14 Mandatory Second Surgical Opinions (Physician fee)

- Deductible not required.
- 100% of covered charges for QCP-listed physician.
- 100% of R&C when physician is QCP-approved, but not listed.

No coverage when physician is not QCP-approved or opinion is not authorized by QCP. Requirement may be waived by QCP.

15 Maternity Care (OB Fee for Pre- and Post-Natal Care)

- Deductible not required.
- PPO physician at 100% of covered charges.
- If you live in a PPO area, non-PPO physician at 80% of PA.
- If you do not live in a PPO area, non-PPO physician located outside of PPO area at 100% of R&C.
- If you do not live in a PPO area but come into PPO area for care, you must use a PPO physician to obtain maximum benefits.

COVERAGE FOR AMNIOCENTESIS PHYSICIAN FEE

- Pregnant women who will be 35 years of age on delivery date.
- PPO physician at 90% of covered charges, after $5 office visit copay and 10% of covered charges, no deductible.
- If you live in a PPO area, non-PPO physician at 80% of PA, deductible required.
- If you do not live in a PPO area, non-PPO physician located outside of PPO area at 90% of R&C, deductible required.
- If you do not live in a PPO area but come into PPO area for care, you must use a PPO physician to obtain maximum benefits.

16 Mental/Nervous Care

All mental/nervous care expenses (inpatient/outpatient), including substance abuse, are limited to a lifetime maximum of $150,000. Participants become eligible for additional $1,000 annual benefit in the year following calendar year in which $150,000 maximum lifetime benefit is reached. The $1,000 annual benefit does not apply to lifetime substance abuse benefit limits.

INPATIENT CARE

No benefit unless certified by QCP, including Medicare eligible participants. Benefits begin prospectively from the date QCP is contacted and certifies medical necessity.

- Admissions must be separated by 60 days to be considered a new admission.
- Deductible required.

HOSPITAL CHARGES OTHER THAN SUBSTANCE ABUSE

Days in the Hospital	PPO Hospital or No PPO in Area	Non-PPO Hospital Within Any PPO Area
< 30	100% of CC	90% of PA
30-59	95% of CC	85% of PA
60-89	90% of CC	80% of PA
90 or >	85% of CC	75% of PA

- Amount participant pays does not apply to OOP. Once OOP reached, these benefits do not increase to 100%.
- Participants who live outside PPO area but receive treatment within PPO area must use a PPO facility to obtain maximum benefits.

Physician Fees

- Deductible required.
- If you live in a PPO area and are admitted to a PPO facility by a PPO physician, 90% of covered charges.
- If you are admitted to a PPO facility by a non-PPO physician in a PPO physician area, the physician fees will be paid up to $75 maximum per visit (maximum to two visits per calendar week/52 visits per calendar year).
- If you live in a PPO area and are admitted to non-PPO facility located within a PPO area by either a non-PPO or PPO physician, their fees will be paid up to $75 maximum per visit (Maximum of two visits per calendar week/52 visits per calendar year).
- If you do not live in a PPO area and are admitted to a non-PPO facility outside of PPO area, 90% of R&C.
- Where there is not a PPO physician network, regular benefits apply.

OUTPATIENT CARE

Physician Fees

- Deductible required.
- 90% of R&C up to $55 maximum (increases to $57 on 1/1/95).
- Limited to two visits per calendar week, not to exceed 52 visits per year.
- Services must be performed by an approved provider.

After OOP limit is reached, payment limits still apply.

17 Out-of-Pocket (OOP) Limit

Individual: $1,100 (increases to $1,200 on 1/1/95)
Family: Two individual family members completely meeting their OOP limits
The following do not count toward OOP limit:

- Deductible.
- QCP penalty.
- Covered charges not paid due to COB.
- Copayments for the Mail Order Prescription Drug Program, PPO pharmacies & physicians and Emergency Room.
- Expenses not covered at all (e.g., expenses due to inpatient care for M/N conditions when not certified by QCP or as a result of a lower benefit schedule).
- Expenses above R&C or PA limits.
- Expenses exceeding the scheduled amount for inpatient and outpatient care of M/N conditions or chiropractic care.

18 Outpatient Pre-Admission Testing (Facility fee

- Deductible not required.
- PPO hospital at 100% of covered charges.
- If you live in a PPO area, non-PPO hospital at 100% of PA.
- If you do not live in a PPO area, non-PPO hospital located outside of PPO area at 100% of covered charges.
- If you do not live in a PPO area and come into PPO for care, you must use a PPO hospital to obtain maximum benefits.

19 Pap Smears Gynecological Exams

LAB TEST ONLY

- Deductible not required.
- PPO hospital at 100% of covered charges.
- If you live in a PPO area, non-PPO hospital located within PPO area at 100% of PA.
- If you do not live in a PPO area, non-PPO hospital located outside of PPO area at 100% of covered charges.
- If you do not live in a PPO area and come into PPO area for care, you must use a PPO hospital to obtain maximum benefits.

PHYSICIAN

- Deductible required.
- Up to $30 per calendar year for physician routine gynecological office visits, in addition to Pap smear covered charges.
- PPO physician at 100% of covered charges for Pap smear procedure only.
- If you live in a PPO area, non-PPO physician at 80% of PA.
- If you do not live in a PPO area, non-PPO physician located outside of PPO area at 100% of R&C
- If you do not live in a PPO area but come into PPO area for care, you must use a PPO physician to obtain maximum benefits.

20 Partial Hospitalization Substance Abuse Rehab Program (Alternate Benefit)

No benefit unless certified by QCP, including Medicare eligible participants. Benefits begin prospectively from the date QCP is contacted and certifies medical necessity.

- Deductible required.
- PPO hospital at 100% of covered charges.
- If you live in a PPO area, non-PPO hospital at 90% of PA.
- If you do not live in a PPO are, non-PPO hsopital at 100% of allowable expense.
- You must use a PPO facility to receive maximum benefits if receiving treatment in a PPO area, regardless of where you live.

Limits

- One program up to 30 days per lifetime.
- You may substitute an inpatient confinement in place of this program up to the cost of a partial hospitalization program.
- Must be separated by 180 days from an inpatient rehab to be considered a separate admission.
- Physician fees must be included in inpatient facility program charges.

21 Physician/Surgeon Fee (Inpatient/Outpatient/Office Visit)

- PPO physician at 90% of covered charges, no deductible ($5 copayment required for office visit).
- If you live in a PPO area, non-PPO physician at 80% of PA, deductible required.
- If you do not live in a PPO area, non-PPO physician located outside of PPO area at 90% of R&C, deductible required.
- If you do not live in a PPO area and come into PPO area for care, you must use a PPO physician to obtain maximum benefits.

INPATIENT PHYSICIAN VISIT

- Limited to one visit per day.
- Consultations limited to one per specialty per admission.

22 QCP Penalty

$250 for each failure to comply with QCP requirements (no calendar-year limit). More than one penalty may be applied for a single hospital confinement.

23 Prescription Drugs

PPO/PCS PHARMACY CARD PROGRAM
- For primary coverage only.
- Medicare primary participants
- Separate $350 annual family out-of-pocket limit.
- May purchase up to a 90-day supply or 200 dosages, whichever is greater.

Effective Jan. 1, 1993, through Dec. 31, 1994

Supply	PPO Copayments Generic/Brand Name	PCS Non-PPO Copayments Generic/Brand Name
30 days	$6/$10	$9/$13
31-60 days	$8/$12	$11/$15
61-90 days	$9/$13	$12/$16

Effective Jan. 1, 1995

Supply	PPO Copayments Generic/Brand Name	PCS Non-PPO Copayments Generic/Brand Name
30 days	$6/$11	$9/$14
31-60 days	$8/$13	$11/$16
61-90 days	$9/$14	$12/$17

- If you live in a PPO area that includes a PPO pharmacy, no benefits for prescription drugs purchased at a non-PPO/non-PCS pharmacy/facility. Cannot file claim with Blue Cross and Blue Shield of Alabama.
- If you live in a PPO area without a PPO pharmacy, participant may use PCS pharmacy or file claim under MAP.
- When a generic is available and allowed by the physician but not chosen, the benefit is the generic copayment for the supply written and participant pays the difference between the cost of the brand name and the generic copayment paid by MAP.
- Over-the-counter drugs and medical supplies are not covered, even if prescribed by a physician.

MAIL ORDER PRESCRIPTION DRUG PROGRAM
- For primary coverage only.
- Medicare primary participants.
- $7 copayment.
- When generic dispensed, $3 coupon returned to be used with next purchase.
- When a generic is available and allowed by the physician but not chosen, participant pays the $7 plus the difference in cost between the generic copayment amount and the brand name drug.
- Over-the-counter drugs and medical supplies are not covered, even if prescribed by a physician.

BLUE CROSS AND BLUE SHIELD OF ALABAMA
- For secondary coverage only.
- Deductible required and COB applies.

Generics
- 90% of R&C.

Brand Names
- If generic not available or generic not allowed by physician, 90% of R&C
- If generic available and allowed by physician but not chosen, only the generic copayment amount is paid

24 Well Child Care (Physician fee)

ANNUAL LIMIT
$250/child; $400/family

- Routine exams and immunizations to age 6.
- Annual screenings for ages 6 through 12.
- Deductible not required.
- $5 copayment.
- PPO physician at 90% of covered charges.
- If you live in a PPO area, non-PPO physician located within PPO area at 80% of PA.
- If you do not live in a PPO area, non-PPO physician located outside of PPO area at 90% of R&C.
- If you do not live in a PPO area but come into PPO area for care, you must use a PPO physician to obtain maximum benefits.

Prenatal vitamins are covered under this provision.

25 Well Baby Care (Physician fee)

- Limited to one visit during mother's confinement.
- Deductible not required.
- PPO physician at 90% of covered charges.
- If you live in a PPO area, non-PPO physician located within PPO area at 80% of PA.
- If you do not live in a PPO area, non-PPO physician located outside of PPO area at 90% of R&C.
- If you do not live in a PPO area but come into PPO area for care, you must use a PPO physician to obtain maximum benefits.

Eligibility

Regular full-time, regular part-time, and retired employees of participating companies are eligible to participate in MAP. Your dependents are also eligible for coverage as long as you enroll them and they qualify as dependents (as defined in the Appendix).

If requested, you may be required to furnish documentation to substantiate any information you have provided in connection with the eligibility of claimed dependents. Such requested documentation may include, as appropriate, cancelled checks, receipts, signed leases, income tax returns, school records, birth certificates, marriage licenses, etc. Falsification or misrepresentation of information provided by you could result in denial of coverage, disciplinary action up to and including dismissal, and/or reimbursement by you to the company for any claims paid inappropriately, as a result of falsification or misrepresentation.

How to Enroll/Change Enrollment

If you are an active, non-management employee or a retiree (management or non-management) of:

- BellSouth Advertising & Publishing Corporation or;

If you are retired from:

- BellSouth Enterprises, Inc.
- BellSouth International, Inc.
- BellSouth Resources, Inc.
- BellSouth Information Systems, Inc.
- SunLink Corporation
- BellSouth New Media, Inc.
- BellSouth Mobility Inc

... you must complete an enrollment form and forward it to the appropriate Benefit Office when enrolling or making changes in your enrollment status for you and your dependents.

If you are employed or retired from ...

- BellSouth Business Systems
- BellSouth D.C., Inc.
- BellSouth Communications, Inc.
- BellSouth Telecommunications, Inc.
- BellSouth Communication Systems (Employees who participate in the BellSouth Personal Retirement Account Pension Plan or the BellSouth Pension Plan)
- BellSouth Corporation
- BellSouth Financial Services Corporation

... you can enroll in MAP or make changes to your enrollment by calling the Active or Retiree Benefit Office. See the section "Plan Administrator" on page 72 for telephone numbers.

Please have the following information available when you call:

- Social Security number(s) for you and any dependents you are enrolling. (If you are enrolling a newborn child, the social security number may be provided later.) A Social Security number is required for all dependents one year of age or older.
- Birthdates for any dependents you are enrolling.
- Your dependents' addresses, if different.
- The name, address, and policy number of any other insurance (including Medicare) for you or your dependents, if applicable.
- For working spouses, date employed and number of hours your spouse works per week.

When changes are made, active employees will receive a confirmation letter through company mail. The Active Benefit Office, located in Birmingham, records all calls for accuracy and verification.

Note: You cannot be enrolled as a covered employee/retiree and a covered dependent at the same time. In addition, no one can be enrolled and covered as a dependent of more than one employee/retiree at the same time.

Disabled Dependent Certification Requirements

A disabled dependent must be certified through your Benefit Office. The company may request recertification of disability or incapacitated status. A Disabled Dependent Eligibility Request Form may be obtained by contacting your Benefit Office.

Spouses Employed by the Same BellSouth Company

If you and your spouse are employees of the same participating company, you are both eligible for coverage under MAP. You have three options:

- You and your spouse each may be covered as an employee. Your eligible dependents must be enrolled with the spouse who has the earlier birthday (month/day) during the year. If you and your spouse were born on the same day of the same month, your dependents must be enrolled with the older spouse;
- You may waive employee coverage and be enrolled as a dependent under your spouse's coverage; or
- Your spouse may waive employee coverage and be enrolled as a dependent under your coverage.

Spouses Employed by Different BellSouth Companies

If you and your spouse are employees of different participating companies and you are both eligible for coverage under MAP, you and your spouse may not waive coverage as an employee.

Your eligible dependents must be enrolled with the spouse who has the earlier birthday (month/day) during the year. If you and your spouse were born on the same day of the same month, your dependents must be enrolled with the older spouse.

Spouses Retired from BellSouth Companies

If you and your spouse are both retired employees of a participating company but one of you has to pay for coverage, the one who must pay may waive coverage as a retired employee and be covered by the other as a dependent.

If you are retired and your spouse is an active employee of a participating company, you may waive retiree coverage and be covered as a dependent of your spouse. However, an active employee cannot waive active coverage and be covered as a dependent of a retired spouse.

When Coverage Starts

Before You Complete Six Months of Service

If you are a new, regular full-time or regular part-time employee, you may enroll for individual or dependent coverage within 31 days of your date of hire by calling the Benefit Office and by paying the full cost of coverage. (See the section "How to Enroll/Change Enrollment" on page 14.) If you elect to pay, coverage will be effective on the first day of the month after your call.

Following Completion of Six Months of Service

If you did not enroll within 31 days from your date of hire, coverage will begin automatically on the day you complete six months of net credited service as a regular full-time employee or a regular part-time employee who works:

- 25 or more hours a week (if hired after Dec. 30, 1980, but prior to Jan. 1, 1990), or
- 37.5 or more hours a week (if hired on or after Jan. 1, 1990).

If you are a regular part-time employee whose coverage is not fully and automatically provided by the company based on the hours you worked (as explained above) and you did not enroll for coverage within 31 days of your date of hire, you may elect to pay for coverage after completing six months of service. Coverage will be effective on the first day of the month following the date you call the Benefit Office to enroll.

Dependent Coverage

Coverage for your dependents (as defined in the Appendix) will be effective on the same day as your coverage as long as you have enrolled them.

If you enroll your dependents after your coverage begins, the effective date of their coverage will depend on the following:

- If the company pays the full cost of dependent coverage, coverage will be effective retroactive to the later of the date when:
  - Your coverage began, or
  - Your dependent qualified as a dependent under MAP.
- If you are required to pay all or part of the cost of the dependent(s)'s coverage, coverage will be effective on the date your dependent qualifies as a dependent under MAP as long as you enroll him/her within 31 days of the date he/she qualified for coverage. If you do not enroll your dependent within 31 days, coverage will be effective on the first day of the month after you call your Benefit Office to enroll your dependent.

Adoption Benefits

When a child is placed in the participant's home for the purpose of adoption, the child will be treated as a Class I dependent. The coverage effective date will be the day the child was placed in the home. The pre-existing condition provision will not apply. Documentation may be required to verify the day the child was placed in the home.

Leaves of Absence

If you return from an approved leave of absence (other than a military leave) as a regular full-time employee, and you did not continue your

coverage while on leave, coverage will begin automatically on the first day of the month following the date you return from leave, provided you have already completed six months of net credited service.

If you are a regular part-time employee and your scheduled equivalent work week classification is less than 37.5 hours a week, you must re-enroll for coverage.

If you return from a military leave, your coverage will begin on your date of reinstatement, provided you return to work before loss of mandatory reinstatement rights under the law.

All dependents must be re-enrolled for coverage.

If you go on a leave that qualifies under the Family Medical Leave Act of 1993 (FMLA), you may be eligible for up to 12 weeks of company-provided medical coverage. Contact the Benefit Office for details.

Cost

Employees and Class I Dependents

Full-Time Employees

The company pays the full cost of coverage for you, your spouse, and other Class I dependents beginning on the date you complete six months of net credited service. If you want coverage prior to that time, you must pay the full cost.

Part-Time Employees

If you are hired or re-engaged after a service break on or after Jan. 1, 1990, you will be required to pay a portion of the cost of your medical coverage for any periods during which you are classified as a regular part-time employee and during which you work less than 37.5 hours per week. The amount you will be required to pay will be based on the percentage of hours you worked compared to a 37.5-hour work week.

For example, if you work 7.5 hours each day for three days a week (a total of 22.5 hours each week), that is 60 percent of a 37.5-hour work week. The company will pay 60 percent of the cost of your coverage – individual, two-party, or family. You will be required to pay the remaining 40 percent of the cost.

If you were hired after Dec. 31, 1980, and were on the payroll on Dec. 31, 1989, as long as you remain continuously employed thereafter (no service break), your weekly cost for periods in which you are classified as a regular part-time employee will be the lesser of the cost in effect on Jan. 1, 1990, and the cost in effect for the period from Dec. 31, 1980, through Dec. 31, 1989.

As information, the percentage paid by the company for employees hired during the period from 1981 through 1989 was based on the following schedule:

Your Weekly Work Schedule	Cost Paid By BellSouth
Less than 17 hours	0%
17-24 hours	50%
25 or more hours	100%

If you were hired prior to Jan. 1, 1981, no contribution is required as long as you were classified as a regular part-time employee after Dec. 31, 1989, and your period of work has been continuous (no service break) since Dec. 31, 1980.

Employees on Leave of Absence

Employees on an approved leave of absence in excess of one month (other than a military leave) must pay the full cost if coverage is desired.

Employees on Care of Newborn Child or Dependent Care Leaves

If the leave is an approved Care of Newborn Child Leave or a Dependent Care Leave which starts on or after Jan. 1, 1990 (provided you were eligible to receive full company-paid coverage prior to the leave), the company will pay the full cost of coverage for up to six months during the leave in any two-year period.

Employees on Sabbatical Leave of Absence

The company will continue to provide coverage for employees on an approved Sabbatical Leave of Absence. Coverage may be continued for Class II and sponsored dependents by continuing to pay the premiums on time.

Employees on Military Leave

Coverage for employees on approved military leaves ends on the last day of the month in which the leave begins. However, dependent coverage may be continued under COBRA (see the section "When Coverage Ends or Changes" on page 61).

Retirees and Class I Dependents

Service or Disability Pension Effective Prior to Jan. 1, 1988

The cost of coverage for you, your spouse, and your other Class I dependents whose coverage began prior to Jan. 1, 1988, is paid in full by the company. However, you must pay the full cost of coverage for your Class I dependents, other than your spouse, added on or after Jan. 1, 1988. The cost of coverage for a spouse added after Jan. 1, 1988, is paid in full by the company.

Service or Disability Pension Effective on or after Jan. 1, 1988, but before Jan. 1, 1992

The cost of coverage for you, your spouse, and your other Class I dependents whose coverage began before your effective retirement date is a percentage based on your years of employment, as shown in the following chart:

Years Of Employment	% Of Cost BellSouth Pays	% Of Cost You Pay
30 or more	100%	0%
20-29	90%	10%
15-19	80%	20%
Less than 15	70%	30%

If you retired on or after Jan. 1, 1988, you must pay the full cost of coverage for your Class I dependents, other than your spouse, added on or after your retirement. The cost of coverage for a spouse added after you retire is the same as the cost of your coverage (see chart on page 18). You are not required to pay the prorated premium if you retire under an early retirement program or severence program that waives the premium; i.e., VEER/VEER '91, or if you retire out of a declared Career Transition Assistance Plan (CTAP) surplus universe.

Service or Disability Pension Effective on or after Jan. 1, 1992

The cost of coverage for you, your spouse, and other Class I dependents whose coverage began before your retirement will be paid by the company beginning in 1993 and each year thereafter, up to the capped amount (1990 actual cost increased by 11.4 percent).

Effective Jan. 1, 1993, your share of the cost for that year and each year thereafter will be the excess of the annual cost in effect two years prior to the year in question and each year thereafter over the capped amount (1990 actual cost increased by 11.4 percent), plus the proration of the cost based on your years of employment (see chart on page 18).

For example, the annual cost in 1993 would be determined by subtracting the capped amount from the 1991 cost. This is in addition to the proration based on your years of employment.

Non-Management Employees

For non-management employees, a Retiree Premium Offset Fund was established that will be applied toward the premium cost through 1995. In addition, a premium will not be required prior to Jan. 1, 1996. The prorated premium for less than 30 years of service will not be affected by this agreement and will still apply.

Management Employees

Since the capped amount is the 1990 cost increased by 11.4 percent, a premium will not be required for management employees until the costs exceed the capped amount, which is estimated to occur on Jan. 1, 1994. The 1994 cost will be determined by subtracting the capped amount from the 1992 cost. The prorated premium for less than 30 years of service will not be affected by this agreement and will still apply.

Retirement under the Supplemental Income Protection Plan on or after January 1990

If you retire under a formal surplus force-reduction program, presently known as the Supplemental Income Protection Plan (SIPP), the Expanded Supplemental Income Protection Plan (ESIPP), or any successor plan, and have less than 30 years of service, you will not be required to pay the prorated percentage of the chart on page 18. You must pay the full cost of coverage for Class I dependents, except your spouse, added after the effective date of your retirement. The cost of coverage for your spouse added after retirement is paid in full by the company.

However, if you retire under SIPP or ESIPP on or after Jan. 1, 1992, you will have to pay the premium associated with the increase in cost above the capped amount (1990 actual cost increased by 11.4 percent).

Class II Dependents

The cost of coverage for Class II dependents enrolled on or before Jan. 1, 1988, is 50 percent of the total cost of coverage for a Class II dependent.

The cost of coverage for Class II dependents enrolled after Jan. 1, 1988, and for Class I dependents reclassified as Class II dependents after Jan. 1, 1988, will be the total cost of coverage for a Class II dependent. Contact your Benefit Office for the rates.

Sponsored Children

You pay the full cost of coverage for these dependents. Contact your Benefit Office for the rates.

Paying for Coverage

If you pay for coverage, payments are made as follows:

- Active employees pay through payroll allotments.
- Retired employees pay through pension allotments.
- Retired employees who elected a lump-sum option in lieu of a monthly pension pay directly to Blue Cross and Blue Shield of Alabama.
- Direct bill participants, such as COBRA-covered individuals, surviving spouses, extended medical participants, etc., pay directly to Blue Cross and Blue Shield of Alabama.
- Long Term Disability Plan non-pension eligibles pay directly to Blue Cross and Blue Shield of Alabama.

How MAP Works

Important Facts to Remember

When reviewing your MAP benefits, please remember:

- Most MAP provisions (e.g., PPO hospital requirements) apply whether MAP is the primary or secondary plan, except for Medicare participants.
- If MAP is your primary plan, precertification through the Quality Care Program (QCP or Blue Cross and Blue Shield's Managed Care Program for Alabama employees and retirees) is required for all inpatient admissions.
- Outpatient physical therapy (includes occupational and speech) must be precertified by QCP (or Blue Cross and Blue Shield's Managed Care Program for Alabama employees and retirees).
- Whether MAP is your primary or secondary plan, precertification is required for all mental/nervous admissions as well as for services considered to be Alternate Benefits.
- PPO provisions may affect MAP benefit levels (see "Hospital Care Benefits," page 27; "Physician/Surgeon Care Benefits," page 31; and "Mental and Nervous Benefits," page 36).
- MAP is designed to cover medical treatment for illness or injury. Routine checkups are not covered, except for certain mammograms, Pap smears, and well child care, specifically identified under MAP.
- Although MAP covers many services, certain items and services are not covered (see "Additional Plan Provisions" on page 43).
- MAP covers licensed physicians and some other providers of service. However, not all providers are eligible for coverage (see "Physician/Surgeon Care Benefits" on page 31).
- You have several options when purchasing prescription drugs. If your physician allows generic substitution, you can maximize your benefits by choosing a generic.

• If you or your dependents become eligible for other insurance coverage, MAP benefits may be affected whether or not you enroll with the other option.

Overview

MAP pays a specified percentage of covered charges, and you pay the remainder of the expenses. However, for some expenses, you must first satisfy the deductible before MAP begins paying benefits.

The percentage of covered charges MAP pays depends on the way you use the plan. To receive maximum MAP benefits, you must:
• Comply with QCP requirements (see "Quality Care Program" on page 24);
• Use Preferred Provider Organization (PPO) hospitals, physicians and pharmacies when they are available;
• Use other cost-effective plan features (such as outpatient surgery).

A PPO network may include hospitals, pharmacies, and physicians separately or in combination who contract with BellSouth to provide medical services at negotiated fees. QCP can tell you whether or not you live in a PPO area (defined in the appendix). If you do, QCP can provide you with the names of the PPO hospitals and physicians in your area.

MAP features that can minimize your out-of-pocket expenses are explained throughout this booklet. They include, but are not limited to, receiving medical care where appropriate (such as having minor surgery performed on an outpatient basis instead of inpatient) and obtaining a confirming second surgical opinion when required. The following sections explain in more detail how these various features can affect your benefit payments.

Covered Charges

Covered charges (defined on page 2) are medically necessary expenses incurred for the treatment of a non-occupational illness or injury. Following are some of the services and expenses covered under MAP:
• Hospital care.
• Outpatient care.
• Physician/Surgeon care.
• Prescription drugs.
• Certain charges for Durable Medical Equipment (defined in appendix).

Your MAP coverage may change periodically. Benefits will be determined by the provision in effect at the time the services are provided.

Covered charges are explained in greater detail in the remainder of this booklet.

Individual Deductible

In most cases, you pay the first $180 of covered expenses for yourself and each dependent each calendar year before MAP begins to pay benefits. Once the deductible requirement has been satisfied, MAP will pay a percentage of covered charges – generally 90 percent. However, the deductible is waived when you take advantage of certain cost-saving plan incentives, such as obtaining services through a PPO physician.

The deductible must be met each calendar year from that year's covered expenses.

Family Deductible

Under MAP your family deductible will be met each calendar year on the earlier of the date when:

- Covered charges applied toward your deductible and/or other family members' individual deductibles total $425, or
- Two $180 individual deductibles have been met.

The deductible will be applied to your claims in the order in which they are processed by the claims administrator, regardless of the order in which they are received.

Once the family deductible is met, no additional covered expenses are applied toward any family member's individual deductible for the rest of the calendar year, even if you and your spouse are employees of different BellSouth participating companies. MAP then considers any future claims that year as if each family member has satisfied the individual deductible requirement.

For example, suppose you submitted $90 in covered charges which applied toward your individual deductible. In addition, you submitted covered charges totaling $150 for your son, $100 for your daughter, and $85 for your spouse – all of which applied toward each person's deductible.

Since the amounts applied toward individual deductibles total $425, the family deductible has been satisfied. This means that each family member's covered charges for the balance of the year will be processed, and benefits will be paid as if each had satisfied his/her individual deductible requirement. Also, the family deductible would be met if your son and daughter each met the $180 individual deductible.

Individual Out-of-Pocket Limit

To protect you from the catastrophic costs of a serious illness or injury, MAP places a $1,100 maximum out-of-pocket limit on the amount you and each of your covered dependents must pay each calendar year for covered charges.

Once the out-of-pocket limit of $1,100 in covered charges has been reached by you or a covered dependent, the MAP benefit level increases to 100 percent for covered charges incurred for the remainder of that calendar year for that individual. However, benefits for mental/nervous conditions do not increase when the out-of-pocket limit is reached (see "Mental and Nervous Care Benefits" on page 36). In addition, copayments (e.g. PPO Pharmacy and Mail Order Prescription Drug) will continue to be required after the out-of-pocket limit is reached.

Effective Jan. 1, 1995, the individual out-of-pocket limit will increase to $1,200.

Family Out-of-Pocket Limit

Once two family members each reach their individual out-of-pocket limits, even if you and your spouse are employees of different BellSouth participating companies, MAP pays benefits as though each covered family member has reached that limit.

Expenses Excluded from Out-of-Pocket Limit

Some expenses do not apply toward reaching the out-of-pocket limit. These include, but are not limited to:

- The $180 individual deductible or $425 family deductible.
- Expenses not covered under MAP, such as the Alternate Benefits (see the section "Quality Care Program" on page 24) and inpatient expenses due to mental/nervous conditions when those expenses are not precertified by QCP.
- Expenses incurred due to pre-existing conditions.
- Expenses not medically necessary.
- Copayments, such as those for the Mail Order Prescription Drug Program, PPO pharmacy, PPO physicians, and non-emergency conditions.
- Covered charges not paid by MAP because of coordination of benefits rules (see the section "Coordination of Benefits" on page 51).
- Expenses above MAP coverage limits, such as the maximum benefit limit of $150,000 for treatment of mental/nervous conditions.
- Expenses above the benefits paid by MAP for inpatient mental/nervous care (see the section "Mental and Nervous Care Benefits" on page 36).
- Expenses above the benefits paid by MAP for outpatient mental/nervous care.
- Expenses above covered charges or payment allowance limits, where applicable.
- The QCP penalty.
- Expenses above the benefits paid by MAP for chiropractic services.

Pre-Existing Condition Provision

Expenses incurred due to a pre-existing condition are not covered by MAP.

A pre-existing condition is an illness, injury, or condition, including pregnancy, for which you or a dependent received treatment (including, but not limited to, medication) during the 90 days prior to the effective date of coverage.

An illness or injury is no longer considered a pre-existing condition under MAP when:
- No treatments have been received for the pre-existing condition during six consecutive months of coverage under MAP, or
- MAP coverage on the participant with the pre-existing condition has been in effect for 12 months.

The Health Maintenance Organization Option

Each year you will be given the choice to continue coverage under MAP or to elect coverage through a health maintenance organization (HMO), approved and offered by the company, in the area in which you live.

You may also enroll in an HMO within 31 days of:
- Your initial employment or reinstatement to active employment;
- The date you move into a new HMO service area; or
- Your pension effective date.

In addition, your eligible dependents may enroll or re-enroll in an HMO (according to that HMO's rules) as long as you are enrolled in that HMO.

If an HMO is available to you, and you elect to use it, the company contributes up to the same amount it would pay toward the cost of MAP coverage. You pay any additional costs (based on the enrollment costs established by that HMO) through payroll or pension allotments. Retirees who took the lump-sum payment option will pay Blue Cross and Blue Shield of Alabama directly.

MAP Lifetime Benefit Maximum

Generally, while you are an active employee, there is no overall lifetime benefit maximum to the amount of benefits payable under MAP for you or your dependents. However, certain benefits, such as for mental/nervous care, have specific limits as described throughout this booklet.

A $1 million individual lifetime benefit maximum applies to:

- Retirees and their dependents, beginning on the first day of the year following retirement;
- Long Term Disability (LTD)-eligibles and their enrolled dependents, beginning on the first day of the year following eligibility for LTD benefits;
- Dependents of deceased active employees with a surviving spouse or surviving Class I benefits beginning on the first day of the year following the date each surviving dependent (including the spouse) reaches age 65.

The Quality Care Program

The Quality Care Program (QCP), administered by United HealthCare, Inc., assists you and your covered dependents in securing quality medical care. QCP provides you with information that allows you, in consultation with your physician, to evaluate medically appropriate alternatives to surgery and hospitalization. In addition, QCP monitors any certified hospital confinement and keeps you informed as to whether or not the stay remains certified under MAP.

QCP also helps by advising you if your maternity charges or other surgeon's charges are within MAP's coverage limits. For QCP to do this, you must provide the physician's Current Procedural Terminology (CPT) code.

Remember, all decisions regarding your medical care are up to you and your physician.

How to Contact QCP

To contact QCP, call toll free, **1-800-541-2234**. To save time, it is recommended that your physician contact QCP; however, you, a family member, or a friend may contact QCP on your behalf. **It is your responsibility to make sure someone contacts QCP.**

When to Call QCP

There are certain circumstances when QCP must be contacted if you are to receive maximum MAP benefits as explained below.

When MAP is the primary plan, QCP precertification is required for:

- Inpatient hospital admissions, including all maternity admissions*;
- Mandatory Outpatient Surgical Procedures performed on an inpatient basis (see the section "Physician/Surgeon Care Benefits" on page 31)*;
- Surgical procedures on the Mandatory Second Surgical Opinion List (see the section "Physician/Surgeon Care Benefits" on page 35)*;
- Outpatient physical therapy (includes occupational and speech)*.

* Alabama employees and retirees are precertified through Blue Cross and Blue Shield of Alabama's Managed Care Program.

QCP certification is required within 48 hours of any emergency hospital admission if the stay is expected to last longer than 48 hours. QCP certification is not required for surgery or hospitalization outside the continental United States.

In order to be covered, QCP precertification is always required for all inpatient mental/nervous care expenses (see the section "Mental and Nervous Care Benefits" on page 36), all therapies (outpatient physical, occupational, and speech) and alternate benefits whether MAP is the primary or secondary plan, even if you or your dependents are Medicare-primary. Rules for determining when MAP is the primary or secondary plan are explained in the section "Coordination of Benefits" on page 51.

The precertification provided in no way represents a guarantee of payment. Benefits for any claim will be provided according to the eligibility, terms and conditions of the participant's contract at the time service is rendered.

You may also contact QCP if you need to know whether or not your physician or hospital is a PPO provider.

QCP Penalty for Non-Compliance

The QCP penalty applies when MAP is the primary medical plan, and QCP is not contacted or does not certify:

- Overnight hospital admissions (including emergency admissions that last longer than 48 hours);
- Inpatient surgeries;
- Mandatory Outpatient Procedures performed on an inpatient basis;
- Surgeries on the Mandatory Second Surgical Opinion List;
- Maternity admissions.

In other words, if you do not contact QCP or do not follow QCP's recommendations, your MAP payments will be reduced by $250 for each failure to comply. Therefore, more than one QCP penalty may be applied for a single hospital confinement. QCP penalties do not apply toward your deductible or out-of-pocket limit.

Whether MAP is your primary or secondary medical plan, and whether or not you or your dependents are Medicare primary, QCP precertification is always required for coverage for Alternate Benefits and Inpatient Mental/Nervous Care. When MAP is primary, QCP precertification is always required for outpatient physical therapy, which includes occupational and speech therapy; otherwise, there is **no coverage** for those expenses, and they will not apply to the deductible or out-of-pocket limit. If precertified once the deductible is met, benefits will be paid at 90 percent of covered charges.

Remember, all decisions regarding your medical care are up to you and your physician.

Alternate Benefits

Alternate Benefits provide options to hospital stays and other medical care or treatments and must be precertified by QCP. The following coverage is included:

- Home health care;
- Extended care/skilled nursing facilities;
- Birthing centers/nurse midwives;
- Hospice care;
- Partial hospitalization for a substance abuse rehabilitation program (see the section "Mental and Nervous Care Benefits" on page 36);

- Expenses due to special arrangements or treatments when medically appropriate;
- Private duty nursing.

If precertified by QCP, once you have met the deductible, 100 percent of the covered charges for Alternate Benefits will be paid by the plan, except private duty nursing which is paid at 90 percent of the covered charges.

If not precertified by QCP, the Alternate Benefits are not considered covered expenses; therefore, they are not eligible for reimbursement under MAP. However, the decision to use an Alternate Benefit is up to you and your physician.

Inpatient Mental and Nervous Care

Benefits for inpatient mental/nervous care, including substance abuse care, are available only if precertified by QCP. Precertification is required regardless of whether MAP is the primary or secondary plan, including Medicare-primary participants.

If QCP does not precertify an inpatient stay for mental/nervous treatment, the expenses are not covered by MAP; therefore, they are not eligible for reimbursement. However, the decision to use inpatient treatment for mental/nervous care is up to you and your physician.

Mental/nervous confinements will be reviewed during the hospitalization to determine the portion of care that is medically necessary treatment versus that which is maintenance or custodial and not covered under MAP. The plan's specific benefit levels for mental/nervous care are explained in the section "Mental and Nervous Care Benefits" on page 36.

Emergencies

In an emergency, QCP must be contacted within 48 hours if you are admitted to the hospital and not released in 48 hours. If you live in a PPO area and are admitted to a non-PPO hospital, or if you do not live in a PPO area but were admitted to a non-PPO hospital in a PPO network, QCP – with your physician's input – will determine if a transfer to a PPO hospital is possible. If it is determined that a transfer is possible and you choose not to move, benefits will be reduced. When transfer arrangements are handled by QCP, MAP pays the full cost of the transfer. Maternity admissions are not considered emergencies and must be precertified by QCP.

The decision to remain in the non-PPO hospital and pay the associated costs or to move to a PPO hospital is yours to make in consultation with your physician.

Hospital Care Benefits

This section outlines the most common hospital care expenses covered under MAP and the associated benefits. If you have questions about hospital expenses not listed here, call QCP or Blue Cross and Blue Shield of Alabama before proceeding with treatment to determine if the charges will be covered.

Inpatient Hospital Benefits

MAP covers expenses for medically necessary hospital services. The amount MAP pays is determined by whether or not you:
- Live in a PPO area;
- Use a PPO hospital, even if MAP is the secondary plan;
- Are a Medicare-primary participant.

Covered hospital services include:
- Semi-private room and board;
- Private room when in a private-room-only hospital (90 percent of the most prevalent private room rate);
- Use of operating, delivery, and recovery rooms plus special equipment;
- General nursing care;
- Laboratory tests and X-rays;
- Special diets;
- Physical therapy (call QCP if therapy continues after the hospital stay);
- Administration of blood (see "Additional MAP Benefits" on page 49).

QCP can give you PPO hospitals' telephone numbers so you can call and ask for the names of physicians with admitting privileges. If a PPO physician network has been established in your area, QCP can provide the names of participating physicians. **For maximum MAP benefits, you must follow the plan's QCP provisions described in the section "Quality Care Program" on page 24.**

Benefits When You or a Dependent is Medicare-Eligible and Medicare is Primary

After the deductible is met, MAP pays 100 percent of covered inpatient hospital charges, less the amount eligible for Medicare payment (and/or any other coverage that is primary to MAP, as explained in the section "Coordination of Benefits" on page 51). MAP's PPO hospital provisions do not affect you.

Benefits When MAP is Primary

After the deductible is met, MAP pays inpatient hospital benefits for covered hospital charges, as follows:
- PPO hospital charges are paid at 100 percent of inpatient covered charges.
- If you live in a PPO area, non-PPO hospital benefits are paid at 90 percent of the PPO area payment allowance for covered inpatient hospital charges. Any charges above the PPO area payment allowance are not covered expenses and do not count toward your deductible or individual out-of-pocket limit. **Therefore, the amount you pay could be 80 percent or more of the non-PPO hospital charges.**
- If you do not live in a PPO area and use a non-PPO hospital located outside of the PPO areas, MAP pays 100 percent of covered charges.
- If you do not live in a PPO area and come into a PPO area for services, you must use a PPO hospital to obtain maximum benefits.

Non-PPO hospital benefits are paid at 90 percent of the PPO area payment allowance for covered hospital charges. Any charges above the payment allowance are not covered and do not count toward the deductible or out-of-pocket limit.

Note: PPO provisions apply whether MAP is the primary or secondary plan.

If you are a non-PPO participant and you come into a hospital PPO network, a hospital PPO waiver will be authorized where there is no physician PPO network and you have had prior treatment for at least two months by the physican who admits you to the non-PPO hospital.

If you are a non-PPO participant and you come into a hospital PPO network, a PPO hospital waiver will be authorized when there is a physician PPO network but you have had treatment outside the network for at least the prior two months by the non-PPO physician who admits the patient to the non-PPO hospital.

Example:
Assume you live in a PPO area. You have met your deductible, and QCP precertified a four-day hospital stay.

PPO Hospital
In a PPO hospital, all covered hospital charges are paid in full.

Non-PPO Hospital
- *You are not Medicare-eligible.*
- *The non-PPO hospital charges $3,500 for your stay*
- *The PPO area payment allowance is $2,100.*

MAP would pay as follows in the chart below:

Non-PPO Hospital Charges		$3,500
MAP Would Pay	90% of payment allowance	90% x $2,100 = $1,890
You Would Pay	Hospital charge minus benefit	$3,500 - $1,890 =$1,610
Applies to Out-of-Pocket Limit	Payment allowance minus benefit	$2,100 - $1,890 = $ 210
Does Not Apply to Out-of-Pocket Limit	Hospital charge minus payment allowance	$3,500 - $2,100 = $1,400

In the example, you would pay $1,610. Only 10 percent of the payment allowance covered charges, which is $210, applies to the out-of-pocket limit. The remaining $1,400 above payment allowance is not a covered expense and does not apply to the out-of-pocket limit.

Remember, the choice of which hospital to use is up to you and your physician. You make the decision each time you require hospitalization.

Special Limitations

Treatment of Mental/Nervous Conditions

Partial hospitalization for substance abuse or treatment of an inpatient mental/nervous condition must have QCP precertification. There are other limitations on mental/nervous care benefits. Refer to the section "Mental and Nervous Care Benefits" on page 36 for more information.

Diagnostic X-Rays/Laboratory Tests, Physical Therapy

If you enter a hospital on an inpatient basis primarily for diagnostic X-rays/laboratory tests or physical therapy, no benefits will be paid toward your room and board charges. These charges are not covered expenses and will not apply toward your deductible or out-of-pocket limit since diagnostic tests and physical therapy can be provided on an outpatient basis.

The expenses for services other than room and board will be covered in the same manner as outpatient hospital benefits, subject to PPO provisions.

Weekend Admissions

If you are admitted to the hospital on a Friday or Saturday for a non-emergency condition, weekend room and board charges will not be precertified, and MAP will not cover them unless, on the day you are admitted 1) you have surgery, or 2) you have a condition that requires hospitalization for medically necessary tests and surgery is performed on the following day.

Rehabilitative/Custodial Expenses

Hospital room and board and ancillary charges are not covered when the admission is custodial or primarily for rehabilitative care that can be provided on an outpatient basis.

Dental Care

Hospitalization for dental care is only covered when:

- Confinement results from accidental bodily injury, or
- A physician, other than a dentist, precertifies through QCP that hospitalization is necessary, due to a non-dental organic impairment, to safeguard the patient's life/health.

No hospitalization benefits are paid for surgical removal of impacted teeth unless there is an underlying medical condition requiring confinement.

Covered dental hospitalization benefits are the same as medical/surgical hospitalization benefits described in this section.

Outpatient Hospital Benefits

Covered charges for non-emergency services from an ambulatory surgical facility or an outpatient department of a hospital are paid as follows, after the deductible (see exceptions below):

- PPO hospital benefits are paid at 100 percent of covered charges.
- If you live in a PPO area, non-PPO hospital benefits are paid at:
  - 90 percent of the payment allowance, including outpatient surgery, unless the charges are for pre-admission or pre-surgical X-rays or tests, or
  - 100 percent of the payment allowance for pre-admission or pre-surgical X-rays or tests (as described below).
- If you do not live in a PPO area and use a non-PPO hospital located outside of the PPO area, MAP pays:
  - 90 percent of covered charges, including outpatient surgery, unless the charges are for pre-admission or pre-surgical X-rays or tests; or
  - 100 percent of covered charges for pre-admission or pre-surgical X-rays or tests.
- If you do not live in a PPO area but come into a PPO area for care, you must use a PPO hospital to obtain maximum benefits. Non-PPO hospital benefits are paid at 90 percent of the payment allowance.
- If you are a Medicare-primary participant, benefits will be paid at 100 percent of covered charges less the benefit paid by Medicare whether you use a PPO or non-PPO hospital.

NOTE: **Covered charges for services/surgery performed at a free-standing clinic are paid as if the services were performed in a physician's office. If the clinic is located on the grounds of a PPO hospital and is part of the PPO Agreement, PPO benefits would apply.**

The deductible is not required for the following:

- Facility charges for outpatient surgery;
- Accidental injury and sudden/serious illness when treated within 72 hours;
- Pre-admission or pre-surgical X-rays or tests;
- Radiation/chemotherapy;
- Electroshock therapy;
- Routine pap smears (lab fee);
- Certain mammograms (see page 46).

In order for services to be considered pre-surgical tests for outpatient surgery or pre-admission tests, all of the following criteria must be met:

- The tests must be necessary and consistent with the diagnosis and treatment of the condition;
- The patient must be physically present for the test;
- The tests must not be performed to determine whether hospital care is necessary;
- The admission or scheduled outpatient surgery must not be cancelled or postponed except as a result of a second surgical opinion or other medical reason;
- In the case of pre-admission tests, a hospital bed must be reserved before the tests are performed, and the admission date must be such that the tests would be medically valid for the treatment.

If tests are duplicated after admission, the tests performed prior to admission will not be covered.

Note: If complications resulting from outpatient services require admission as an inpatient, all facility charges will be considered at inpatient MAP benefit levels. This admis-

sion will be subject to all PPO provisions and QCP penalties.

Remember, the decisions regarding treatment are up to you and your physician.

Physician/Surgeon Care Benefits

Where it is economically feasible, and enough physicians elect to participate, MAP will continue to implement physician Preferred Provider Organizations (PPOs). Contact QCP to determine whether a PPO physician network has been established in your area. If Medicare is primary, PPO physician provisions do not apply.

Note: A PPO physician waiver may be authorized when a non-PPO participant uses the same non-PPO physician for services in the PPO network as was used by the participant for prior services out of the network area.

Office Visits

Benefits for office visits are paid as follows:
- PPO physician services will be paid at 90 percent of covered charges, no deductible, after a $5 copayment.
- If you live in a PPO area, non-PPO physician services will be paid at 80 percent of the payment allowance after the deductible, even if MAP is the secondary plan.
- If you do not live in a PPO area, services from non-PPO physicians located outside the PPO area will be paid at 90 percent of R&C after the deductible.
- If you do not live in a PPO area but come into a PPO area for care, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services will be paid at 80 percent of the payment allowance after the deductible.

Office visits and services for routine health check-ups or examinations are not covered under MAP unless specifically stated as being covered.

Hospital Visits, Surgery, Anesthesia Administration

Benefits for covered charges are as follows:
- PPO physician services will be paid at 90 percent of covered charges, no deductible required.
- If you live in a PPO area, non-PPO physician services will be paid at 80 percent of the payment allowance after the deductible has been met.
- If you do not live in a PPO area, services from non-PPO physicians located outside the PPO area will be paid at 90 percent of R&C, after the deductible has been met.
- If you do not live in a PPO area but come into a PPO area for care, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services will be paid at 80 percent of the payment allowance after the deductible.

Covered charges include one hospital visit per day by your primary physician. Inpatient consultations by physicians other than your primary physician are limited to one consultation for each specialty, per admission. (Benefits for emergency physician care are explained on page 44.)

For substance abuse rehabilitation, inpatient physician charges which are not part of the program and are not billed by the facility are not covered.

Surgery

When medically necessary, MAP also provides benefits for an assistant surgeon at the same level as those provided for the surgeon. MAP does not cover surgical assistants who are not licensed medical doctors. The assistant surgeon must assist and not simply be present in order to have services covered.

Benefits for Multiple Procedures Performed During the Same Operative Session

When two or more surgical procedures are performed during the same operative session, the surgeon's time pertaining to the treatment of the patient is not increased two-fold. The medical visits leading up to the actual surgery, the preparation of the patient, and the post-operative medical visits associated with the surgery are included in determining the R&C allowance. The physician generally renders the same amount of follow-up medical care for two or more surgical procedures as for one. That is why many physicians charge less for a procedure when it is performed as a secondary procedure than when it is performed as a single surgery. That is also why MAP's benefit levels are unique for multiple procedures performed during the same surgical session.

MAP's intent is not to penalize the patient for having more than one procedure performed. This provision is designed to provide R&C reimbursement for the physician's time and skill needed in performing the services.

Covered expenses are determined as follows:

- Multiple surgical procedures during the same operative session performed through the same incision or in the same operative fields are covered up to the surgeon's R&C charge for the most expensive procedure.
- Effective Jan. 1, 1993, for accidents and major trauma, MAP will cover multiple surgical procedures during the same operative session performed through the same incision or in the same operative fields at 100 percent of the surgeon's R&C charge for the most expensive procedure and 25 percent of the R&C for the second procedure only. If a third or fourth procedure is performed, there will be no additional benefit. This benefit does not apply to elective or anticipated surgeries.
- Multiple surgical procedures performed during the same operative session through separate incisions and in separate operative fields are covered up to the surgeon's R&C charge for the total procedure, but not more than the R&C charge for the more expensive procedure and 50 percent of the R&C charge for the less expensive procedure(s).
- Bilateral procedures (i.e., removing cataracts from both eyes) performed during the same operative session in separate operative fields are covered up to the surgeon's R&C charge for the total procedure up to 150 percent of R&C for the unilateral procedure.

For the multiple surgical procedures listed below ...

- Cesarean-section with tubal ligation,
- Vaginal delivery with tubal ligation,
- Hysterectomy with appendectomy,
- Laparotomy with dilation and curettage,
- Laparoscopy with dilation and curettage,

... MAP benefits will be determined as follows:

- Multiple surgical procedures during the same operative session performed through the same incision or in the same operative fields are covered up to the surgeon's R&C for the most expensive procedure, and 50 percent of R&C for the other procedures.
- Multiple surgical procedures performed during the same operative session through