCBS. you and your child will be given a full and fair review. The provisions of the plan dealing with claims or appeals are found further on in this booklet.

ELIGIBILITY

Eligibility and Application for the Plan

Eligibility information can be found on the ALL Kids website. Families can apply on-line or print out an application from the ALL Kids web site at www.adph.org. Families may also contact ALL Kids Customer Service at 1-888-373-5437.

Beginning of Coverage

Effective Date of Coverage

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

Effective Date of Coverage for Hospitalization

If your child is hospitalized on his or her effective date of coverage, health services related to the hospitalization are covered as long as: (a) you notify the claims administrator of the hospitalization within 48 hours of the effective date or as soon as reasonably possible; and (b) health services are received in accordance with the terms, conditions, exclusions, and limitations of the policy.

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

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

Termination of Coverage

Your child's coverage shall automatically terminate on the earliest of the date specified below:

- The last day of the month of your child's annual enrollment period, unless your child's application for renewal is approved for coverage.

- The date your child moves out of Alabama. You/your child is responsible for notifying ALL Kids that he/she has moved from Alabama.
- The last day of the month in which your child turns 19 years of age.
- The date the policy is terminated, as specified by ALL Kids. (ALL Kids will instruct BCBSAL to terminate coverage of your child. ALL Kids is responsible for notifying you of the termination of the policy.)
- The date specified by ALL Kids that coverage will terminate due to fraud or misrepresentation or because the parent, guardian or child knowingly provided false material information. ALL Kids has the right to rescind coverage back to the effective date.
- The date specified by ALL Kids that all coverage will terminate because the parent, guardian, or child permitted the use of the child's ID card by any unauthorized person or used another person's card.

If pregnant at the time of renewal: Upon request by the enrollee, the current ALL Kids coverage will be extended until a date projected to 60 days post partum as long as the enrollee continues to be under the age of 19 and reside in the State. If the enrollee turns 19 before the projected 60th post partum day, then coverage is only extended until the end of the month during which she turns 19.

HIPAA Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) creates a concept known as "creditable coverage." Your coverage under this plan is considered creditable coverage under HIPAA. If you have sufficient creditable coverage under this plan and your child does not incur a break in coverage (63 continuous days of no creditable coverage), your child may be able to reduce or eliminate the application of a pre-existing illness exclusion in another health plan.

At any time up to 24 months after the date on which your child's coverage ceases under the plan, you may request a copy of a certificate of creditable coverage. In order to request this certificate, you or someone on your behalf must call or write Blue Cross and Blue Shield Customer Service.

COST SHARING

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

Fee Categories in ALL Kids

- **No Fee:** Children who have been excluded from cost sharing by federal regulation will not have any premiums or copayments when receiving health care services through ALL Kids.
- **Low Fee:** Children whose family incomes are between 100 and 150% of the Federal Poverty Level will pay an annual premium of $52 per child per year (up to a maximum of $156 per family per year). These children will have copayments ranging from $3 to $200 when receiving medical and dental services through ALL Kids providers. There will be no copayment for preventive services.

  There is a $1 copayment for Generic prescription drugs. Copayment for Preferred brands will be $5. Non-Preferred brands are not covered. (A list of Preferred brands can be obtained from the Blue Cross and Blue Shield of Alabama website at www.bcbsal.com.)

- **Fee:** Children whose family incomes are between 151 and 300% of the Federal Poverty Level will pay an annual premium of $104 per child per year (up to a maximum of $312 per family per year). These children will have copayments ranging from $6 to $200 when receiving medical and dental services through ALL Kids providers. There will be no copayment for preventive services.

  There is a $5 copayment for Generic prescription drugs. Copayment for Preferred brands will be $25. Non-Preferred brands are not covered. (A list of Preferred brands can be obtained from the Blue Cross and Blue Shield of Alabama website at www.bcbsal.com.)

Calendar Year Deductible

There is no calendar year deductible for ALL Kids.

Member's Plan Year Out-of-Pocket Maximum

The maximum out-of-pocket expense (premiums and copayments) any family should pay, shall not exceed 5% of the annual family income used for determining eligibility. Should a family's annual out-of-pocket expenses (premiums and copayments) approach this maximum, the family should notify ALL Kids.

Lifetime Maximum

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

Other Cost Sharing Provisions

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

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

Out-of-Area Services

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

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

A. BlueCard® Program

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

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

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

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

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

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

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

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

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

C. Non-Participating Healthcare Providers Outside the Blue Cross and Blue Shield of Alabama Service Area

1. Member Liability Calculation

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

2. Exceptions

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

HEALTH, MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Mental Health and Substance Abuse Benefits

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

Inpatient Hospital Benefits

Attention: Preadmission Certification is required for all hospital admissions except maternity admissions.

For emergency hospital admissions, 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.

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

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

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

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

INPATIENT HOSPITAL BENEFITS			
SERVICE OR SUPPLY	**NO FEE**	**LOW FEE**	**FEE**
365 days of care during each confinement	100% of the allowed amount, no copayment	100% of the allowed amount, subject to a $200 copayment per admission	100% of the allowed amount, subject to a $200 copayment per admission

Attention: If your child receives inpatient hospital services in an out-of-network hospital in the Alabama service area, no benefits are payable under the plan unless services are to treat an accidental injury.

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 your child if administered in the hospital;
- Regular nursery care and diaper service for a newborn baby while its mother has coverage;
- Blood transfusions administered by a hospital employee.

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

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

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

Outpatient Hospital Benefits

OUTPATIENT HOSPITAL FACILITY SERVICES	
Surgery	**No Fee:** No copay, then covered at 100% of the allowance **Low Fee:** $6 copay, then covered at 100% of the allowance **Fee:** $100 copay, then covered at 100% of the allowance
Medical Emergency/ Accidental Injury	**No Fee:** No copay, then covered at 100% of the allowance **Low Fee:** $6 copay, then covered at 100% of the allowance **Fee:** $60 copay, then covered at 100% of the allowance
Diagnostic X-ray	**No Fee:** No copay, then covered at 100% of the allowance **Low Fee:** $6 copay, then covered at 100% of the allowance **Fee:** $65 copay, then covered at 100% of the allowance
Diagnostic lab, hemodialysis, IV therapy, chemotherapy, radiation therapy, and treatment of non-emergency services in the emergency room	**No Fee:** No copay, then covered at 100% of the allowance **Low Fee:** No copay, then covered at 100% of the allowance **Fee:** No copay, then covered at 100% of the allowance

Attention: If your child receives outpatient hospital services in an out-of-network hospital in the Alabama service area, no benefits are payable under the plan unless services are to treat an accidental injury .

BCBS may reclassify services or supplies provided to a hospital patient to a level of care determined by BCBS to be medically appropriate given the patient's condition, the services rendered, and the setting in

which they were rendered. This means that BCBS may, at times, reclassify an outpatient hospital service as an inpatient admission. There may also be times in which BCBS will deny benefits altogether based upon the determination that services or supplies were furnished at an inappropriate level of care.

Certain outpatient diagnostic imaging services may require prior authorization as to the medical necessity of the diagnostic service. Information about these prior authorization requirements can be found on BCBS's web site at www.bcbsal.com/providers/preferredRadiologyProgram. Your child's in-network provider should help you and your child comply with these requirements.

Physician Benefits

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

PHYSICIAN BENEFITS			
SERVICE OR SUPPLY	**NO FEE**	**LOW FEE**	**FEE**
Office visits and consultations Note: Office visits for Obesity are limited to 4 visits per member each calendar year. Office visits for Medical Nutritional Therapy by a Nutritionist or PMD for Obesity are limited to 2 visits per member each calendar year. (These services are subject to meeting medical criteria)	100% of the allowed amount, no copayment	100% of the allowed amount, subject to a $3 copayment Note: Office visits for mental health and substance abuse are subject to one copay, per member, per day	100% of the allowed amount, subject to a $13 copayment Note: Office visits for mental health and substance abuse are subject to one copay, per member, per day
Physician fees in the emergency room	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Surgery and anesthesia for a covered service	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Maternity care	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Inpatient visits	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Inpatient consultations by a specialty provider (limited to one consult per specialist per day)	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Diagnostic lab, X-rays, and pathology	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Chemotherapy and radiation therapy	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Allergy testing	100% of the allowed amount, no copayment	100% of the allowed amount, subject to a $6 copayment	100% of the allowed amount, subject to a $17 copayment
Allergy treatment	100% of the allowed amount, no copayment	100% of the allowed amount, subject to a $3 copayment	100% of the allowed amount, subject to a $12 copayment
Temporomandibular joint disorder (TMJ)	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment

The following terms and conditions apply to 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.
- Certain diagnostic imaging services performed in a physician's office may require prior authorization as to the medical necessity of the diagnostic service. Information about these prior authorization requirements can be found on BCBS's web site at www.bcbsal.com/providers/preferredRadiologyProgram. Your child's in-network provider should help you comply with these requirements.

Physician Preventive Benefits

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

PHYSICIAN PREVENTIVE BENEFITS			
SERVICE OR SUPPLY	**NO FEE**	**LOW FEE**	**FEE**
Routine newborn exam (in hospital)	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Routine Well Child exams: First 2 years of life – 9 visits Ages 2-6 years – 1 visit (based on birth year) Age 7 and older – 1 visit per calendar year	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Routine Immunizations (See www.bcbsal.com/immunizations for a listing of the specific immunizations)	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Routine lab and diagnostic testing – includes urinalysis, TB skin test, complete blood count (CBC)	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Routine HIV testing One per calendar year	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
HPV vaccine for males ages 9-18	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Routine developmental testing Limited to 4 visits between ages 8 months and 36 months	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment

Other Covered Services

OTHER COVERED SERVICES			
SERVICE OR SUPPLY	**NO FEE**	**LOW FEE**	**FEE**
Accident-related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury. May be received concurrent with treatment.	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Chiropractic: Professional services of a licensed chiropractor practicing within the scope of his license	100% of the allowed amount; no copayment; limited to the lesser of 12 visits or $400 per member each calendar year	100% of the allowed amount, subject to a $2 copayment; limited to the lesser of 12 visits or $400 per member each calendar year	100% of the allowed amount, subject to a $5 copayment; limited to the lesser of 12 visits or $400 per member each calendar year
Dialysis services at a renal dialysis facility	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
DME: Durable medical equipment and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints	100% of the allowed amount; no copayment (for DME the allowed amount will generally be the smaller of the rental or purchase price)	100% of the allowed amount; no copayment (for DME the allowed amount will generally be the smaller of the rental or purchase price)	100% of the allowed amount; no copayment (for DME the allowed amount will generally be the smaller of the rental or purchase price)
Eyeglasses or contact lenses: One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment
Occupational therapy Precertification is required for Occupational Therapy after 15 visits. If no precertification is received, then no additional benefits beyond the initial 15 visits are available	100% of the allowed amount, no copayment	100% of the allowed amount, subject to a $3 copayment	100% of the allowed amount, subject to a $13 copayment

OTHER COVERED SERVICES			
SERVICE OR SUPPLY	**NO FEE**	**LOW FEE**	**FEE**
Physical therapy Precertification is required for Physical Therapy after 15 visits. If no precertification is received, then no additional benefits beyond the initial 15 visits are available	100% of the allowed amount, no copayment	100% of the allowed amount, subject to a $3 copayment	100% of the allowed amount, subject to a $13 copayment
Speech therapy Precertification is required for Speech Therapy after 15 visits. If no precertification is received, then no additional benefits beyond the initial 15 visits are available	100% of the allowed amount, no copayment	100% of the allowed amount, subject to a $3 copayment	100% of the allowed amount, subject to a $13 copayment
Home Health care **Precertification is required for the nursing visits, when services are rendered outside of Alabama – call 1-800-821-7231**	100% of the allowed amount, no copayment; limited to 60 visits per member each calendar year	100% of the allowed amount, no copayment; limited to 60 visits per member each calendar year	100% of the allowed amount, no copayment; limited to 60 visits per member each calendar year
Hospice care, which consists of services, supplies, or drugs included in the daily fee for hospice care, rendered by a hospice provider to a terminally ill member, when a physician certifies the member's life expectancy of less than six months, regardless of continuing palliative treatment **Precertification is required for the hospice visits, when services are rendered outside of Alabama – call 1-800-821-7231**	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment

Orthodontia Services

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

Skilled Nursing Facility Benefits

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

The following terms and conditions apply to skilled nursing facilities:

- The admission must take place within 14 days after the patient leaves the hospital and that hospital stay must have lasted at least three days in a row for the same illness or injury.

- The patient's doctor must visit 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.

Ambulance Services

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

Routine Vision Services

ROUTINE VISION SERVICES			
SERVICE OR SUPPLY	**NO FEE**	**LOW FEE**	**FEE**
Routine vision examinations	100% of the allowed amount, no copayment; limited to one examination per member every 24 months Limited to $48 for a new patient; $37 for an established patient	100% of the allowed amount, subject to a $3 copayment; limited to one examination per member every 24 months Limited to one copayment per day for the exam and one copay for frames and lenses Limited to $48 for a new patient; $37 for an established patient	100% of the allowed amount, subject to a $13 copayment; limited to one examination per member every 24 months Limited to one copayment per day for the exam and one copay for frames and lenses Limited to $48 for a new patient; $37 for an established patient
Lenses and frames	100% of the allowed amount, no copayment; limited to one pair of eyeglasses every 24 months Limited to $180 for single vision; $230 for bifocal; $250 for trifocal or progressive **No coverage for contact lenses**	100% of the allowed amount, subject to a $3 copayment; limited to one pair of eyeglasses every 24 months Limited to one copayment per day for the exam and one copay for frames and lenses Limited to $180 for single vision; $230 for bifocal; $250 for trifocal or progressive **No coverage for contact lenses**	100% of the allowed amount, subject to a $13 copayment; limited to one pair of eyeglasses every 24 months Limited to one copayment per day for the exam and one copay for frames and lenses Limited to $180 for single vision; $230 for bifocal; $250 for trifocal or progressive **No coverage for contact lenses**
Low visual aids	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment

The following terms and conditions apply to routine vision services:

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

- Vision exam
- Glasses
- Frames
- Low visual aids

Exclusions for vision care benefits:

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

Hearing Services

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

Prescription Drug Benefits

PRESCRIPTION DRUG BENEFITS			
SERVICE OR SUPPLY	**NO FEE**	**LOW FEE**	**FEE**
Prescription drugs No benefits are available for drugs purchased at a non-participating pharmacy Generic drugs are mandatory when equivalents are available Benefits are provided for oral, injectable and transdermal contraceptives	No copayment for generic drugs, preferred brand name drugs. Non-preferred brand drugs are not covered	**Generic drugs:** $1 copayment **Preferred brand name drugs:** $5 copayment **Non-preferred brand name drugs:** Not covered	**Generic drugs:** $5 copayment **Preferred brand name drugs:** $25 copayment **Non-preferred brand name drugs:** Not covered

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

- In-network pharmacies are pharmacies that have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense prescription drugs.
- To determine whether a drug is a preferred brand drug, see the Prescription Drug Guides found in the “My Blue Cross” section of the BCBS web site. Once there, you can download a copy of the current preferred brand drug list or search for the drug by name.
    - The preferred brand drug list consists of brand-name drugs that are generally believed within the industry to be cost effective and have been approved for inclusion on the list by a panel of physicians and pharmacists on Blue Cross and Blue Shield of Alabama's Pharmacy and Therapeutics Committee. The preferred brand drug list is updated periodically.
    - Any brand-name drug that is not on the preferred drug list is considered a non-preferred drug.
    - A generic drug is one that the FDA has approved under an Abbreviated New Drug Application (ANDA) and no New Drug Application (NDA) is on file.

Attention: Just because a drug is on the preferred brand drug list or any other list on the BCBS web site or is a generic equivalent does not mean the drug is safe or effective for your child. Only you and your child's prescribing physician can make that determination.

- To be eligible for benefits, drugs must be legend drugs prescribed by a physician and dispensed by a licensed participating pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal law prohibits dispensing without a prescription."
- Prescription drug coverage is subject to Drug Coverage Guidelines developed and modified over time based upon daily or monthly limits as recommended by the Food and Drug Administration, the manufacturer of the drug, and/or peer-reviewed medical literature. These guidelines can be found in the "My Blue Cross" section of the BCBS web site. Even though your child's physician has written a prescription for a drug, the drug may not be covered or a clinical edit(s) may apply (i.e. prior authorization, step therapy, quantity limitation). The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. You may call the customer service number on your child's card for more information. Your child's in-network pharmacist should help you comply with the Drug Coverage Guidelines.
- Compound drugs may be covered if at least one of the drugs in the compound is a legend drug.
- Drugs can be dispensed up to a maximum 34-day supply. Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used (e.g., 23 days in a 30-day supply).
- Insulin, needles, and syringes purchased on the same day in the same quantity will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day in the same quantity will have one copayment. Otherwise, each has a separate copayment. Glucose monitors always have a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan.

Health Management Benefits

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

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

Your child may also qualify to participate in the disease management program. Disease management is designed for individuals whose long-term medical needs require disciplined compliance with a variety of medical and lifestyle requirements. If the manager of the disease management program determines from your child's claims data that your child is a good candidate for disease management, the manager will contact you and ask if you would like your child to participate. Participation in the program is completely voluntary. If you would like to obtain more information about the program, call BCBS's customer service department.

Additional Benefit Information

Baby Yourself Program

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

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

Women's Health and Cancer Rights Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema.

Organ and Bone Marrow Transplants

The organs for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney; and (6) intestinal/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 the BCBS list of approved facilities for that type of transplant and it must have BCBS's advance written approval. When BCBS approves a facility for transplant services it is limited to the specific types of transplants stated. Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma.

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

Transplant benefits for living donor expenses are limited to:

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

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member such as deductibles, copays, coinsurance, pre-existing condition exclusions 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 the BCBS approved list for that type or for which BCBS did not give written approval in advance.

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

COORDINATION OF BENEFITS (COB)

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

Order of Benefit Determination

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

Determination of Amount of Payment

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

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

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

COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term “allowable expense” means any health care expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term “allowable expense” does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for cosmetic surgery, acupuncture, orthodontia for cosmetic purposes, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term “allowable expense” does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan's provisions concerning second surgical opinions or precertification of

admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

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

Custodial Parent: The term “custodial parent” means:

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

SUBROGATION

Right of Subrogation

If BCBS pays or provide any benefits for your child under this plan, BCBS is subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount

of benefits BCBS has paid or provided. That means that BCBS may use you and your child 's right to recover money from that other person or organization.

Right of Reimbursement

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

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

Right to Recovery

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

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

HEALTH, MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT EXCLUSIONS

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

A

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

Services or expenses for **acupuncture**, biofeedback, behavioral modification and other forms of self-care or self-help training.

Anesthesia services or supplies or both by local infiltration.

Services, care, treatment, or supplies furnished by a provider that is not recognized by BCBS as an **approved provider** for the type of service or supply being furnished. For example, BCBS 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. Call Customer Service if you have any question as to whether your child's provider is recognized as an approved provider for the services or supplies that your child intends to receive.

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

C

Services or expenses of a hospital stay, except one for an emergency, unless BCBS **certifies** it before your child's admission. Services or expenses of a hospital stay for an emergency if BCBS is not notified within 48 hours, or on our next business day after your child's admission, or if BCBS determines that the admission was not medically necessary.

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

Services or expenses for a **claim** we have not received within 12 months after services were rendered or expenses incurred.

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

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

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

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

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

- You may contact BCBS prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your child's physician must prove to the satisfaction of BCBS that surgery is reconstructive and not cosmetic. You must show BCBS history and physical exams, visual field measures, photographs and medical records before and after surgery. BCBS may not be able to determine prior to your child's surgery whether or not the proposed procedure will be considered cosmetic.

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

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

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

D

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

E

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

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

Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy. This exclusion does not apply to benefits stated in Routine Vision Care benefits.

F

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

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

G

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

I

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

L

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

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

M

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

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

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

N

Services or expenses of any kind for **nicotine addiction** such as smoking cessation treatment. The only exception to this exclusion is expenses for nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist from an in-network pharmacy. The only exception to this exclusion is expenses for nicotine withdrawal drugs prescribed by a physician and dispensed by a licensed pharmacist.

Services, care or treatment your child receives during any period of time with respect to which BCBS has not been paid for your child's coverage and that **nonpayment** results in termination.

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

O

Services or expenses for treatment of any condition including, but not limited to, **obesity** (except as previously stated covered), 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.

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

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

P

Services and expenses rendered by a **licensed physician assistant** (P.A.) (including physician assistants who assist with surgery) who is not employed by and acting under the direct supervision of a preferred provider.

Private duty nursing.

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

R

Services or expenses for **recreational** or educational therapy.

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 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.

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

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

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

S

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

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

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

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

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

Services or supplies furnished by a facility that is solely classified as a **substance abuse** outpatient or residential facility. This does not exclude covered substance abuse services or supplies furnished by a General Hospital or Psychiatric Specialty Hospital.

T

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

Services provided through **teleconsultation**.

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

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

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

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

W

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

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

DENTAL BENEFITS

All services must be rendered by a Preferred Dentist. Orthodontic services are covered for some conditions as stated previously in the medical sections of this booklet. For services exceeding $1500 per person per year, approval from the plan must be sought by the provider. Basic diagnostic and preventive services, and wisdom teeth removal and related services are excluded from this maximum benefit amount.

Benefits are paid toward the lesser of the Preferred Dentist Fee Schedule or the dentist's actual charge for

services. All Preferred Dentists agree that the BCBS payment is payment in full except for your child's copayments.

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

BASIC DIAGNOSTIC AND PREVENTIVE BENEFITS			
SERVICE OR SUPPLY	**NO FEE**	**LOW FEE**	**FEE**
Basic diagnostic and preventive services, consisting of: **Dental exams, up to twice per calendar year** **Dental X-ray exams:** • **Full mouth X-rays, one set during any 36 months in a row;** • **Bitewing X-rays, up to twice per calendar year; and** • **Other dental X-rays, used to diagnose a specific condition** **Tooth sealants on teeth numbers 2, 3, 14, 15, 18, 19, 30, and 31, limited to one application per tooth each calendar year; limited to a maximum payment of $20 per tooth through age 18.** **Fluoride treatment for children through age 18, twice per calendar year** **Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18** **Routine cleanings, twice per calendar year**	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment	100% of the allowed amount, no copayment

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

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

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

100% of the Limits on prosthetic services:

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

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

Payment of Benefits

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

DENTAL BENEFIT LIMITATIONS

Limits to all benefits:

- Examination and diagnosis no more than twice during any benefit period.
- Full mouth X-rays will be provided once each 36 months; two bitewings no more than twice during any calendar year.
- Routine cleaning will be provided no more than twice during any benefit period.
- Fluoride treatment will be provided to members through age 18 no more than twice during any benefit period.
- Tooth sealants on teeth numbers 2, 3, 14, 15, 18, 19, 30 and 31, limited to not more than one application per tooth each benefit period. Benefits are limited to a maximum payment of $20 per tooth through age 18.
- If your child changes dentists while being treated, or if two or more dentists do one procedure, BCBS will pay no more than if one dentist did all the work.
- When there are two ways to provide treatment and both are services covered under the plan, BCBS will pay toward the less expensive one. The dentist may bill you for any excess charges.
- Prosthetic – Gold, baked porcelain restorations, veneers, crowns and jackets – If a tooth can be restored with a material such as amalgam, BCBS will pay toward that method of treatment even if a more expensive means is used.
- Prosthetic – Payment will be made toward eliminating oral disease and replacing missing teeth.
- Orthodontics – Orthodontia services are covered under the health plan, (not a part of the dental plan). See Orthodontia Services under the Health Benefits section of this booklet for more information.
- Administration of nitrous oxide is limited to a maximum payment of $22 per visit.

DENTAL BENEFIT EXCLUSIONS

We will not provide benefits for the following:

A

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

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

B

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

C

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

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

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

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

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

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

D

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

E

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

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

F

Charges to use any **facility** such as a hospital in which dental services are rendered, whether the use of such a facility was dentally necessary.

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

G

Gold foil restorations.

I

Charges for **implants**.

Charges for **infection** control.

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

L

Services or expenses covered in whole or in part under the **laws** of the United States, any state, county, city, town or other governmental agency that provide or pay for care, through insurance or any other means. This applies even if the law does not cover all your child's expenses.

M

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

N

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

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

O

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

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

P

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

Charges for **plaque control program**.

R

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

W

Dental services or expenses in cases covered in whole or in part by **workers' compensation** or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for dental services as such. Finally, it applies whether your employer has insurance coverage for benefits under the law.

ALL Kids PLUS

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

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

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

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

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

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

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

CLAIMS AND APPEALS

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

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

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

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

You must act on your child's behalf or through an authorized representative if you wish to exercise your child's rights under this section of this booklet. An authorized representative is someone you designate in writing to act on your child's behalf. BCBS has developed a form that you must use if you wish to designate an authorized representative. You can obtain the form by calling the BCBS Customer Service Department. You can also go to the Internet web site at www.bcbsal.com and request copy of the form. If a person is not properly designated as your child's authorized representative, BCBS will not be able to deal with him or her in connection with the exercise of your child's rights under this section of this booklet.

For urgent pre-service claims, BCBS will presume that your child's provider is your child's 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), BCBS must receive a properly completed and filed claim from you or your child's provider.

In order for BCBS to treat a submission by you or your child's provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide BCBS with the data elements that BCBS specifies in advance. Most providers are aware of BCBS claim filing requirements and will file claims for your child. If your child's provider does not file the claim for you, you should call the BCBS Customer Service Department and ask for a claim form. Tell the Customer Service representative the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and they will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to BCBS at 450 Riverchase Parkway

East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by BCBS within 12 months after the service takes place to be eligible for benefits.

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

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

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

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

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from BCBS 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 child's provider must call the BCBS Health Management Department at 205-988-2245 or 1-800-248-2342 (toll-free). You must tell BCBS your child's contract number, the name of the facility in which your child is being admitted (if applicable), the name of a person BCBS can call back, and a phone number to reach that person. You may also submit pre-service claims in writing. Written pre-service claims should be sent to BCBS at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to BCBS during regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to BCBS within 48 hours of the admission and BCBS certifies the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if your child is admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD Physician). If your child's plan provides chiropractic, physical therapy, or occupational therapy benefits and your child receives covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your child's provider is responsible for initiating the precertification process for your child. For home health care and hospice benefits (if covered by your child's 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 the procedures for doing so, BCBS will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). BCBS notification may be oral, unless you ask for it in writing. BCBS will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of BCBS that is customarily responsible for handling benefit matters, and (2), 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: BCBS will treat your child's claim as urgent if a delay in processing your child's claim could seriously jeopardize your child's life, health, or ability to regain maximum function or, in the opinion of your child's treating physician, a delay would subject your child to severe pain that cannot be managed without the care or treatment that is the subject of your child's claim. If your child's treating physician tells BCBS that your child's claim is urgent, BCBS will treat it as such.

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

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

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

Concurrent Care Determinations

Determinations by BCBS to Limit or Reduce Previously Approved Care: If BCBS has previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and then later decides to limit or reduce the previously approved stay or course of treatment, you will be given 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 BCBS establishes 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 child's approved care. You may make this request in writing or orally either directly to BCBS or through your child's treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

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

- For in-network physical therapy or occupational therapy (if covered by your plan) call 205-220-7202.
- For care from an in-network chiropractor (if covered by your child's plan) call 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, BCBS will give you the 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, BCBS will give you the determination within 72 hours. If your request is not urgent, BCBS will treat it as a new claim for benefits, and will make a determination on your child's claim within the pre-service or post-service time frames discussed above, as appropriate.

Your Right To Information

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

Appeals

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

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

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

How to Appeal Post-Service Adverse Benefit Determinations: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim BCBS recommends that you use a form that BCBS has developed for this purpose. The form will help you provide BCBS with the information that BCBS needs to consider your appeal. To get the form, you may call BCBS's customer service department. You may also go to BCBS's Internet web site at www.bcbsal.com. Once there, you may request a copy of the form.

If you choose not to use BCBS's appeal form, you may send BCBS 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 child's 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 Appeals
P.O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write BCBS without following the rules just described for filing an appeal, BCBS will not treat your inquiry as an appeal. BCBS will, of course, do everything possible 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 205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network physical therapy or occupational therapy (if covered by your child's plan) call 205-220-7202.
- For care from an in-network chiropractor (if covered by your child's plan) call 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 – Appeals
P.O. Box 2504
Birmingham, Alabama 35201-2504

or

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

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

Your written appeal should provide BCBS with your child's 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 BCBS without following the rules just described for filing an appeal, BCBS will not treat your inquiry as an appeal. BCBS will, of course, do everything possible to resolve your questions or concerns.

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

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

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

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

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

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

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

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

- You may ask the BCBS customer service department for further help;
- You may file a voluntary appeal (discussed below); or,
- You may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your ALL Kids plan if your child's claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If BCBS has given you the 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), BCBS will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. BCBS will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, BCBS will not impose any fees or costs on you as part of your voluntary appeal.

You may ask BCBS 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.

COBRA

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

Not all group health plans are covered by COBRA. As a general rule, COBRA applies to all employer sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related

corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan. You must contact your plan administrator (normally your group) to determine whether this plan is covered by COBRA.

COBRA coverage can be particularly important for several reasons. First, it will allow you to continue group health care coverage beyond the point at which you would ordinarily lose it. Second, it can prevent you from incurring a break in coverage (persons with 63-day breaks in creditable coverage may be required to satisfy pre-existing condition exclusion periods if they obtain health coverage elsewhere). And third, it could allow you to qualify for coverage under state law. For example, in Alabama you may qualify for coverage under the Alabama Health Insurance Program (AHIP). See the section Coverage Options After COBRA Ends for more information. You do not have to demonstrate evidence of insurability in order to qualify for COBRA coverage.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the group changes the plan coverage, coverage will also change for you. You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes.

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

COBRA Rights for Covered Employees

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

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

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

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

If the plan provides health coverage for retired employees, sometimes filing a proceeding in bankruptcy under Title 11 of the United States Bankruptcy Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the group, and the bankruptcy results in the loss of coverage of any covered retired employee, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage.

COBRA Rights for a Covered Spouse and Dependent Children

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

- The covered employee dies;
- The covered employee's hours of employment are reduced;
- The covered employee's employment ends for any reason other than his or her gross misconduct;

- The covered employee becomes enrolled in Medicare;
- Divorce of the covered employee and spouse; or,
- For a dependent child, the dependent child loses dependent child status under the plan.

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

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

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

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

Extensions of COBRA for Disability

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

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

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

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

Extensions of COBRA for Second Qualifying Events

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

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

For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the section Notice Procedures for more information about the notice procedures you must use to give this notice.

Notice Procedures

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

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

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

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

Adding New Dependents to COBRA

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

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

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

Medicare and COBRA Coverage

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

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

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

Electing COBRA

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

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

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

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

COBRA Premiums

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA

coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment.

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

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

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under these tax provisions, “eligible individuals” can either take a tax credit or get advance payment of 65% of the allowed amount of premiums paid for qualified health insurance, including COBRA coverage.

The Trade Adjustment Assistance Extension Act of 2011 temporarily increases the amount of the HCTC to 72.5% for certain HCTC-eligible individuals ending December 31, 2013. This act also temporarily modifies the maximum required COBRA coverage period for certain HCTC-eligible individuals, but does not extend any periods of coverage beyond December 31, 2013.

If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center at 1-866-628-4282 (toll-free). TTD/TTY callers may call at 1-866-626-4282 (toll-free).

Early Termination of COBRA

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

- The group no longer provides group health coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA coverage, you become covered under another group health plan that does not contain any exclusion or limitation on any pre-existing condition that you may have or you have sufficient creditable coverage to preclude application of the new plan's pre-existing condition exclusion period to you;
- After electing COBRA coverage, you become enrolled in Medicare; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

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

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

Coverage Options After COBRA Ends

If you exhaust your COBRA coverage you may be eligible for a conversion health contract from Blue

Cross. Please contact Blue Cross to determine whether a conversion contract is available. Conversion contracts have more limited coverage than COBRA coverage.

You may also qualify for coverage under state law. In Alabama, you can continue coverage through the Alabama Health Insurance Plan (AHIP). You can reach AHIP by calling the State Employees' Insurance Board in Montgomery, Alabama. In other states, you should call the state insurance department. If you elect to buy a conversion contract instead of enrolling in AHIP, you will not be able to enroll at a later date in AHIP.

By contrast, if COBRA coverage ends because you stop paying for it, then you will not have any further coverage under the group health plan and you will not be eligible to buy conversion coverage (if available) and you may not qualify for continued coverage under any applicable state law program. For example, in Alabama, you would not qualify for continued coverage under AHIP.

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

RESPECTING YOUR PRIVACY

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

Disclosures of Protected Health Information to the Plan Sponsor:

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

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

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

- The plan sponsor will only use or disclose your child's protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your child's protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your child's protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your child's protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.

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

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

- Administrative Director

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

Security of Your Child's Personal Health Information:

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

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your child's electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your child's electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your child's electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

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

Our Use and Disclosure of Your Child's Personal Health Information:

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

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

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

Whenever BCBS makes reasonable determinations that are neither arbitrary nor capricious in BCBS's administration of the plan, those determinations will be final and binding on 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).

Notice

BCBS gives you notice when you are sent information by mail or electronically to you or ALL Kids at the latest address BCBS has. You and ALL Kids are assumed to receive notice three days after it is mailed. ALL Kids is your agent to receive notices from BCBS and as such is responsible for giving you all notices from BCBS. BCBS is not responsible if ALL Kids fails to do so.

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

Correcting Payments

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

Responsibility for Providers

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

Misrepresentation

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

Multiple Coverage

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

Governing Law

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

Termination of Benefits and Termination of the Plan

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

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

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

Changes in the Plan

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

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

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

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

DEFINITIONS

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

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

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

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

See Out-of-Area Services, earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Alabama**Out-of-Network Providers:** The allowed amount for care rendered by out-of-network providers is often determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to in-network providers or may be based on the average charge for the care in the area. In other cases, Blue Cross and Blue Shield of Alabama determines the allowed amount using historical data and information from various sources such as, but not limited to:

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

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

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

Application: The child's original application form and any written supplemental application we accept.

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

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

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

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

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

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

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

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

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

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

Elective Abortion: An abortion performed for reasons other than the compromised physical health of the mother, severe chromosomal or fetal deformity, or conception due to incest or rape.

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

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

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

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

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

In-Network Provider: A provider is considered to be an in-network provider if, and only to the extent that, the provider is furnishing a service or supply that is specified as an in-network benefit under the terms of the contract between the provider and the Blue Cross and/or Blue Shield plan (or its affiliates). Examples include BlueCard PPO providers, Preferred Medical Doctors (PMD physicians), Blue Choice

Behavioral Health Network providers, and Participating Pharmacies. A provider will be considered an in-network provider only if the local Blue Cross and/or Blue Shield plan designates the provider as an In-Network provider for the service or supply being furnished. This means that if your child receives a service or supply from a provider that has a contractual relationship with a Blue Cross and/or Blue Shield plan but is not designated by the local Blue Cross and/or Blue Shield plan as a BlueCard PPO provider, the service will be considered as out-of-network.

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

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

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

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

Medical Emergency: A medical condition that occurs suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention to prevent permanent damage to the health, other serious medical results, serious impairment to bodily function, or serious and permanent lack of function of any bodily organ or part.

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

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your child's medical condition;
- Provided for the diagnosis or direct care and treatment of your child's 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 child, your family, your child's 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 child's medical condition. A "setting" may be your child's home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when your child is an inpatient, or another type of facility providing a lesser level of care. Only your child's medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance your child lives from a hospital or other facility, or any other non medical factor is not considered. As your child's medical condition changes, the setting your child needs may also change. Ask your child's physician if any of your child's services can be performed on an outpatient basis or in a less costly setting.

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

Member: Your ALL Kids enrolled child or adolescent.

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

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

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

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

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

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

Plan: The plan is the group health benefit plan of ALL Kids Children's Health Insurance, as amended

from time to time. The plan documents consist of the following:

- This benefit booklet, as amended;
- The BCBS contract with the group, as amended;
- Any benefit matrices upon which BCBS have relied with respect to the administration of the plan; and,
- Any draft benefit booklets that BCBS is treating as operative. "Operative," means that a draft of the booklet has been provided to ALL Kids that will serve as the primary, but not the sole, instrument upon which the administration of the plan, without regard to whether the group finalizes the booklet or distributes it to the plan's members.

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

Plan Administrator: ALL Kids.

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

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

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

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

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

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

Subscriber: Your ALL Kids enrolled child or adolescent.

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

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

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and health care

provider. Teleconsultations include consultations by e-mail or other electronic means.

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

You, Your: The parent, guardian, or member as shown by the context.

STATEMENT OF ERISA RIGHTS

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

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group healthplan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why

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

Assistance With Your Questions

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

Administrative Information

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

- The plan's official name is: All Kids Children's Health Insurance Program Group Health Care Plan.
- The plan sponsor and plan administrator is the employer. The employer is responsible for discharging all obligations that ERISA and its regulations impose upon plan sponsors and plan administrators, such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law.
- The plan number assigned by the plan sponsor is: 501.
- The IRS Employer Identification Number (EIN) of the sponsor is: 63-1106545.
- The plan provides hospital and medical benefits as administered under an administrative services agreement between Blue Cross and Blue Shield of Alabama and the employer. Blue Cross has complete discretion to interpret and administer the provisions of the plan. The administrative functions performed by Blue Cross include paying claims, determining medical necessity, etc. The plan benefits are self-insured.
- The agent for legal process is the employer.
- The records of the health plan are kept on the basis of a plan year which begins on October 1st and ends on the following September 30th.
- The employer currently intends to continue the plan as described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan and coverage at any time for active employees, retirees, former employees, and all dependents.
- This is an employer-employeeshared cost plan. The sources of the contributions to this plan are currently the employer and the employee in relative amounts as determined by the employer from

time to time. While the employer may change its level of contribution at any time, the employer must always contribute at least a portion of the employee's premiums. Any information concerning what is to be paid by the employee in the future will be furnished by the employer in writing and will constitute a part of this plan. Your contribution is determined by the employer based on the plan's experience and other factors.

- Plan Administrator Contact Information:

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

  Attention: Employee Benefits (COBRA)
  All Kids Children's Health Insurance Program
  201 Monroe Street Suite 400
  Montgomery, Alabama 36104-3746

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

Customer Service:

1-800-760-6851 toll-free

Preadmission Certification:

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

Web site:

www.bcbsal.com

05000
Health Plan

04/2014