Special Open Enrollment

An HCTC Qualified Health Plan

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA
SPECIAL OPEN ENROLLMENT CERTIFICATE
Effective Date of Amendment: January 1, 2012

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate. The changes made by this amendment are effective for services rendered and supplies and/or prescription drugs purchased on or after January 1, 2012.

- The **Physician Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to add a footnote marker ******** after the **Non-PMD Physician** cost-sharing amounts for **Emergency Room Physician Care**.

- The **Summary of Health Benefits** section of your Certificate is amended to add the following footnote at the end of the **Physician Benefits** matrix to read as follows:

  **** If you receive other Non-PMD Physician services (such as Non-PMD Physician laboratory services) for a medical emergency in the emergency department of a hospital, those services will be paid at the applicable PMD Physician coinsurance amounts for such services described in the matrix above, but subject to the calendar year deductible. The allowed amount for such Non-PMD Physician services will be determined in accordance with the requirements of the Patient Protection and Affordable Care Act.

- The first row (Routine Immunizations) of the **Preventive Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is deleted in its entirety.

- The second row of the **Preventive Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is deleted in its entirety and replaced with the following to read as follows:

Routine preventive services and immunizations See www.bcbsal.com/preventive services for a listing of the specific preventive services and immunizations	100% of the allowed amount, no deductible or coinsurance	Not Covered

- The first sentence of the second paragraph of the **Prescription Drug Benefits** subsection of the **Health Benefits** section of your Certificate is amended to add the words “FDA approved” before the word “legend” in such first sentence.

- The sixth paragraph of the **Prescription Drug Benefits** subsection of the **Health Benefits** section of your Certificate is amended to add the following new sentence at the end of such paragraph to read as follows:

  A generic drug is also one that is manufactured by more than one manufacturer and is designated as a multi-source product by the major drug database providers, Medispan and First DataBank.

- The second paragraph in the **Individual Case Management** subsection in the **Additional Benefit Information** section of your Certificate is deleted in its entirety and replaced with the following paragraph:

  You may also qualify to participate in the disease management program. The disease management program is available for members with heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD) and asthma. This program offers personalized care designed to meet your lifestyle and health concerns. Our staff of healthcare professionals will help you cope with your illness and serve as a source of information and education. Participation in the program is completely voluntary. If you would like to enroll in the program or obtain more information, call 888-841-5741 (Monday – Friday, 8 a.m. to 4:45 p.m. CST), or e-mail diseasemanagement@bcbsal.org.

- In the **Claims and Appeals** section of your Certificate, the second subparagraph in the **Urgent Pre-Service Claims** paragraph in the **Pre-Service Claims** subsection is deleted in its entirety and replaced with the following second subparagraph to read as follows:

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

- In the **Claims and Appeals** section of your Certificate, the last paragraph in the **Concurrent Care Determinations** subsection is deleted in its entirety and replaced with the following last paragraph to read as follows:

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

- The **If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies** paragraph in the **Appeals** subsection of the **Claims and Appeals** section of your Certificate is deleted in its entirety and replaced with the following to read as follows:

  If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you filed an appeal and are dissatisfied with our response, you may do one or more of the following:
  - You may ask our Customer Service Department for further help;
  - You may file a voluntary appeal (discussed below);
  - You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below); or,
  - You may file a claim for arbitration, as explained under the section of this booklet dealing with arbitration.

- The **External Reviews** subsection in the **Claims and Appeals** section of your Certificate is deleted in its entirety and replaced with the following new subsection to read as follows:

  External Reviews

  For claims involving medical judgment and/or rescissions of coverage, you may also file a request with us for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address: Blue Cross and Blue Shield of Alabama, Attention: Customer Service Appeals, P.O. Box 1215185, Birmingham, AL 35202-2185.

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

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

- The **General Information** section of your Certificate is amended to add the following new subsection at the end of such section. The following new subsection applies ***only*** when you obtain services outside of our service area for a medical emergency or accidental injury:

  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 you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

  Typically, when accessing care outside our service area, you 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, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, we 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 you access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

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

Estimated pricing and average pricing, 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 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 calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

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

Exceptions

In some exception cases, we may pay such claims based on the payment we would make if we were paying a non-participating provider inside of our service area, as described elsewhere in this benefit booklet, where the Host Blue's corresponding payment would be more than our in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a

provider on an exception basis. In other exception cases, we may use other payment bases, such as billed covered charges, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you 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.

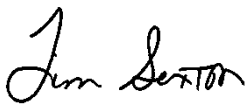
- Exclusion number 55 (implantable devices) in the **Exclusions** section of your Certificate is amended by replacing the term “in-network” with “preferred” in all instances.

- Exclusion number 56 (third party vendor) in the **Exclusions** section of your Certificate is amended by replacing the term “out-of-network” with “non-preferred” in front of the words “third party vendor”.

- The **Definitions** section of your Certificate is amended by adding the following new definition to such section immediately following the definition of “Blue Cross” to read as follows:

  BlueCard Program: If you receive services for a medical emergency or accidental injury out of our service area, your claims may be processed through the BlueCard Program. The BlueCard Program is a national program among the Blue Cross and/or Blue Shield 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 the Out-of-Area section of this Certificate.

Except as expressly modified herein, all other terms, conditions and provisions of your Certificate remain in full force and effect.



Tim Sexton
Senior Vice President & Chief Marketing Officer

MKT-475-Q (Effective 1/1/2012)

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA
SPECIAL OPEN ENROLLMENT CERTIFICATE
Effective Date of Amendment: June 1, 2011

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate. The changes made by this amendment are effective for services rendered and supplies and/or prescription drugs purchased on or after June 1, 2011.

1. The **Prescription Drug Benefits** subsection of the **Health Benefits** section of your Certificate is amended to add the following new paragraphs at the end of such subsection to read as follows:

    6. 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.

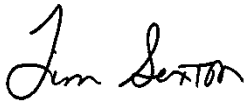
    7. Prescription drug coverage is subject to Drug Coverage Guidelines over time based upon daily or monthly limits as recommended by the Food and Drug Administration, the manufacturer of the drug, and/or peer-reviewed medical literature. These guidelines can be found in the *my*BlueCross section of our website. Even though your physician has written a prescription for a drug, the drug may not be covered under the plan or a clinical edit(s) may apply (i.e. prior authorization, step therapy, quantity limitation) in accordance with the guidelines. 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 card for more information.

2. **Exclusion number 55** (implantable devices**)** in the **Exclusions** section of your Certificate is deleted in its entirety and replaced with the following:

    55. Implantable devices (and services, supplies, equipment and accessories ancillary to implantation of same), unless provided by an in-network provider or in-network third party vendor and covered by the terms of the applicable in-network contract.

3. The first sentence of **exclusion number 56** (third party vendor**)** in the **Exclusions** section of your Certificate is amended by inserting the word “out-of-network” in front of the words “third party vendor”.

Except as expressly modified herein, all other terms, conditions and provisions of your Certificate remain in full force and effect.



Tim Sexton
Senior Vice President & Chief Marketing Officer

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA
SPECIAL OPEN ENROLLMENT CERTIFICATE
Effective Date of Amendment: January 1, 2011

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate. The changes made by this amendment are effective for services or supplies rendered on or after January 1, 2011.

Special Open Enrollment Provisions for Blue Cross and/or Blue Shield Plan Members Entitled to a Conversion Contract

Blue Cross and Blue Shield of Alabama is offering this Special Open Enrollment Plan to persons who are or were members of Blue Cross and/or Blue Shield Plans ("Prior Plan") and who, on the date of application for this Special Open Enrollment Plan, are entitled to a conversion contract under the terms of that Prior Plan.

To be eligible for coverage, you (1) must be between 19 and 64 years of age and a resident of Alabama; (2) must have been covered under a Prior Plan and entitled, on the date of your application for this Plan, to a conversion contract under the terms of that Prior Plan; (3) must not be covered by any other group or individual health plan (other than your Prior Plan); (4) must not be eligible for COBRA coverage through an employer plan; and (5) must not be eligible for Medicare.

If you obtain coverage under this Blue Cross and Blue Shield of Alabama Special Open Enrollment Plan as a Prior Plan member entitled to a conversion contract as described above, ***all of the provisions of the Special Open Enrollment Certificate apply to you except as provided below:***

Applying for this Plan

To apply for this Special Open Enrollment Health Plan, you must fill out an application form completely and give it to us within the time limit set forth in your Prior Plan. You must name all eligible dependents to be covered on the application. Once your application has been accepted, you will receive an identification card and we will begin sending you a monthly billing statement (unless you elect the automatic payment option). Payment must be received within 30 days from your effective date. Your coverage begins on the first of the month following acceptance.

Eligible Dependents

Your eligible dependents (1) must be described in the Certificate provision entitled "Eligible Dependents;" (2) must be or have been covered under your Prior Plan on the ending date of your Prior Plan; (3) must not be covered under a group or individual health plan (other than your Prior Plan); (4) must not be eligible for COBRA coverage through an employer plan; and (5) must not be eligible for Medicare.

If you choose to enroll for individual coverage, you will not be allowed to later convert to family coverage except in the limited circumstances set forth in the Certificate.

Pre-Existing Condition and Exclusion Periods

The pre-existing condition exclusion period and the exclusion periods for some surgical procedures and for maternity care benefits described in the Certificate provision entitled "Pre-Existing Condition and Exclusion Periods" apply to all individuals eligible for this Special Open Enrollment for Prior Plan members entitled to a conversion contract under the terms of the Prior Plan. However, we will give you credit for pre-existing condition waiting periods and any like waiting periods for certain surgical procedures and for maternity care benefits that you served under that Prior Plan.

Tim Sexton
Senior Vice President & Chief Marketing Officer

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective Date of Amendment: January 1, 2011

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate. The changes made by this amendment are effective for services or supplies rendered on or after January 1, 2011.

- In the **Summary of Health Benefits** section of your Certificate, the **General Provisions matrix** is amended by deleting the **Lifetime Maximum ***** row of the matrix in its entirety including the footnote denoted *** thereto.

- In the **Summary of Health Benefits** section of your Certificate, the **Preadmission Certification** row of the **Inpatient Hospital Benefits** matrix is amended to add the words "emergency hospital admissions and" after the word "except" and before the word "maternity".

- The **Outpatient Hospital Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the **Non-Preferred Outpatient Facility** cost-sharing amounts for **Accidental Injury and Medical Emergency** as follows:

  100% of the allowed amount, subject to the calendar year deductible after payment of a $300 facility copayment

- The **Physician Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the **Non-PMD Physician***** cost-sharing amounts for **Emergency Room Physician Care** as follows:

  80% of the allowed amount, subject to the calendar year deductible after payment of a $75 per visit copayment

- The **Preventive Benefits** matrix of the **Summary of Benefits** section of your Certificate is deleted in its entirety and replaced with a new **Preventive Benefits** matrix to read as follows:

Preventive Benefits

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

Benefit	PMD Physician	Non-PMD Physician
Routine immunizations See www.bcbsal.com/immunizations for a listing of the specific immunizations	100% of the allowed amount, no deductible or coinsurance	Not covered
Routine preventive services See www.bcbsal.com/preventiveservices For a listing of the specific preventive services	100% of the allowed amount, no deductible or coinsurance	Not covered

- Under the **Eligibility and Pre-Existing Exclusions** section of your Certificate, the **For Pre-Existing Conditions** subsection is amended by deleting the second sentence of such subsection in its entirety and replacing it with the following new second sentence to read as follows:

  This does not apply to any member who is under age 19 on the effective date of his or her coverage under the plan.

- Under the **Eligibility and Pre-Existing Exclusions** section of your Certificate, the **Exclusion Period for Some Surgical Procedures** subsection is amended by adding the following sentence at the end of such subsection to read as follows:

  The 365-day exclusion period for treatment of birth defects and any related surgery does not apply to any eligible member who is under age 19 on the effective date of coverage under the plan.

- The **Preventive Benefits (Only When Using PMD)** subsection of the **Health Benefits** section of your Certificate is deleted in its entirety.

- In the **Claims and Appeals** section of your Certificate, the second subparagraph in the **Urgent Pre-Service Claims** paragraph in the **Pre-Service Claims** subsection is deleted in its entirety and replaced with the following second subparagraph to read as follows:

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

- In the **Claims and Appeals** section of your Certificate, the last paragraph in the **Concurrent Care Determinations** subsection is deleted in its entirety and replaced with the following last paragraph to read as follows:

  If your request for additional care is urgent, we will give you our decision within 24 hours of when your request is submitted. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

- The first paragraph in the **Appeals** subsection of the **Claims and Appeals** section of your Certificate is deleted in its entirety and replaced with the following to read as follows:

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

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

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

How to Appeal Initial Eligibility Determinations and Retroactive Rescissions: If you wish to file an appeal of our denial of your or your dependents' initial eligibility under the plan or of our retroactive rescission of plan coverage for fraud or intentional material misrepresentation, you may send us a letter and state that you are filing an appeal. You must send your appeal to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Consumer Products Appeals - CAD
450 Riverchase Parkway East
Birmingham, Alabama 35244

- The **If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies** paragraph in the **Appeals** subsection of the **Claims and Appeals** section of your Certificate is deleted in its entirety and replaced with the following to read as follows:

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

  1. You may ask our Customer Service Department for further help; or
  2. You may file a claim for external review, as explained under the section of this booklet dealing with external reviews.

- The following new **External Review** subsection is added at the end of the **Claims and Appeals** section of your Certificate to read as follows:

  External Reviews
  For most types of claims, you have the right to file a request with the Office of Personnel Management (OPM) for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. You can request an external review with OPM in writing by sending your request electronically to DisputedClaim@opm.gov; by faxing it to 1-202-606-0036, or by sending it by mail to: OPM, P.O. Box 791, Washington, D.C. 20044. If you request an external review, the examiner will review our decision and provide you with a written determination.

- The first paragraph of the **Arbitration** subsection of the **General Information** section of your Certificate is amended to read as follows:

  IN CONSIDERATION OF COVERAGE UNDER THE PLAN AND PAYMENT OF PREMIUMS, YOU (AND WE) AGREE THAT ANY ONE OR MORE OF THE FOLLOWING CLAIMS FOR WHICH AN EXTERNAL REVIEW (AS DESCRIBED ABOVE) IS NOT AVAILABLE OR FOR WHICH YOU (OR WE) HAVE FURTHER RIGHTS UNDER ANY APPLICABLE LAW FOLLOWING SUCH EXTERNAL REVIEW SHALL BE RESOLVED BY FINAL AND BINDING ARBITRATION:

- The **Misrepresentation** subsection of the **General Information** section of your Certificate is deleted in its entirety and replaced with the following:

  Misrepresentation
  If you commit fraud or make any intentional misrepresentation of material fact in applying for coverage, when we learn of this we may terminate your coverage back to your effective date. We need not even refund any payment for your coverage. You have the right to appeal our decision. Your rights to appeal are explained in the Claims and Appeals section of this booklet.

- The **Allowed Amount** definition in the **Definitions** section of your Certificate is amended by adding the following at the end of such definition:

  For emergency services for medical emergencies provided within the emergency room department of a non-preferred/non-participating hospital, the allowed amount will be determined in accordance with the requirements of the Patient Protection and Affordable Care Act.

- The **Medical Emergency** definition in the **Definitions** section of your Certificate is deleted in its entirety and replaced with the following definition:

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

Except as expressly modified herein, all other terms, conditions and provisions of your Certificate remain in full force and effect including (without limitation) those benefit changes previously sent to you in an insert dated June 1, 2010 that are to become effective January 1, 2011.

Tim Sexton
Senior Vice President & Chief Marketing Officer

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective as of June 1, 2010

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate.

Under the **Eligibility** section of your Certificate, the first three paragraphs of the **Eligible Dependents** subsection is hereby deleted and replaced with the following to read as follows:

Eligible Dependents

Your eligible dependents are:

1. Your spouse (of the opposite sex).

2. An unmarried or married child up to age 26.

3. An unmarried incapacitated child age 26 and over who is not able to support himself and who depends on you for support, if the incapacity occurred before age 26.

The child may be:

1. A natural child.
2. A stepchild.
3. A legally adopted child.
4. A child placed for adoption.
5. Any other child for whom the insured has permanent legal custody.

A grandchild is **not** an eligible dependent unless you adopt that child.

Tim Sexton
Senior Vice President & Chief Marketing Officer

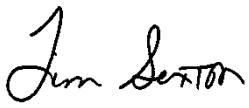
AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective Date of Amendment: June 1, 2010

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate.

Effective June 1, 2010:

- Under the **Eligibility** section of your certificate, the word "25" is deleted in all places where "25" appears in the **Eligible Dependents** subsection and replaced with "26" in all such places in such subsection so that the maximum eligibility age for dependent children is **age 26**. All other eligibility requirements for dependents remain the same.



Tim Sexton
Senior Vice President & Chief Marketing Officer

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA
SPECIAL OPEN ENROLLMENT CERTIFICATE
Effective Date of Amendment: June 1, 2010

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate. The changes made by this amendment are effective for services or supplies rendered on or after June 1, 2010 unless otherwise specifically stated below.

- The **Physician Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following copay amounts for the following benefits provided by a **PMD Physician**** as follows:

Office Visits and Outpatient Consultations	Subject to the calendar year deductible Covered at 80% of the Allowed Amount, after **$50** office visit copay*

- The **Physician Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following copay amounts for the following benefits provided by a **PMD Physician**** as follows:

Emergency Room Physician Care	Subject to the calendar year deductible Covered at 80% of the Allowed Amount, after **$75** ER visit copay*

- The **Preventive Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following copay amounts for the following benefits provided by a **PMD Physician**** as follows:

Routine Well Child Office Visits	Subject to the calendar year deductible Covered at 80% of the Allowed Amount, after **$50** office visit copay*

- The **Prescription Drug Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following copay amounts for the following benefits as follows:

Prescription Drugs	Subject to the prescription drug deductible per person each calendar year **$20** copay for generic**; $60** copay for Preferred brand**; $80** copay for Non-Preferred brand

- Effective July 1, 2010, the **Exclusions** section of your Certificate is amended to include the following additional exclusions:

55. Implantable devices (and services, supplies, equipment and accessories ancillary to implantation of same), unless provided in and billed by an in-network hospital, in-network out-patient facility, or in-network ambulatory surgery center, and covered by the terms of the applicable in-network contract.

56. 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.

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

    - Hot and cold packs;
    - Standard batteries used to power medical or durable medical equipment;
    - Solutions used to clean or prepare skin or minor wounds including alcohol solution or wipes, povidone- iodine solution or wipes, hydrogen peroxide, and adhesive remover;
    - Standard dressing supplies and bandages used to protect minor wounds such as band aids, 4 x 4 gauze pads, tape, compression bandages, eye patches;
    - Elimination and incontinence supplies such as urinals, diapers, and bed pans; and
    - Blood pressure cuffs, sphygmometers, stethoscopes and thermometers.

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

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

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

- Effective July 1, 2010, the **Definitions** section of your Certificate is amended by adding the following new definition:

  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.

- Effective July 1, 2010, paragraph 1 of the **Prescription Drug Benefits** subsection of the **Health Benefits** section of your Certificate is amended to add the following at the end of such paragraph 1:

  Specialty Drugs can only be dispensed by a Specialty Participating Pharmacy.

- Effective July 1, 2010, paragraph 3 of the **Prescription Drug Benefits** subsection of the **Health Benefits** section of your Certificate is deleted and a new paragraph 3 is added in lieu thereof to read as follows:

  3. Drugs can be dispensed in a maximum of a 30-day supply for each drug or refill. Refills are allowed only after 75% of the previous prescription has been used, e.g., 23 days into a 30 day supply.

- Effective July 1, 2010, the **Participating Pharmacy** definition in the **Definitions** section of your Certificate is amended to read as follows:

  Participating Pharmacy: Any pharmacy with which Blue Cross or its pharmacy benefit manager(s) has a contract for dispensing prescription drugs. Specialty drugs can only be dispensed by a Specialty Participating Pharmacy.

- Effective July 1, 2010, the Definitions section of your Certificate is amended to add the following new definitions:

  Specialty Participating Pharmacy: Any pharmacy with which Blue Cross or its pharmacy benefit manager(s) has a contract for dispensing Specialty Drugs.

  Specialty Drugs: Specialty drugs are high-cost drugs that may be used to treat certain complex and rare medical conditions and are often self-injected or self-administered. Specialty drugs often grow out of biotech research and may require refrigeration or special handling. The Specialty Drug list that is posted on www.bcbsal.com is the most current listing but is subject to change without notice. Specialty drugs can only be dispensed by a Specialty Participating Pharmacy.

- Effective January 1, 2011, the **General Provisions** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following amounts:

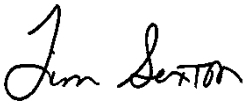
Calendar Year Deductible*	The first **$2,500** of covered expenses per person each calendar year; **$7,500** family maximum per year
Prescription Drug Deductible	The first **$350** of covered prescriptions per person each calendar year
Calendar Year Out-of-Pocket Maximum**	**$7,500** individual calendar year out-of-pocket maximum including the calendar year deductible

- Effective January 1, 2011, the second footnote of the **General Provisions** matrix of the **Summary of Health Benefits** section of your Certificate is amended to provide that outpatient hospital copay amounts do not apply towards the calendar year out-of-pocket maximum to read as follows:

  ** The Out-of-Pocket Maximum does **not** include the inpatient hospital daily copay, **outpatient hospital copay**, copays to PMD Physicians, coinsurance to Non-Participating and Non-Preferred providers, prescription drug deductible and copays, or non-covered expenses. After the out-of-pocket maximum is met, services which are applicable to the out-of-pocket maximum will be paid at 100% of the Allowed Amount for the remainder of the year.

- The **Summary of Health Benefits** section of your Certificate is amended to change all references to calendar year deductible, prescription drug deductible, and calendar year out-of-pocket maximum amounts to the new amended calendar year deductible, prescription drug deductible, and calendar year out-of-pocket maximum amounts set forth above (and on the respective effective dates set forth above) in this Amendment.

- Except as expressly modified herein, all **asterisks** (*) by any terms in this Amendment refer to the same footnotes that such asterisks referred to in your Certificate. Except as expressly modified herein, all other benefits, terms and conditions of your Certificate (as amended) remain in full force and effect.



Tim Sexton
Senior Vice President & Chief Marketing Officer

MKT-475-K

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Date of Amendment: July 6, 2009

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate.

- Effective June 1, 2009 through December 31, 2009, the **General Provisions** matrix of the **Summary of Health Benefits** section of your Certificate is amended to decrease the following amounts as follows:

Calendar Year Deductible*	The first $1,000 of covered expenses per person each calendar year; $3,000 family maximum per year
Prescription Drug Deductible	The first $250 of covered prescriptions per person each calendar year
Calendar Year Out-of-Pocket Maximum**	$3,000 individual calendar year out-of-pocket **including** the calendar year deductible

- Effective January 1, 2010, the **General Provisions** matrix of the **Summary of Health Benefits** section of your Certificate is amended to increase the following amounts as follows:

Calendar Year Deductible*	The first **$2,000** of covered expenses per person each calendar year; **$6,000** family maximum per year
Prescription Drug Deductible	The first **$300** of covered prescriptions per person each calendar year
Calendar Year Out-of-Pocket Maximum**	**$6,000** individual calendar year out-of-pocket maximum **including** the calendar year deductible

- The **Summary of Health Benefits** section of your Certificate is amended to change all references to calendar year deductible, prescription drug deductible, and calendar year out-of-pocket maximum amounts to reflect the new amended decreased calendar year deductible, prescription drug deductible, and calendar year out-of-pocket maximum amounts for dates of service on or after June 1, 2009 through December 31, 2009 and then thereafter to reflect the new amended increased amounts for dates of service on or after January 1, 2010, all as set forth above in this Amendment.

- All **asterisks** (*) by any terms in this Amendment refer to the same footnotes that such asterisks referred to in your Certificate.

- Except as expressly modified herein, all other benefits, terms and conditions of your Certificate (as amended) remain in full force and effect.

Tim Sexton
Senior Vice President & Chief Marketing Officer

MKT-475-J

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective Date of Amendment: June 1, 2009

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate.

- The **Summary of Health Benefits** section of your Certificate is amended by adding the following paragraphs after the first paragraph of the **Summary of Health Benefits** section to read as follows:

  Hospital Tiered Network in Alabama

  Blue Cross and Blue Shield of Alabama has developed a Hospital Tiered Network within the state of Alabama. Hospitals are categorized into one of three "tiers", based on their performance in fiscal, quality and patient safety awareness. Tier 1 hospitals are recognized as having attained the highest level of compliance across those areas. Tier 1 hospitals also include certain specialty hospitals and ambulatory surgical centers within the state of Alabama that do not participate in the Hospital Tiered Network. Tier 1 hospitals also include some Participating Hospitals outside the state of Alabama. Tier 2 and Tier 3 hospitals are those facilities in Alabama that are not Tier 1.

  Copay and deductible amounts for inpatient and outpatient services will vary between tiers as indicated in this benefit summary, with Tier 1 having the lowest copay and deductible amounts.

  To determine the tier level of a particular hospital, please visit our web site at **www.bcbsal.com**. The tier level will be indicated next to the name of the hospital for those who participate in the Hospital Tiered Network. If you have any questions, please contact our Customer Service department at 1 800 292-8868.

- The **General Provisions** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following amounts:

Calendar Year Deductible*	The first **$2,000** of covered expenses per person each calendar year; **$6,000** family maximum per year
Prescription Drug Deductible	The first **$300** of covered prescriptions per person each calendar year
Calendar Year Out-of-Pocket Maximum**	**$6,000** individual calendar year out-of-pocket maximum **including** the calendar year deductible

- The **Summary of Health Benefits** section of your Certificate is amended to change all references to calendar year deductible, prescription drug deductible, and calendar year out-of-pocket maximum amounts to the new amended calendar year deductible, prescription drug deductible, and calendar year out-of-pocket maximum amounts set forth above in this Amendment.

- The **Inpatient Hospital Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following cost sharing amounts for Inpatient Hospital Coverage provided by a **Participating Hospital** as follows:

  Inpatient Hospital Coverage provided by a Participating Hospital*:

  Tier 1: 100% of the allowed amount, subject to a $**300** copay for each of the 1st through the 5th days

  Tier 2 and 3: 100% of the allowed amount, subject to a $**600** copay for each of the 1st through the 5th days

- The **Outpatient Hospital Benefits*** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following cost sharing amounts for the following benefits provided by a **Preferred Outpatient Facility** as follows:

Surgery, Diagnostic Lab and X-ray	**Tier 1:** 100% of the allowed amount, subject to a $**300** copay; **Tier 2 and 3:** 100% of the allowed amount, subject to a $**600** copay

Accidental Injury and Medical Emergency	100% of the allowed amount subject to the **$300** facility copay

- The **Physician Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following cost sharing amounts for the following benefits provided by a **PMD Physician**** as follows:

Office Visits and Outpatient Consultations	Subject to the calendar year deductible Covered at 80% of the allowed amount, after **$40** office visit copay*

- The **Preventive Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following cost sharing amounts for the following benefits provided by a **PMD Physician**** as follows:

Routine Well Child Office Visits	Subject to the calendar year deductible Covered at 80% of the allowed amount subject to **$40** office visit copay*

- The **Prescription Drug Benefits** matrix of the **Summary of Health Benefits** section of your Certificate is amended to change the following cost sharing amounts for the following benefits as follows:

Prescription Drugs	Subject to a **$300** prescription drug deductible per person each calendar year **$50** copay for Preferred brand**; $75** copay for Non-Preferred brand

- All **asterisks** (*) by any terms in this Amendment refer to the same footnotes that such asterisks referred to in your Certificate. Except as expressly modified herein, all other benefits, terms and conditions of your Certificate (as amended) remain in full force and effect.

Tim Sexton
Senior Vice President & Chief Marketing Officer

MKT-475-I

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE
Effective Date of Amendment: November 18, 2008

Special Open Enrollment Provisions for Former Physicians Medical Center Carraway Group Health Plan Members

Blue Cross and Blue Shield of Alabama is offering a one-time Special Open Enrollment to eligible persons who were formerly covered on November 30, 2008 under the Physicians Medical Center Carraway Group Health Plan administered by Blue Cross and Blue Shield of Alabama. **This is a temporary offering - You must apply before December 31, 2008.**

If you obtain coverage under the Blue Cross and Blue Shield of Alabama Special Open Enrollment Plan under this temporary offering, and you are a former Physicians Medical Center Carraway Group Health Plan member as described below, ***all of the provisions of the Special Open Enrollment Certificate apply to you except as provided below:***

Eligibility for This Certificate for Applicants who are Former Physicians Medical Center Carraway Group Health Plan Members

To be eligible for coverage, you (1) must be between 19 and 64 years of age and a resident of Alabama; (2) must have been covered on November 30, 2008 as an eligible employee under the Physicians Medical Center Carraway Group Health Plan administered by Blue Cross and Blue Shield of Alabama; (3) must not be covered by any other group or individual health plan (other than the Physicians Medical Center Carraway Group Health Plan); (4) must not be eligible for Medicare; (5) must not be covered by or receive assistance from Medicaid; and (6) must apply for coverage by December 31, 2008.

Applying for the Plan

To apply for the Special Open Enrollment Health Plan, you must fill out an application form completely and send it to us by December 31, 2008. You must name all eligible dependents to be covered on the application. Once your application has been accepted, you will receive an identification card and we will begin sending you a monthly billing statement (unless you elect an automatic payment option). Payment must be received within 30 days from your effective date. If accepted, your coverage begins on the following applicable date after receipt of your application: December 1, 2008, December 15, 2008 or January 1, 2009.

Eligible Dependents

Your eligible dependents (1) must meet the criteria described in the Certificate provision entitled “Eligible Dependents;” (2) must have been covered on November 30, 2008 as an eligible dependent under the Physicians Medical Center Carraway Group Health Plan administered by Blue Cross and Blue Shield of Alabama; (3) must not be covered by any other group or individual health plan (other than the Physicians Medical Center Carraway Group Health Plan); (4) must not be eligible for Medicare; and (5) must not be covered by or receive assistance from Medicaid.

If you choose to enroll for individual coverage, you will not be allowed to later convert to family coverage except for the following situations:

1. A dependent (spouse or child) acquired by marriage after December 31, 2008, and an enrollment application is submitted to us within 30 days of the marriage;

2. A child is born, placed for adoption or adopted after December 31, 2008, and an enrollment application is submitted to us within 30 days of the event.

Dependents in numbers one or two above not added within the specified 30 days will not be permitted to enroll at a later date.

Pre-Existing Condition and Exclusion Periods

The pre-existing condition exclusion period and the exclusion periods for some surgical procedures and for maternity care benefits described in the Certificate provision entitled “Pre-Existing Condition and Exclusion Periods” apply to all individuals eligible for this Special Open Enrollment for Former Physicians Medical Center Carraway Group Health Plan Members. However, we will credit the time you were covered under another prior plan toward the pre-existing condition exclusion period and the exclusion periods for some surgical procedures and for maternity care benefits described in the Certificate if (1) there is no greater than a 63-day break in prior coverage, and (2) the last coverage was “creditable coverage,” i.e., under an individual or group health plan including COBRA, Medicare, Medicaid, U.S. Military, TRICARE, Federal Employee Program, Indian Health Service, Peace Corps Service, State Children’s Health Insurance Program (SCHIP), a State risk pool or a plan established or maintained by a State, U.S. Government, foreign country or any political subdivision of a State, U.S. Government or foreign country.

Tim Sexton
Sr. VP and Chief Marketing Officer

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective Date of Amendment: September 1, 2008

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate.

Under the **Eligibility** section of your Certificate, the first three paragraphs of the **Eligible Dependents** subsection is hereby deleted and replaced with the following to read as follows:

Eligible Dependents

Your eligible dependents are:

1. Your spouse (of the opposite sex).

2. An unmarried child under age 25 who depends on you for over one-half support.

3. An incapacitated child who is not able to support himself and who depends on you for support, if the incapacity occurred before age 25 while he was dependent on you for over one-half support.

The child may be:

1. A natural child.
2. A stepchild residing in the household of the eligible insured.
3. A legally adopted child.
4. A child placed for adoption.
5. Any other unmarried child for whom the insured has permanent legal custody and who depends solely on the insured for support and regularly and permanently resides with the member in a parent-child relationship.

A grandchild is **not** an eligible dependent unless you adopt that child.

Gene Linton
Vice President Large Group Marketing and LTC

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective Date of Amendment: October 1, 2007

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your Certificate.

The Certificate is amended to add the following to the "Preventive Benefits" matrix in the Summary of Health Benefits section of the Certificate:

PHYSICIAN PREVENTIVE BENEFITS		
BENEFIT	**PMD PHYSICIAN****	**NON-PMD PHYSICIAN**
Routine Prostate Cancer Screening (Prostate specific antigen test and digital rectal exam) One screening each year for males age 40 and over	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount	Not covered

* PMD copays required for each office visit per person; PMD copays do not count toward your calendar year out-of-pocket maximum.

** Your 20% PMD coinsurance counts toward your calendar year out-of-pocket maximum.

Tommy Hudgins

Tommy Hudgins
Vice President, Sales

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective Date of Amendment: September 1, 2006

Special Open Enrollment Provisions for Fall 2006 Temporary Opening

Blue Cross and Blue Shield of Alabama will accept applications for enrollment into the Special Open Enrollment Plan from September 1, 2006 through November 30, 2006. **This is a temporary offering - You must apply before November 30, 2006.**

If you obtain coverage under the Blue Cross and Blue Shield of Alabama Special Open Enrollment Plan under this temporary offering, ***all of the provisions of the Special Open Enrollment Certificate apply to you except as provided below:***

Eligibility for This Certificate for Applicants for Fall 2006 Temporary Opening

To be eligible for coverage, you (1) must be between 19 and 64 years of age and a resident of Alabama; (2) must not be covered by any other group or individual health plan; (3) must not be eligible for Medicare; (4) must not be covered by or receive assistance from Medicaid; and (5) must apply for coverage by November 30, 2006.

Applying for the Plan

To apply for the Special Open Enrollment Health Plan, you must fill out an application form completely and submit it to us prior to November 30, 2006. You must name all eligible dependents to be covered on the application. Once your application has been accepted, you will receive an identification card and we will begin sending you a monthly billing statement (unless you elect an automatic payment option). Payment must be received within 30 days from your effective date. Your coverage begins on the first of the month following acceptance.

Eligible Dependents

Your eligible dependents (1) must be described in the Certificate provision entitled “Eligible Dependents;” (2) must not be covered under a group or individual health plan; (3) must not be eligible for Medicare; and (4) must not be covered by or receive assistance from Medicaid.

If you choose to enroll for individual coverage, you will not be allowed to later convert to family coverage except for the following situations:

1. A dependent (spouse or child) acquired by marriage after November 30, 2006, and an enrollment application is submitted to us within 30 days of the marriage;

2. A child is born, placed for adoption or adopted after November 30, 2006, and an enrollment application is submitted to us within 30 days of the event.

Dependents in numbers one or two above not added within the specified 30 days will not be permitted to enroll at a later date.

Tommy Hudgins

Tommy Hudgins
Vice President, Sales

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective Date of Amendment: March 1, 2006

Special Open Enrollment Provisions For Former HealthSpring of Alabama Members

Blue Cross and Blue Shield of Alabama is offering a one time Special Open Enrollment Plan to persons who are between 19 and 64 years of age and who were formerly covered under a HealthSpring of Alabama individual health insurance contract on or after January 31, 2006. **This is a temporary offering - You must apply before May 31, 2006.**

If you obtain coverage under the Blue Cross and Blue Shield of Alabama Special Open Enrollment Plan under this temporary offering, and you are a former HealthSpring of Alabama member as described below, ***all of the provisions of the Special Open Enrollment Certificate apply to you except as provided below:***

Eligibility for This Certificate for Applicants who are Former HealthSpring of Alabama Members

To be eligible for coverage, you (1) must be between 19 and 64 years of age and a resident of Alabama; (2) must have been covered under a HealthSpring of Alabama individual health insurance contract on or after January 31, 2006; (3) must not be covered by any other group or individual health plan (other than your HealthSpring of Alabama individual contract); (4) must not be eligible for COBRA coverage through an employer plan; (5) must not be eligible for Medicare; (6) must not be covered by or receive assistance from Medicaid; and (7) must apply for coverage by May 31, 2006.

Applying for the Plan

To apply for the Special Open Enrollment Health Plan, you must fill out an application form completely and give it to us prior to May 31, 2006. You must name all eligible dependents to be covered on the application. Once your application has been accepted, you will receive an identification card and we will begin sending you a monthly billing statement (unless you elect the automatic payment option). Payment must be received within 30 days from your effective date. Your coverage begins on the first of the month following acceptance.

Eligible Dependents

Your eligible dependents (1) must be described in the Certificate provision entitled “Eligible Dependents;” (2) must have been covered under a HealthSpring of Alabama individual health insurance contract on or after January 31, 2006; (3) must not be covered under a group or individual health plan (other than a HealthSpring of Alabama individual contract); (4) must not be eligible for COBRA coverage through an employer plan; (5) must not be eligible for Medicare; and (6) must not be covered by or receive assistance from Medicaid.

If you choose to enroll for individual coverage, you will not be allowed to later convert to family coverage except for the following situations:

1. A dependent (spouse or child) acquired by marriage after May 31, 2006, and an enrollment application is submitted to us within 30 days of the marriage;

2. A child is born, placed for adoption or adopted after May 31, 2006, and an enrollment application is submitted to us within 30 days of the event.

Dependents in numbers one or two above not added within the specified 30 days will not be permitted to enroll at a later date.

Tommy Hudgins

Tommy Hudgins
Vice President, Sales

MKT-475 -d

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA

SPECIAL OPEN ENROLLMENT CERTIFICATE

Effective Date of Amendment: September 27, 2005

Special Open Enrollment Provisions For Certain Individuals Impacted by Hurricane Katrina

Blue Cross and Blue Shield of Alabama is offering a one time Special Open Enrollment Plan to individuals who lost health insurance coverage due to Hurricane Katrina. **This is a temporary offering - you must apply before December 31, 2005.**

If you obtain coverage under the Blue Cross and Blue Shield of Alabama Special Open Enrollment Plan under this temporary offering, and you are an individual impacted by Hurricane Katrina as described below, ***all of the provisions of the Special Open Enrollment Certificate apply to you except as provided below:***

Eligibility for This Certificate for Individuals Impacted by Hurricane Katrina

To be eligible for coverage, you must have been a resident of the following affected Alabama counties on August 29, 2005 and thereafter - Baldwin, Mobile, Pickens, Greene, Hale, Tuscaloosa or Washington. If you are not a resident of the affected counties, but you lost your employer group health plan coverage because your employer was located in the affected counties, you may still be eligible for coverage. In addition, you must be at least 19 years of age. You and any covered dependents may not be covered by any other group or individual health plan, may not be eligible for COBRA coverage through an employer plan, may not be eligible for Medicare due to age or disability and may not be covered by or receive assistance from Medicaid.

Applying for the Plan

To apply for the Special Open Enrollment Health Plan, you must fill out an application form completely prior to December 31, 2005. You must name all eligible dependents to be covered on the application. Once your application has been accepted, you will receive an identification card and we will begin sending you a monthly billing statement (unless you elect the automatic payment option). Payment must be received within 30 days from your effective date. Your coverage begins on the first of the month following acceptance.

Eligible Dependents

Your eligible dependents are described in the Certificate provision entitled “Eligible Dependents.”

If you choose to enroll for individual coverage, you will not be allowed to later convert to family coverage except for the following situations:

1. A dependent (spouse or child) acquired by marriage after December 31, 2005, and an enrollment application is submitted to us within 30 days of the marriage;
2. A child is born, placed for adoption or adopted after December 31, 2005, and an enrollment application is submitted to us within 30 days of the event.

Dependents in numbers one or two above not added within the specified 30 days will not be permitted to enroll at a later date.

Pre-Existing Condition and Exclusion Periods

The pre-existing condition exclusion period and the exclusion periods for some surgical procedures and for maternity care benefits described in the Certificate provision entitled “Pre-Existing Condition and Exclusion Periods” apply to all individuals eligible for this Special Open Enrollment for individuals impacted by Katrina. However, if you were covered by a Blue Cross and Blue Shield of Alabama plan on August 29, 2005, we will give you credit for pre-existing condition waiting periods served under that plan.

Tommy Hudgins

Tommy Hudgins
Vice President, Sales
MKT-475-C

AMENDMENT TO SPECIAL OPEN ENROLLMENT CERTIFICATE

This is an amendment to your Special Open Enrollment Certificate, MKT-475. You should retain this amendment with your benefit certificate. The changes made by this amendment are effective for services or supplies rendered on or after September 1, 2005.

(1) The following table replaces the table of the same name under the SUMMARY OF HEALTH BENEFITS in your Certificate:

INPATIENT HOSPITAL BENEFITS		
BENEFIT	**PARTICIPATING HOSPITAL***	**NON-PARTICIPATING HOSPITAL**
Inpatient Hospital Coverage 365 days of care during each hospital confinement	$200 copay per day for the 1st through the 5th days 100% coverage after daily copay for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries**	Not covered **Exception for Accidental Injury or Medical Emergency:** Covered at 80% of the Allowed Amount subject to $1,000 calendar year deductible
Preadmission Certification	Required for all hospital admissions except maternity. Emergency admissions require notification within 48 hours of admission. **For precertification, call 1 800-248-2342 toll-free.**	

* Participating hospitals are those facilities contracted to do business with Blue Cross and Blue Shield of Alabama.
** If you are discharged and readmitted to a hospital within 90 days, the days of each stay will apply toward your 365 day maximum; Inpatient hospital days are limited to combined maximum of days in Participating and Non-Participating Hospitals.

(2) The following replaces the section called "Coverage after Age 64 and Eligibility for Medicare" which is found under (i) ELIGIBILITY AND PRE-EXISTING EXCLUSIONS, and (ii) COORDINATION OF BENEFITS in your Certificate:

Coverage after Age 64 and Eligibility for Medicare

If you become eligible for or entitled to Medicare, regardless of whether you actually obtain coverage under Medicare, you may continue to keep coverage under the plan, but the **only** benefits payable under the plan will be for services that are not included in the coverage of Medicare. This same rule applies to any of your covered dependents that become eligible for or entitled to Medicare. This results in the following:

For services or supplies that are included in the coverage of Parts A or B of Medicare or would be covered upon proper application and enrollment (e.g., most or all hospital and physician services), the plan will not pay primary, secondary or supplemental benefits to benefits under Parts A or B. The plan will not pay for the copays and deductibles left by Parts A or B, regardless of whether you have enrolled in Part B.

Effective January 1, 2006, for services or supplies that are included in the coverage of Part D of Medicare or would be covered under proper application and enrollment (i.e., most or all outpatient prescription drugs), the plan will not pay primary, secondary, or supplemental benefits to benefits under Part D. The plan will not pay for the copays, deductibles, or out-of-pocket expenses imposed under Part D, regardless of whether you have enrolled in Part D.

Important Note: Because this plan does not pay supplemental benefits to Medicare, you should consider enrolling in Medicare and purchasing a Medicare supplement contract when you become eligible for Medicare (generally upon attaining age 65). Medicare supplements - unlike this plan - are designed to fill in most of the gaps in coverage left by Medicare.

(3) In the "Definitions" section, the definition of Physician is amended to read as follows:

"Physician: One of the following when licensed and acting within the scope of that license at the time and place you are treated or receive 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.), and Psychologist (Ph.D., Psy.D. or Ed.d.) as defined in section 27-1-18 of the Alabama Code, Preferred Certified Registered Nurse Practitioners (CRNP) and Preferred Certified Nurse Midwives (CNM).

The term "physician" will also include a licensed physician assistant (P.A.) or surgeon assistant (S.A.) so long as the following requirements are satisfied at the time services are rendered: (i) the P.A. or S.A. is employed by and acting under the direct supervision of a medical doctor (M.D.) who is a preferred provider; (ii) the P.A. or S.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. or S.A.; and (iii), the services of the P.A. or S.A. would have been covered if provided directly by the M.D. "

Tommy Hudgins

Tommy Hudgins
Vice President, Sales

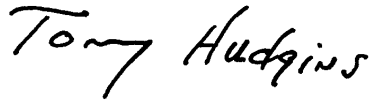
WELCOME

All of us at Blue Cross and Blue Shield of Alabama pledge to you that we will provide the best service we can in the administration of your health plan. The following certificate summarizes your benefits, and it summarizes conditions, limitations, and exclusions to those benefits. There are also sections explaining eligibility and defining certain words. Please be sure to read this information in its entirety. The best time to review the certificate is now… before you or someone in your family needs health care.

Except for emergency care for accidental injury or medical emergency, it is important that you use providers who contract services with Blue Cross and Blue Shield of Alabama in order to receive any benefits under this plan. We encourage you to use our network of Preferred Providers to get the most benefit from your Special Open Enrollment (SOE) coverage. Preferred Providers are identified in our Preferred Provider directories. You can get updated provider information by visiting our web site at **www.bcbsal.com** or by calling our Customer Service Department at 1-800-292-8868 or 988-2200 in Birmingham.

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 Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama 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.

If you have any questions, please call our Customer Service Department at 1-800-292-8868.



Tommy Hudgins

Vice President, Sales

This booklet contains a summary in English of your plan rights and benefits. If you have questions about your benefits please contact Customer Service at 1-800-292-8868. Simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

Atencion Por Favor – Spanish
Este folleto contiene un resumen en Inglés de su 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 1-800-292-8868. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.

MKT-475

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SUMMARY OF HEALTH BENEFITS

The following tables summarize your benefits and are subject to all other terms and conditions described in this certificate. You should carefully read the entire certificate to fully understand your benefits and coverage limits, including the limits on eligibility, pre-existing conditions, certain surgical procedures and maternity benefits. **Please be aware that most benefits under this certificate are limited to those services or supplies furnished by physicians, hospitals or other health care providers or facilities in Alabama with whom Blue Cross and Blue Shield of Alabama has a contract.** In addition, not all providers will be recognized by us as approved providers for the type of service or supply being furnished as explained more fully in the section titled, "Benefit Conditions."

GENERAL PROVISIONS	
Calendar Year Deductible*	The first $1,000 of covered expenses per person each calendar year $3,000 family maximum per year
Prescription Drug Deductible	The first $250 of covered prescriptions per person each calendar year
Calendar Year Out-of-Pocket Maximum **	$3,000 individual calendar year out-of-pocket maximum including the $1,000 calendar year deductible
Lifetime Maximum ***	$1,000,000 lifetime maximum for each covered member
Mental and Nervous Disorders and Substance Abuse	Benefits are only available when using an EPS provider; benefit details to follow later in this matrix and in the Benefits for Mental and Nervous Disorders and Substance Abuse section of this certificate.

* Deductibles are applied to claims in the order in which they are processed regardless of the order in which they are received. Deductible is not applicable to all services (see specific categories).

** The Out-of-Pocket Maximum does not include the inpatient hospital daily copay, copays to PMD Physicians, coinsurance to Non-Participating and Non-Preferred providers, prescription drug deductible and copays, or non-covered expenses. After the out-of-pocket maximum is met, services which are applicable to the out-of-pocket maximum will be paid at 100% of the Allowed Amount for the remainder of the year.

*** The $1,000,000 Lifetime Maximum for each covered member applies to all covered services.

INPATIENT HOSPITAL BENEFITS		
BENEFIT	**PARTICIPATING HOSPITAL***	**NON-PARTICIPATING HOSPITAL**
Inpatient Hospital Coverage 365 days of care during each hospital confinement	$200 copay per day for the 1st through the 5th days 100% coverage after daily copay for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries**	Not covered **Exception for Accidental Injury or Medical Emergency:** Covered at 80% of the Allowed Amount subject to $1,000 calendar year deductible
Preadmission Certification	Required for all hospital admissions except maternity. Emergency admissions require notification within 48 hours of admission. **For precertification, call 1 800-248-2342 toll-free.**	

* Participating hospitals are those facilities contracted to do business with Blue Cross and Blue Shield of Alabama.

** If you are discharged and readmitted to a hospital within 90 days, the days of each stay will apply toward your 365 day maximum; Inpatient hospital days are limited to combined maximum of days in Participating and Non-Participating Hospitals.

OUTPATIENT HOSPITAL BENEFITS* (Facility charges only – benefit charges for physician and other medical expenses may apply as detailed in the following sections.)		
BENEFIT	**PREFERRED OUTPATIENT FACILITY**	**NON-PREFERRED OUTPATIENT FACILITY**
Surgery, Diagnostic Lab and X-Ray	Covered at 100% of the Allowed Amount, subject to $200 facility copay	Not Covered
Dialysis, IV Therapy Chemotherapy and Radiation Therapy	Covered at 100% of the Allowed Amount, No copay required	Not Covered
Accidental Injury and Medical Emergency	Covered at 100% of the Allowed Amount, Subject to $200 facility copay	Covered at 80% of the Allowed Amount subject to the $1,000 calendar year deductible

* Benefits will be determined under "Major Medical Benefits" in the Summary of Health Benefits and Health Benefits sections of this booklet for (1) services in the emergency room if the patient's condition does not meet the definition of a Medical Emergency, and (2) outpatient hospital services not listed in this table. Outpatient benefits in Non-Participating Hospitals are available only in cases of Accidental Injury and Medical Emergency.

PHYSICIAN BENEFITS		
BENEFIT	**PMD PHYSICIAN****	**NON-PMD PHYSICIAN*****
Office Visits and Outpatient Consultations	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount after $30 office visit copay*	Subject to $1,000 calendar year deductible **In Alabama:** Covered at 50% of the Allowed Amount **Outside Alabama:** Not Covered
Emergency Room Physician Care	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount, after the $60 ER visit copay*	Subject to $1,000 calendar year deductible **In Alabama:** Covered at 50% of the Allowed Amount **Outside Alabama:** Covered at 80% of the Allowed Amount
Surgery and Assistant Surgery **Anesthesia** **Laboratory and Pathology** **X-Rays** **Chemotherapy and Radiation Therapy** **Second Surgical Opinions** **In-Hospital Physician Care** **In-Hospital Physician Consultations** **Maternity**	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount	Subject to $1,000 calendar year deductible **In Alabama:** Covered at 50% of the Allowed Amount **Outside Alabama:** Not Covered
Inpatient Physician Care for Accidental Injury and Medical Emergency	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount	Subject to $1,000 calendar year deductible **In Alabama:** Covered at 50% of the Allowed Amount **Outside Alabama:** Covered at 80% of the Allowed Amount

* PMD copays required for each office visit per person; PMD copays do not count toward your calendar year out-of-pocket maximum.

****** Your 20% PMD coinsurance counts toward your calendar year out-of-pocket maximum

******* The amount you must pay a Non-PMD physician does not count toward your calendar year out-of-pocket maximum. If you use a Non-PMD provider, you may have to file your claim, and you will be responsible for charges in excess of the Allowed Amount, applicable deductible, and coinsurance.

PREVENTIVE BENEFITS		
BENEFIT	**PMD PHYSICIAN****	**NON-PMD PHYSICAN**
Routine Well Child Office Visits Includes four visits during the first year of a baby's life and one visit each year for ages 1 through 5	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount subject to $30 office visit copay*	Not covered
Routine Immunizations (Age limitations apply to certain immunizations)	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount	Not covered
In-Hospital Visit for Routine Newborn Care	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount	Not covered
Laboratory Charges for Routine Pap Smear	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount, limited to one per year	Not covered
Laboratory Charges for Routine Mammogram	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount, limited to one baseline exam for females age 35-39 and one per calendar year for age 40 and over These limits may not apply if you have a family history of breast cancer.	Not covered

* PMD copays required for each office visit per person; PMD copays do not count toward your calendar year out-of-pocket maximum.

** Your 20% PMD coinsurance counts toward your calendar year out-of-pocket maximum.

MAJOR MEDICAL BENEFITS*		
BENEFIT	**PREFERRED PROVIDER**	**NON-PREFERRED PROVIDER**
Chiropractor Services **Limited to a maximum payment of $600 per person each calendar year**	Subject to $1,000 calendar year deductible Covered at 80% of Allowed Amount	Not covered
Home Health and Hospice Care	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount	Not covered
Occupational Therapy Services for the Hand and/or Treatment of Lymphedema; Physical Therapy **Limited to a combined maximum of 15 visits per person each calendar year**	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount	Subject to $1,000 calendar year deductible **In Alabama:** Covered at 50% of the Allowed Amount **Outside Alabama:** Not Covered
Durable Medical Equipment	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount	Subject to $1,000 calendar year deductible Covered at 80% of the Allowed Amount
Ambulance Services	Subject to $1,000 calendar year deductible Covered at 80% of Allowed Amount	
Allergy Testing & Treatment **Limited to a combined maximum of $200 per person each calendar year**	Subject to $1,000 calendar year deductible Covered at 80% of Allowed Amount	

* When using a Preferred or Participating Provider, the provider will bill us and we will pay him or her directly. You will be responsible for applicable deductibles, copays, and coinsurance. If you use a Non-Preferred or Non-Participating provider, you may have to file your claim, and you will be responsible for charges in excess of the Allowed Amount, applicable deductible, and coinsurance.

Benefits for Mental and Nervous Disorders and Substance Abuse **Note: Benefits are available only when using an Expanded Psychiatric Services (EPS) Provider. There are a limited number of these providers. They are listed on www.bcbsal.com under "Alabama Physician Finder" or you may call Customer Service for a listing.**			
BENEFIT	**Maximum Benefit Amounts**	**Deductible**	**Copay**
Facility Inpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage up to 30 days of inpatient care each calendar year when a member is admitted by an EPS Provider	No deductible	No Copay
Physician Inpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage up to 30 days of inpatient care each calendar year when a member is treated by an EPS Provider	No deductible	No Copay
Outpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage, no visit limit when treated by an EPS Provider	No deductible	No Copay

PRESCRIPTION DRUG BENEFITS	
Prescription Drugs	Subject to a $250 prescription drug deductible per person each calendar year $15 copay for generic; $30 copay for Preferred brand; $50 copay for Non-Preferred brand No benefits are available for drugs purchased at a Non-Participating Pharmacy or for brand name drugs for which there is a generic equivalent available See Prescription Drug Benefits in the Health Benefits section for a listing of the diabetic supplies in the program Note: To view the most current Preferred Brand Drug List, visit our web site at www.bcbsal.com. Your physician and pharmacist should also have access to the list.

INDIVIDUAL CASE MANAGEMENT	
Individual Case Management	Services available through Comprehensive Managed Care; see the Individual Case Management section for details

YOUR BENEFIT DESCRIPTIONS CONTINUE THROUGHOUT THIS CERTIFICATE. YOU SHOULD CAREFULLY READ THE ENTIRE CERTIFICATE TO FULLY UNDERSTAND YOUR BENEFITS AND COVERAGE LIMITS.

AMENDMENT TO BLUE CROSS AND BLUE SHIELD OF ALABAMA
2003 SPECIAL OPEN ENROLLMENT PLAN
Effective Date: October 20, 2003

SPECIAL OPEN ENROLLMENT PROVISIONS FOR HCTC ELIGIBLE INDIVIDUALS

On October 20, 2003, the State of Alabama certified the Blue Cross and Blue Shield of Alabama Special Open Enrollment program as a "qualified health plan" under the Health Coverage Tax Credit (HCTC) Program enacted under the Trade Act of 2002. Under the HCTC Program, HCTC eligible individuals may be entitled to assistance from the Federal government in paying health plan premiums for health coverage for themselves and their qualifying family members. If you are eligible for this assistance you should receive notification from the HCTC Program Office at the Internal Revenue Service in Washington, D.C. The HCTC Program Office makes all determinations of eligibility for the HCTC program. If you have any questions about eligibility for the HCTC Program or the details of that Program, you should contact the HCTC Customer Contact Center at 1-866-628-HCTC (4282), or you may read about the program on the internet at www.irs.gov/individuals/index.html.

If you obtain coverage under the Blue Cross and Blue Shield of Alabama Special Open Enrollment on or after October 1, 2003, and you are an HCTC eligible individual, ***all of the provisions of the Special Open Enrollment Certificate apply to you except as provided below:***

Eligibility for This Certificate

An applicant who is certified by the HCTC Program Office as an eligible individual under the HCTC Program ("HCTC eligible individual") is eligible for coverage under the Special Open Enrollment Plan, provided that the applicant is a resident of the State of Alabama and at least 19 years of age. If the HCTC eligible individual is applying for family coverage, he or she must have qualifying family members as determined by the HCTC Program Office. If an HCTC eligible individual or a qualifying family member later becomes ineligible for the HCTC Program, such individual may continue to be covered by this Plan, subject to the provisions of the Certificate set forth under "Eligible Dependents," "Coverage Termination Dates," and "Coordination of Benefits."

Applying for this Plan

To apply for the Special Open Enrollment Plan, you must fill out an application form completely and provide verification of your eligibility for the HCTC Program. You must also provide verification that any dependents you list on the application form are qualifying family members for the HCTC Program. The November 30, 2003 deadline that applies to other Special Open Enrollment applicants does not apply to HCTC eligible individuals and qualifying family members.

Eligible Dependents

If you are an HCTC eligible individual, the eligibility of your dependents for enrollment under the Special Open Enrollment Plan is determined solely by the HCTC Program Office and not by the Certificate provision entitled "Eligible Dependents." To be eligible to enroll in the Plan, your dependents must be

qualifying family members under the HCTC Program. If a qualifying family member later becomes ineligible for the HCTC Program, such member may continue coverage under this Plan, subject to the provisions of the Certificate set forth under "Eligible Dependents," “Coverage Termination Dates,” and “Coordination of Benefits.”

If you choose to enroll for individual coverage, you will not be allowed to later convert to family coverage unless you have or acquire a dependent who later becomes a qualifying family member under the HCTC Program.

Pre-Existing Condition and Exclusion Periods

The pre-existing condition exclusion period and the exclusion periods for some surgical procedures and for maternity care benefits described in the Certificate provision entitled “Pre-Existing Condition and Exclusion Periods” do not apply to an HCTC eligible individual if such individual was continuously covered for at least three months by another health plan before becoming covered by this Special Open Enrollment Plan, **and**

1. there is not a “break in coverage” of more than 63 days (i.e., the time from the date that the last health plan coverage terminated and the date that the individual applies for coverage under this Certificate is not more than 63 days); **and**

2. the last coverage was “creditable coverage”, (i.e., under an individual or group health plan including COBRA, Medicare, Medicaid, U.S. Military, Champus, Federal employee Program, Indian Health Service, Peace Corps Service, a State risk pool or a public health service).

HCTC eligible individuals who have prior health plan coverage that meets all of the above criteria and their qualifying family members are defined under the HCTC Program as “qualifying individuals.” These qualifying individuals are the only individuals who are not subject to the pre-existing and other exclusion periods under this Certificate.

All other references in this Certificate to pre-existing conditions or exclusions apply to all individuals covered by this Certificate except for “qualifying individuals” as defined above.

ELIGIBILITY AND PRE-EXISTING EXCLUSIONS

Eligibility for This Certificate

To be eligible to apply for benefits under this Certificate, an individual (1) must be a resident of the State of Alabama and between ages 19 and 64; (2) must not be eligible for or entitled to Medicare due to age or disability or Medicaid; (3) must not have health coverage under a group or individual policy or plan; and (4) must apply for coverage by November 30, 2003 except for newly acquired dependents, as described below. If the individual is applying for family coverage, he or she must have eligible dependents under age 65 who are not eligible for Medicare or Medicaid. After enrolling in this plan, members who become covered by another health plan or who become eligible for Medicare or Medicaid may continue to be covered by this plan, subject to the provisions set forth under Coverage Termination Dates and Coordination of Benefits, below. This certificate excludes benefits covered by Parts A or B of Medicare, regardless of whether the member is actually enrolled for coverage under Medicare or Medicaid.

Applying for the Plan

To apply for the Special Open Enrollment Health Plan, you must fill out an application form completely prior to November 30, 2003. You must name all eligible dependents to be covered on the application.

Eligible Dependents

Your eligible dependents are:

1. Your spouse (of the opposite sex).
2. An unmarried child under age 19.
3. An unmarried child age 19 to 25 while a full-time student in a state accredited school, not working full-time and chiefly depending on you for support.
4. An incapacitated child who is not able to support himself and who depends on you for support, if the incapacity occurred before age 19 (or 25 if a “full-time student”).

The child may be:

1. A natural child.
2. A stepchild residing in the household of the eligible insured.
3. A legally adopted child.
4. A child placed for adoption.
5. Any other unmarried child for whom the insured has permanent legal custody and who depends solely on the insured for support and regularly and permanently resides with the member in a parent-child relationship.

A grandchild is **not** an eligible dependent unless you adopt that child.

An individual who chooses to enroll for individual coverage will not be allowed to later convert to family coverage except for the following situations:

1. A dependent (spouse or child) acquired by marriage after November 30, 2003, and an enrollment application is submitted to us within 30 days of the marriage;

2. A child is born, placed for adoption or adopted after November 30, 2003, and an enrollment application is submitted to us within 30 days of the event.

Dependents in numbers one or two above not added within the specified 30 days will not be permitted to enroll at a later date.

Coverage Effective Dates

If we accept your application, you will receive an identification card and we will begin sending you a monthly billing statement (unless you elect the automatic bank draft payment option). Payment must be received within 30 days from your effective date. Your coverage begins on the effective date shown on your identification card. A newborn baby's effective date is its birth date when added within 30 days of birth to an existing policy. A dependent added to an existing policy by adoption is effective on the date of the placement for adoption if added within 30 days of the placement. A dependent added by marriage to an existing policy is effective on the date of the event if added within 30 days of marriage. If existing policy is a single plan, family dues difference must be collected within 30 days of marriage. Any dependent(s) not added within the time given will not be eligible to apply at any time.

If you only have individual coverage, you must apply and pay the additional fees for family coverage within 30 days of acquiring a new dependent to obtain coverage for him/her.

Pre-Existing Condition and Exclusion Periods

For Pre-Existing Conditions

The first 365 days you are covered under this plan there are no benefits for "pre-existing conditions." This does not apply to newborns enrolled within 30 days of birth or children under 18 who are adopted or have been placed for adoption and added to a family plan. A pre-existing condition is any condition, no matter how caused, for which you received medical advice, a diagnosis, care, or for which treatment was recommended or received during the two-year period preceding your enrollment date. Even if your condition is not diagnosed until after your enrollment date, we will treat your condition as pre-existing if treatment was recommended or received during the two-year period preceding your enrollment date for symptoms that are consistent with the presence of your condition.

Exclusion Period for Some Surgical Procedures

The first 365 days you are covered by this plan there are no plan benefits for removal of tonsils and adenoids, a hysterectomy, to put tubes in the ears, to replace any joint such as a knee, or to treat a birth defect. This applies to any related surgery, such as removing the ovaries with a hysterectomy. This does not apply to a newborn added within 30 days of birth or a child under 18 who has been adopted or placed for adoption and added to a family plan.

Exclusion Period for Maternity Care Benefits

Each female subscriber or wife of a male subscriber must serve a waiting period of 365 consecutive days before benefits for maternity care are available to her under this Certificate. There are no maternity care benefits for dependents other than a spouse of a male subscriber. The entire 365 day waiting period must be served before she receives services or supplies or is admitted to the hospital for maternity care.

Coverage after Age 64 and Eligibility for Medicare

If you become eligible for or entitled to Medicare, regardless of whether you actually obtain coverage under Medicare, you may continue to keep coverage under the plan, but the **only** benefits payable under the plan will be for services that are not included in the coverage of Medicare. This same rule applies to any of your covered dependents that become eligible for or entitled to Medicare. This results in the following:

For services or supplies that are included in the coverage of Parts A or B of Medicare or would be covered upon proper application and enrollment (e.g., most or all hospital and physician services), the plan will not pay

primary, secondary or supplemental benefits to benefits under Parts A or B. The plan will not pay for the copays and deductibles left by Parts A or B, regardless of whether you have enrolled in Part B.

Effective January 1, 2006, for services or supplies that are included in the coverage of Part D of Medicare or would be covered under proper application and enrollment (i.e., most or all outpatient prescription drugs), the plan will not pay primary, secondary, or supplemental benefits to benefits under Part D. The plan will not pay for the copays, deductibles, or out-of-pocket expenses imposed under Part D, regardless of whether you have enrolled in Part D.

Important Note: Because this plan does not pay supplemental benefits to Medicare, you should consider enrolling in Medicare and purchasing a Medicare supplement contract when you become eligible for Medicare (generally upon attaining age 65). Medicare supplements - unlike this plan - are designed to fill in most of the gaps in coverage left by Medicare.

Coverage Termination Dates

Plan coverage ends when the first of the following happens:

1. Contracts will be cancelled, as of the due date of the unpaid fees, if the payment is not received within 30 days of the due date.

2. A dependent's coverage ends on the first day of the month following the date he or she ceases to be a dependent.

3. The date of death for any member.

In all cases the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you in the proper amount has been made to that date. If it has not, termination will occur back to the date to which coverage was last paid.

Health Plan Changes

1. By giving 30 days notice in writing to the subscriber, we may change the amount of the payment for coverage or change, add, or remove any other provisions in the plan or in your coverage.

2. The notice of change will state the effective date of the change. The change will apply to all benefits for services you receive on or after the stated effective date.

3. The plan can be changed only through changes made in writing and signed by Blue Cross's officer in the manner stated above. None of Blue Cross's representatives, officers, employees, or agents can make any contract changes orally, as by telephone, or in any other way except in writing as described above.

Change in Family Status

Upon divorce, other termination of marriage or death of one or more members we must be notified within 30 days in order for coverage to continue for all affected members and for us to make any necessary changes in this coverage. For example, we need to establish separate contracts upon the divorce of covered members.

HEALTH BENEFITS

All benefits are subject to all deductibles, conditions, limitations and exclusions of the plan.

BEFORE YOUR HOSPITAL ADMISSION--CAUTION: One of several requirements for hospital benefits is that we certify the medical necessity of your hospital stay in advance, except for emergencies or when you are admitted to a Concurrent Utilization Review Hospital by a Preferred Medical Doctor. Emergency admissions require notice to us within 48 hours and must also be certified by us as both medically necessary and as an

emergency admission. You may appeal these decisions. **Failure to obtain our certificate of medical necessity will result in no benefits being paid for your hospital stay or the admitting physician.** Just because we certify a hospital admission as medically necessary does NOT mean we have decided to pay benefits for it. For example, the admission may be for a pre-existing condition or any other excluded condition.

Benefit Conditions

To qualify as plan benefits, medical services and supplies must meet the following:

1. They must be furnished after your coverage becomes effective.

2. Services or supplies for any pre-existing condition must be furnished after the 12-month (365 days) pre-existing condition exclusion period.

3. We must determine before, during or after services and supplies are furnished that they are medically necessary.

4. Preferred Care benefits must be furnished while you are covered by this plan and the provider must be a Preferred Provider when the services or supplies are furnished to you

5. Separate and apart from the requirement in paragraph 3, above, services and supplies must be furnished by a provider (whether a Preferred Provider or not) who is recognized by us as an approved provider for the type of service or supply being furnished. For example, we reserve 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 whether your provider is recognized by us as an approved provider for the services or supplies you plan on receiving.

6. Services and supplies must be furnished when the plan and your coverage both are in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the plan or your coverage ends.

Inpatient Hospital Benefits

1. Bed and board and general nursing care in a semiprivate room; **or**

2. Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them; **and**

3. Use of operating, delivery, recovery, and treatment rooms and the equipment in them.

4. Administration of anesthetics by hospital employees and all necessary equipment and supplies.

5. Casts and splints, surgical dressings, treatment and dressing trays.

6. Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and x-rays.

7. Physical therapy, hydrotherapy, radiation therapy and chemotherapy.

8. Oxygen and equipment to administer it.

9. All drugs and medicines used by you and administered in the hospital.

10. Regular nursery care and diaper service for a newborn baby while its mother has coverage.

11. Blood transfusions administered by a hospital employee,.

Note: Benefits for Non-Participating Hospitals in Alabama and all hospitals outside of Alabama are available only in cases of accidental injury or medical emergency.

Outpatient Hospital Benefits

1. Treatment of an accidental injury
2. Dialysis
3. Lab tests, x-rays and pathology services
4. Services of a Participating Ambulatory Surgical Facility
5. Surgery and related services
6. Chemotherapy and radiation therapy
7. IV therapy
8. Medical emergency

Note: Benefits for Non-Participating Hospitals in Alabama and all hospitals outside of Alabama are available only in cases of accidental injury or medical emergency.

Physician Benefits

1. Anesthesia for a covered service.
2. Second surgical opinion services.
3. Obstetrical care for childbirth, pregnancy, and the usual care before and after those services.
4. Inpatient visits while you're a hospital patient for other than surgery, obstetrical care, or radiation therapy except for an unrelated condition.
5. Consultation for a medical, surgical or maternity condition, but only one for each hospital stay.
6. Diagnostic lab, x-ray and pathology services when related to covered services but not allergy testing. (See "Major Medical Benefits" for diagnostic allergy testing benefits.)
7. Radiation therapy and chemotherapy.
8. Care in the emergency room of a hospital for other than surgery or maternity.
9. Exam, diagnosis, and treatment for an illness or injury excluding allergy treatment. (See "Major Medical Benefits" for diagnostic allergy testing benefits.)
10. Surgery which includes preoperative and postoperative care, reduction of fractures and endoscopic procedures, maternity deliveries and heart catheterization. The UCR and PMD fees for surgical care follow these rules:
    a. If two or more related surgical procedures are done in the same sessions, we allow for only the procedure with the largest fee. If the procedures are not related but done during the same session, we allow the full amount for the procedure with the largest fee and one-half of the fee for each of the others.
    b. For delivery of twins, triplets, etc., we allow the one largest fee, whatever the number of babies or how they are delivered.

c. When two different specialists assist each other to operate in the same field as co-surgeons, we allow each 75% of the fee for the surgery. We won't allow them more for assisting at surgery, as they assisted each other.

Note: Outside Alabama benefits are available only in cases of accidental injury or medical emergency

Preventive Benefits (only when using PMD)

1. Routine immunizations by a PMD physician to prevent diphtheria, tetanus, pertussis, polio, rubella, mumps, measles, Hib (meningitis, epiglottitis and joint infections), hepatitis B, chicken pox, and invasive pneumococcal disease in children during the first two years of life

2. Routine well child care office visits by a PMD physician for physical exams limited to four visits during the first year of the baby's life; annual exams for age one through five

3. One routine pap smear per calendar year by a PMD physician for females

4. One baseline mammogram by a PMD physician for females age 35-39; one mammogram a year by a PMD for age 40 and over. Limits may not apply if you have a family history of breast cancer.

Preferred Home Health and Hospice Benefits

Preferred Home Health Care benefits which are home IV therapy, intermittent home nursing visits by an R.N. or L.P.N. and home phototherapy for newborns. The services must be ordered by your physician and provided by a Preferred Home Health Care Provider. Services are only covered when rendered by a Preferred Home Health care provider. .

Preferred Hospice benefits which are physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management. The services and supplies are covered only when furnished by a Preferred Hospice Care Provider to a member certified by his physician to have less than six months to live.

Note: Private Duty Nursing Services are not covered under Preferred Home Health Care.

Major Medical Benefits

1. Semiprivate room and board, general nursing care, and all necessary hospital services and supplies when your inpatient hospital benefits are all used

2. Outpatient hospital services

3. Radiation therapy and chemotherapy

4. Lab and x-ray exams and other diagnostic tests

5. Diagnostic allergy testing and allergy treatment

6. Artificial arms and other prosthetics; leg braces and other orthopedic devices

7. Medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints

8. Treatment of natural teeth injured by a force outside your mouth or body, if service is received within 90 days of the injury

9. Professional ambulance service to the closest hospital that could treat the condition

10. The lesser of rental or purchase price of durable medical equipment such as wheelchairs and hospital beds

11. Dialysis services of a Participating Renal Dialysis Facility

12. Occupational therapy services when the following conditions are met:

    a. The services must be medically necessary and performed by a licensed occupational therapist.

    b. The services must be related to the hand and/or treatment of Lymphedema, and must be of a type that we cover under our occupational therapy program. Call Customer Service at the number on the back cover to determine what specific diagnostic codes and procedures are covered.

13. Physical therapy and hydrotherapy given by a licensed physical therapist

14. Chiropractic services

Benefits for Mental and Nervous Disorders and Substance Abuse

You must use EPS providers for treatment of mental and nervous disorders or substance abuse. EPS providers participate in a program called Expanded Psychiatric Service (EPS). The EPS program provides members with a broad range of services for treatment of mental and nervous disorders and substance abuse. You need to be sure that your treating and/or admitting physician is an EPS provider in order to receive any mental and nervous and substance abuse benefits. A list of EPS providers can be found in the Expanded Psychiatric Services Network directory:

1. Inpatient care for mental and nervous disorders and substance abuse;

2. Outpatient visits;

3. Individual, group and family therapy or counseling;

4. Psychological tests;

5. Lab tests;

6. Services by professional staff members such as psychologist and social workers trained in mental and chemical dependency;

The following treatment, services or supplies are not covered under the EPS program:

1. Speech therapy;

2. Diagnosis or treatment of mental retardation;

3. Rehabilitation of a temporary or permanent disability or for hearing or vision impairment;

4. Any treatment not recommended by the EPS provider, even if court ordered;

5. Treatment for chronic pain solely for obesity;

6. Services related to narcotic maintenance therapy such as methadone maintenance therapy;

7. Services related to nicotine addiction;

8. Sex therapy programs or treatment for sex offenders;

9. Prescription drugs (drugs are not dispensed by EPS providers but are covered according to contract benefits for drugs related to mental and nervous disorders and substance abuse);

10. Residential psychiatric facilities.

Prescription Drug Benefits

1. Benefits are only for prescriptions purchased from Participating Pharmacies. Prescriptions purchased from Non-Participating Pharmacies in any state or for brand drugs for which there is a generic equivalent available are not covered. Participating Pharmacies bill us and we pay them. You pay the copay and the amount of the drug if it is less than the copay, after the calendar year prescription drug deductible.
2. To be eligible for benefits, drugs must be legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal Law prohibits dispensing without a prescription." Compound drugs are covered if at least one of the drugs in the compound is a legend drug. In some cases, drugs may require prior authorization. Your participating Pharmacist will advise if this is a requirement.
3. Drugs can be dispensed in a maximum of a 30-day supply for each drug or refill. Refills are allowed only after 60% of the previous prescription has been used, e.g., 18 days into a 30-day supply.
4. Maintenance drugs (including certain diabetic supplies) can be dispensed up a maximum of a 90-day supply (a copay will be taken for each 30 day supply). Participating Pharmacies should have a list of maintenance drugs.
5. Insulin, needles and syringes purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. Blood glucose strips and lancets purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. Glucose monitors always have a separate copay. These are the only diabetic supplies available through the Prescription Drug program.

ADDITIONAL BENEFIT INFORMATION

Individual Case Management

Unfortunately, some people suffer from catastrophic, long-term, and chronic illness or injury. If you have a catastrophic, long-term or chronic illness or injury, a Blue Cross Registered Nurse may assist you in accessing the most appropriate health care for your condition. The nurse case manager will work with you, your physician, and other health care professionals to design a treatment plan to best meet your health care needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to you and your physician. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through Individual Case Management are subject to your benefit contract maximums. If you think that you may benefit from Individual Case Management, please call the Health Management division at (205)733-7067 or 1-800-821-7231.

If you suffer from certain long-term, chronic, diseases or conditions you may qualify to participate in the Care Management Program. Care 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 Care Management Program determines from your claims data that you are a good candidate for Care Management, the manager will contact you and ask if you would like to participate. Participation in the program is completely voluntary. If you would like to obtain more information about the program, call Customer Service at the number on the back cover.

Organ, Tissue and Bone Marrow/Cell Transplants

The organs and tissue for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas; (5) kidney; (6) heart-valve; (7) skin; (8) cornea; and (9) small bowel. Bone marrow transplants, which include stem cells and tissue to restore or make stronger the bone marrow function, are also included. The transplant must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve a facility for transplant services it is limited to the specific types of transplants stated. Donor organ costs are limited to search, removal, storage and transporting of the organ and removal team.
There are no transplant benefits for: (1) any artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other coverage; (4) if any government funding is provided; (5) the recipient is not covered by this plan; (6) recipient or donor room, food, or transportation costs

we did not approve in writing; (7) a condition or disease for which a transplant is considered investigational; (8) transplants performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

Mastectomy and Breast Reconstruction

As required by the Women's Health and Cancer Rights Act of 1998, a member who is receiving benefits for a medically necessary mastectomy will also receive coverage for:

1. reconstruction of the breast on which a mastectomy was performed;

2. surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. prostheses; and

4. treatment of physical complications to all stages of the mastectomy, including lymphedema.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same deductibles, coinsurance and/or copayment provisions that apply for the other medical and surgical benefits.

COORDINATION OF BENEFITS (COB)

We coordinate the benefits under this Certificate (also called a plan) with other health plans. The determination of which plan is primary is decided by the first rule below that applies. If this plan is secondary, it will not pay more than if it had been primary. If a member is covered by this contract and by another contract we issue, the member will be entitled to benefits only under the one that provides the most coverage.

1. If the other plan has no COB provision, it is primary.

2. Employer Sponsored Plan: The benefits of the plan which covers the person as an employee, former employee, retiree, COBRA beneficiary, or dependent of an employee, former employee, retiree, or COBRA beneficiary are determined before the benefits of this plan.

3. Non-Employer Sponsored Plan: The benefits of the plan which covers the person under a non-employer sponsored plan as an applicant or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

4. Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. If both plans don't use this "birthday rule" the other plan's rule will be used.

5. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:

    a. first, the plan of the parent with custody;

    b. then, the plan of the spouse of the parent with custody;

    c. last, the plan of the parent without custody.

    d. If there is a court order that specifically states that one parent must provide the child's health expenses, that parent's plan is primary.

6. Longer/Shorter Length of Coverage: If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

If this plan is secondary, it will not pay more than if it had been primary.

Coverage after Age 64 and Eligibility for Medicare

If you are eligible for Medicare, or become eligible for Medicare due to a disability, the only benefits that will be covered under your health coverage will be for services that are not included in the coverage of Parts A or B of Medicare, but are otherwise eligible for coverage under this plan – such as the purchase of authorized prescription drugs.

In other words, once you reach age 65 or become eligible for Medicare, your current health coverage will not pay primary, secondary or supplemental benefits to Medicare. Your coverage will not pay for any services included in the benefits provided by Medicare, nor will it pay for the copays and deductibles left by Medicare.

SUBROGATION

Right of Subrogation

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

Right of Reimbursement

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

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

Right to Recovery

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

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged you by your attorney for obtaining the recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

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

CLAIMS AND APPEALS

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

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

In General

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

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

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

Post-Service Claims

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

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

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

Processing of Claims: Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. The most common example of this is medical records that we may need in order to determine whether services or supplies were medically necessary. If we need this sort of additional

information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

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

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

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

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. For example, you may be required to obtain precertification 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. Pre-service claims pertain only to the medical necessity of a service or supply. If we grant a pre-service claim, we are not telling you that the service or supply is, or will be, covered; we are only telling you that the service or supply meets our medical necessity guidelines. For example, we might precertify your inpatient hospital admission but later deny your claim because the admission related to a pre-existing condition or was for a service or supply that is excluded under the plan.

In order to file a pre-service claim you or your provider must call our Health Management Department at 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review (CURP) hospital by a Preferred Medical Doctor (PMD Physician). If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from a Participating Chiropractor, Preferred Physical Therapist, or Preferred Occupational Therapist, your provider is responsible for initiating the precertification process for you. For home health care and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

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

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

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

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

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

Concurrent Care Determinations

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

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

- For inpatient hospital care, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy (if covered by your plan) call 205-220-7202.
- For care from a Participating Chiropractor (if covered by your plan) call 205-220-6128.

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

benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

Your Right To Information

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

Member Satisfaction

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write our Customer Service Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
- You may file an appeal if you have received an adverse benefit determination.

Your satisfaction is important to us. We will do our utmost to maintain it.

Appeals

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

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

In all cases other than determinations by us to limit or reduce previously approved care, you have 180 days following our 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 we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our Customer Service Department. You may also go to our Internet web site at www.bcbsal.com. Once there, you may ask us to send a copy of the form to you.

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

- the patient's name;

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

You must send your appeal to the following address:

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

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

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

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

- For inpatient hospital care and admissions, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy (if covered by your plan) call 205-220-7202.
- For care from a Participating Chiropractor (if covered by your plan) call 205-220-6128.

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

- For inpatient hospital care and admissions:

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

  and

- For Preferred Physical Therapy, Occupational Therapy, or care from a Participating Chiropractor (when covered by your plan):

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

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

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

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

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

We will consider your appeal fully and fairly.

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

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

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

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

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

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

- you may ask our Customer Service Department for further help;
- you may file a voluntary appeal (discussed below); or,
- you may file a claim for arbitration, as explained under the section of this booklet dealing with arbitration.

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

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

GENERAL INFORMATION

Discretionary Authority to Blue Cross

We have 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 administrative services under the plan. Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, our decisions will be determinative, subject only to your right of review under the plan and thereafter to arbitration to determine whether our determination was arbitrary or capricious.

ARBITRATION

IN CONSIDERATION OF COVERAGE UNDER THE PLAN, YOU (AND WE) AGREE THAT ANY ONE OR MORE OF THE FOLLOWING CLAIMS SHALL BE RESOLVED BY BINDING ARBITRATION:

- **ANY CLAIM THAT ARISES OUT OF OR RELATES TO THE PLAN;**
- **ANY CLAIM THAT INVOLVES ANY RELATIONSHIPS THAT RESULT FROM OR RELATE IN ANY WAY TO THE PLAN;**
- **ANY CLAIM THAT ALLEGES ANY CONDUCT BY YOU OR US, REGARDLESS OF WHETHER RELATED TO THE PLAN; OR,**
- **ANY CLAIM THAT CONCERNS THE VALIDITY, ENFORCEABILITY, SCOPE, OR ANY OTHER ASPECT OF THIS ARBITRATION PROVISION.**

EXCEPT AS OTHERWISE PROVIDED IN THE FIRST PARAGRAPH ABOVE, THIS ARBITRATION PROVISION IS INTENDED TO HAVE THE BROADEST SCOPE PERMISSIBLE BY LAW, AND INCLUDES ANY AND ALL CLAIMS, WHETHER IN CONTRACT, TORT, OR OTHERWISE, WHETHER ARISING BEFORE, ON, OR AFTER THE DATE OF COVERAGE UNDER THE PLAN, AND INCLUDING WITHOUT LIMITATION ANY STATUTORY, COMMON LAW, INTENTIONAL TORT, OR EQUITABLE CLAIMS.

THE ARBITRATION SHALL BE CONDUCTED IN ACCORDANCE WITH, AND WITHIN THE FIXED TIME LIMITS ESTABLISHED BY, THE AMERICAN ARBITRATION ASSOCIATION'S ("AAA") DISPUTE RESOLUTION PROCEDURES FOR INSURANCE CLAIMS (A COPY OF WHICH MAY BE OBTAINED BY WRITTEN REQUEST TO US), EXCEPT AS MODIFIED IN THE PLAN. THE CLAIMANT IS RESPONSIBLE FOR STARTING THE ARBITRATION PROCEEDINGS. WE WILL BEAR ALL COSTS OF ARBITRATION OTHER THAN YOUR COSTS OF REPRESENTATION. IF YOU INITIATE ARBITRATION, AND IF THE ARBITRATOR FINDS THAT THE DISPUTE IS WITHOUT SUBSTANTIAL JUSTIFICATION, THE ARBITRATOR HAS THE AUTHORITY TO ORDER THAT THE COST OF THE ARBITRATION PROCEEDINGS BE BORNE BY YOU.

THE ARBITRATION WILL BE CONDUCTED BEFORE A SINGLE ARBITRATOR IN THE COUNTY IN WHICH YOU RESIDE UNLESS YOU AND WE AGREE TO CONDUCT THE ARBITRATION IN SOME OTHER COUNTY. PRIOR TO THE ARBITRATION, IF ALL PARTIES CONSENT TO MEDIATE THE CLAIM, THE ARBITRATOR WILL REFER THE CLAIM TO A SEPARATE MEDIATOR, BUT ARBITRATION WILL FOLLOW IF NO SETTLEMENT IS REACHED. THE ARBITRATOR SHALL APPLY ALL APPLICABLE SUBSTANTIVE LAW, ANY STATUES OF LIMITATIONS, AND ANY CLAIMS OF PRIVILEGE RECOGNIZED BY LAW. THE ARBITRATOR SHALL BE EMPOWERED TO GRANT WHATEVER RELIEF WOULD BE AVAILABLE IN COURT UNDER LAW OR EQUITY, EXCEPT AS EXPRESSLY LIMITED IN THE PLAN. THE ARBITRATOR'S DECISION SHALL BE SPECIFIC ABOUT THE BASIS FOR THE DECISION, AND THE TYPE OF ANY DAMAGES OR RELIEF AWARDED. THE ARBITRATOR'S DECISION MAY NOT BE REVIEWED IN COURT EXCEPT TO THE LIMITED EXTENT PERMITTED UNDER THE FEDERAL ARBITRATION ACT, 9 U.S.C. SECTION 1 ET SEQ.

YOU UNDERSTAND AND AGREE THAT THIS ARBITRATION AGREEMENT IS MADE PURSUANT TO A TRANSACTION INVOLVING INTERSTATE COMMERCE, AND SHALL BE GOVERNED BY THE FEDERAL ARBITRATION ACT, 9 U.S.C. SECTION 1 ET SEQ. IF ANY PORTION OF THIS ARBITRATION PROVISION IS DEEMED INVALID OR UNENFORCEABLE, THE REMAINING PORTIONS SHALL CONTINUE IN FULL FORCE AND EFFECT.

Notice

We give you notice when we mail it or send it electronically to you at the latest address we have. You are assumed to receive notice three days after we mail it. You may mail notices to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858, with your full name and contract number. We get notice when it arrives at this address.

Correcting Payments

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

Responsibility for Providers

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

Misrepresentation

If you make any material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to your effective date. We need not even refund any payment for your coverage.

Respecting Your Privacy

To administer this plan we need your personal health information from physicians, hospitals and others. To decide if your claim should be paid or denied or whether other parties are legally responsible for some or all of your expenses, we need records from health care providers other insurance companies, and other plan administrators. By applying for coverage and participating in this plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer this plan or to perform any function authorized or permitted by law. You further direct all other persons to release all records to us about you and your minor dependents that we need to administer this plan. If you or any provider refuses to provide records, information or evidence we request within reason, we may deny your benefit payments.

Additionally, we may use or disclose your personal health information for treatment, payment, or health care operations, or as permitted or authorized by law, pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have prepared a privacy notice that explains our obligations and your rights under the HIPAA privacy regulations. To request a copy of our notice or to receive more information about our privacy practices or your rights, please contact us at the following contact office:

Blue Cross and Blue Shield of Alabama
Privacy Office
P. O. Box 2643
Birmingham, Alabama 35202-2643
Telephone: 1-888-246-5430

Multiple Coverage

If you are covered both by this contract and by a non-group contract we issue, you will be entitled to benefits only under the one that provides the most coverage for you.

HEALTH BENEFIT EXCLUSIONS

We **will not** provide benefits for the following:

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

2. Services, care, or treatment you receive during any period of time that we have not been paid for your coverage and that nonpayment results in plan termination.

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

4. Services, care, treatment or expense for cosmetic services including cosmetic surgery. This means any service that is done primarily to improve or change the way one appears. Examples include drugs used primarily to treat photo-aging, tanning beds used primarily for tanning purposes and not for the treatment of a medical condition such as psoriasis, girdles and other support garments used primarily to enhance appearance and not for a medical condition, and surgery performed primarily to improve or change appearance and not for reconstructive purposes.

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

   "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 Breast Reconstruction” 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.

   Please contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual fields measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.

5. 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).

6. 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, to those services by a

physician to treat or replace natural teeth which are harmed by accidental injury covered under Major Medical Benefits.

7. 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.

8. Dental treatment for or related to temporomandibular joint (TMJ) disorders. This includes Phase I and Phase II Treatment, therapy or exams, 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.

9. 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 hospital or medical services as such. Finally, it applies whether or not your employer has insurance coverage for benefits under the law.

10. 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. This applies even if the law does not cover all your expenses.

11. 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.

12. Routine well child care and routine immunizations except for the limited services described in the "Preventive Benefits" section.

13. Routine physical examinations except for the limited services described in the "Preventive Benefits" section.

14. 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.

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

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

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

18. Services or expenses for speech, recreational, educational, or occupational (except as stated covered previously) therapy.

19. Services and expenses provided to a hospital patient at a covered facility, which could have been provided on an outpatient basis, given the patient's condition and the services provided. Major Medical benefits for those services will apply as though the services were provided on an outpatient basis. Examples are hospital stays primarily for diagnosis, diagnostic study, medical observation, rehabilitation, physical therapy and hydrotherapy.

20. Services or expenses for, or related to, sexual dysfunctions or inadequacies not related to organic disease or which are related to surgical sex transformations.

21. Services for or related to pregnancy, including the six week period after delivery, of any dependent other than the member's wife.

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

23. Services or expenses for treatment of injury sustained in the commission of a crime or for treatment while confined in a prison, jail, or other penal institution.

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

25. Services or expenses for treatment of any condition including, but not limited to, obesity, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion includes bariatric surgery and gastric restrictive procedures and any complications arising from bariatric surgery and gastric restrictive procedures.

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

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

28. Services or expenses for or related to the treatment of infertility and/or 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.

29. Eyeglasses or contact lenses or related examination or fittings. One pair of eyeglasses, contact lenses or one pair of each will be considered under Major Medical if they replace the lens of the eye after eye surgery or injury or defect.

30. 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 refractive surgeries (including LASIKS) and any complications or later surgery related in any way to these procedures, even if medically necessary.

31. 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.

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

33. Hearing aids or examinations or fittings for them.

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

35. Services or expenses of private duty nurses unless previously stated as a covered service.

36. Services provided by Psychiatric Specialty Hospitals which do not participate with nor are considered members of any Blue Cross and/or Blue Shield Plan.

37. Services, care, treatment, or supplies furnished by a provider that is not recognized by us as an approved provider for the services rendered as explained more fully in paragraph 5 under the “Health Benefits” section of this summary called “Benefit Conditions.”

38. 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.

39. Services provided by Substance Abuse Facilities including Substance Abuse Residential Facilities.

40. 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 a Participating Pharmacy.

41. Drugs or medicines dispensed from a pharmacy that is not a Participating Pharmacy or for brand name drugs for which there is a generic equivalent available.

42. Travel, even if prescribed by your physician.

43. Treatment for mental and nervous disorders or disease (including alcoholism and drug addiction) except under your Expanded Benefits for Psychiatric Services.

44. Services or expenses of any kind provided by a Non-Participating Hospital for any benefits under this plan, except for inpatient and outpatient hospital benefits in case of accidental injury or medical emergency , as more fully described under "Inpatient Hospital Benefits" and "Outpatient Hospital Benefits".

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

46. Services or expenses for physical therapy which does not require a licensed physical therapist, 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.

47. Services or expenses in any federal hospital or facility except as provided by federal law.

48. Services or expenses for sanitarium care, convalescent care, or rest care.

49. Anesthesia services or supplies, or both, by local infiltration.

50. Services provided through teleconsultation.

51. Services received from providers who do not have a participating contract with Blue Cross and Blue Shield of Alabama except for accidental injury or medical emergency.

52. Services or expenses for treatment of sleep disorders.

53. Services provided by a Non-Participating Renal Dialysis Facility.

54. Services or expenses for or related to the treatment of impotence or erectile dysfunction, including prescription medications and surgery to implant or remove a penile prosthesis.

DEFINITIONS

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

Allowed Amount: The amount of a provider's charge that any Blue Cross Plan recognizes for payment for plan benefits. Payment for covered services is based on the usual, customary and reasonable (UCR) fee or the Fee Schedule that would otherwise be paid to a Preferred Provider furnishing the same services or supplies, as determined by us.

Alternative Benefits: A benefit program that gives you and your family an alternative to lengthy hospitalizations. It is designed to provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as “Comprehensive Managed Care,” “Individual Case Management,” and “Care Management.”

Application: The subscriber'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.

Certification of Medical Necessity: The written results of our review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours of the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not mean that you have paid us all monies due from you. Certification of medical necessity does not consider whether your admission is excluded by this plan.

Charge: The reasonable charge not exceeding the provider's actual charge regularly and customarily made for those services or supplies. For services or supplies furnished to a member by a Preferred Provider, "charge" means the amount for those services or supplies which Blue Cross has agreed upon with the Preferred Provider. In the case of services or supplies for which a usual, customary and reasonable fee exists (other than a Preferred Provider) the charge will be the UCR fee.

Concurrent Utilization Review Program (CURP): A program designed to promote the most efficient and effective use of health care resources while utilizing cost-effective methods to administer benefits.

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 "Exclusions" section.

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

Dependent: See the explanation in the "Eligibility and Enrollment" section.

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

Effective Date: The date on which the coverage of each individual subscriber and dependent begins as listed in Blue Cross's records.

Family Coverage: Coverage for a subscriber and one or more dependents.

Hospice: A Participating or a Non-Participating Hospice.

Hospital: A Participating or a Non-Participating Hospital as defined in this plan.

Individual Case Management: Benefits that are an alternative to more expensive covered benefits. They provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as “Comprehensive Managed Care” and “Care Management.”

Inpatient: A registered bed patient in a hospital.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:
* The technology must have final approval from the appropriate government regulatory bodies;
* The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
* The technology must improve the net health outcome;
* The technology must be as beneficial as any established alternatives; and,
* The improvement must be attainable outside the investigational setting.

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

Medical Emergency: A medical condition that 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: We use these terms to help us determine whether a particular service or supply will be covered. When possible, we develop written criteria (called medical criteria) that we use to determine medical necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is not medically necessary according to one of our published medical criteria policies, we will not pay for it. If a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be medically necessary only if we determine that it is:
* appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
* provided for the diagnosis or direct care and treatment of your medical condition;
* in accordance with standards of good medical practice accepted by the organized medical community;
* not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
* not "investigational"; and,
* performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

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

Member: A subscriber or eligible dependent who has coverage under the contract.

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

Non-Participating Home Health Care Agency: Any home health care agency which is not a Participating Home Health Care Agency, but which meets Medicare's definition.

Non-Participating Hospice: Any hospice which is not a Participating Hospice but which meets the conditions for participation in Medicare.

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those that are classified or could be classified under standards of the American Hospital Association as "special" hospitals. Examples of these "special" hospitals are those classified for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

Non-Participating Pharmacy: Any pharmacy that is not a Participating Pharmacy.

PMD Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

Participating Ambulatory Surgical Facility: Any facility with which Blue Cross has a Participating Ambulatory Surgical Facility contract for furnishing health care services.

Participating Home Health Care Agency: Any home health care agency in the state of Alabama with which Blue Cross has a contract.

Participating Hospice: Any hospice in the state of Alabama with which Blue Cross has a contract.

Participating Hospital: Any hospital with which Blue Cross has a contract for furnishing health care services.

Participating Pharmacy: Any pharmacy with which Blue Cross or its subsidiary, Preferred Care Services, Inc., has a contract for dispensing prescription drugs.

Participating Renal Dialysis Facility: Any freestanding Dialysis facility with which Blue Cross has a contract for furnishing health care services.

Physician: One of the following when licensed and acting within the scope of that license at the time and place you are treated or receive 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.), and Psychologist (Ph.D., Psy.D. or Ed.d.) as defined in section 27-1-18 of the Alabama Code, Preferred Certified Registered Nurse Practitioners (CRNP) and Preferred Certified Nurse Midwives (CNM).

The term "physician" will also include a licensed physician assistant (P.A.) or surgeon assistant (S.A.) so long as the following requirements are satisfied at the time services are rendered: (i) the P.A. or S.A. is employed by and acting under the direct supervision of a medical doctor (M.D.) who is a preferred provider; (ii) the P.A. or S.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. or S.A.; and (iii), the services of the P.A. or S.A. would have been covered if provided directly by the M.D. “

Plan: This Certificate describing the benefits of your Health Benefits Plan.

Preadmission Certification and Postadmission Review: 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 Care: A program whereby providers have agreements with Blue Cross to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical and surgical procedures, certain services and supplies to members entitled to benefits under the Preferred Care Program.

Preferred Medical Doctor or Preferred Physician: A physician who has an agreement with us to provide surgical and medical services to members entitled to benefits under the PMD Program.

Preferred Provider or Participating Provider: Any provider of health care services or supplies (such as a Preferred Physician, Preferred Medical Laboratory, Preferred Radiology Provider, or Preferred Outpatient Facility) who has an agreement with Blue Cross to furnish services or supplies to members entitled to benefits under the Preferred Care 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.

Private Duty Nursing: Nursing care provided in the patient's home by a licensed professional nurse (R.N.) or a licensed practical nurse (L.P.N.) who does not reside in the patient's home and is not related to the patient by blood or marriage.

Subscriber: The eligible person whose application for coverage under the contract is made and accepted by Blue Cross.

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

UCR (Usual, Customary and Reasonable Fee): That part of a provider's charge that we will allow as covered expenses. The usual, customary and reasonable value of the provider's service is based on historical data developed from the following criteria:

- How much he charges his patients for the same or a similar service
- The variance in the charges by most providers for the same service in the same geographic area, if possible
- Whether the procedure requires more time, skill, or experience than it usually requires
- The value of the procedure compared to other services
- Whether the UCR fee exceeds the PMD fee for the same services
- Out-of-state adjustments to account for the way providers charge in other states
- The rate of inflation using any generally recognized measure; this may cap any increase in the PMD fee

The UCR allowance will not exceed the amount the provider charges.

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

You, Your: The subscriber or member as shown by context.

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

Customer Service:
1-888-246-5430 toll-free

Preadmission Certification:
988-2245 (in Birmingham)
or 1-800-248-2342 toll-free

Rapid Response:
988-5401 (in Birmingham)
or 1-800-248-5123 toll-free

Web Site:
www.bcbsal.com

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Health Plan

MKT 475 (Rev. 8-2006)