separate incisions and in separate operative fields are covered up to the surgeon's R&C for the total procedure, but not more than the R&C for the more expensive procedure, and 75 percent of the R&C charge for the less expensive procedure(s).

Maternity

For coverage information on maternity-related expenses, see page 44.

Chiropractic Charges

MAP pays 90 percent of R&C, up to a $100 benefit, for the first covered visit (one per lifetime) processed under MAP, and up to a $50 benefit for subsequent visits. The first visit normally includes X-rays, an examination, and the determination of treatment.

Covered charges are limited to two visits each calendar week and 20 visits each calendar year. Charges above these limits do not apply to the deductible or out-of-pocket limit.

Outpatient Surgeon's Charges

Benefits for all outpatient surgeon's charges, including charges for procedures listed on the Mandatory Outpatient Surgical Procedures List below, 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.

For benefits when more than one surgery is performed during the same operative session see "Surgical Benefits For Multiple Procedures Performed During The Same Operative Session" in the section "Physician/Surgeon Care Benefits" on page 32.

Mandatory Outpatient Surgical Procedures List

Procedure	Description
Dilation and Curettage	Dilation and scraping of uterus
Excision of lesions of skin	Removal of cysts, tumors, subcutaneous and soft lipomas, etc. tissue (malignant/ benign)
Eye muscle operations	Surgery to correct muscle imbalance
Hammertoe repair	Surgery to correct congenital deformity of toes
Hemorrhoidectomy	Removal of hemorrhoids
Herniorrhaphy	Hernia repair
Mastoidectomy	Removal of part of mastoid process
Neuroplasty	Surgery on nerves/nerve tissue
Submucous resection	Partial excision of nasal septum
Tendon (sheath) release/ repair	Incision or repair of tendons

Varicose vein ligation*	Surgery on enlarged veins

*This procedure requires a second surgical opinion and must be precertified by QCP.

Mandatory Outpatient Surgical Procedures Performed on an Inpatient Basis

MAP will cover inpatient expenses for procedures listed above only when precertified by QCP that it is medically necessary to have the procedure performed on an inpatient basis or that there is no outpatient facility within 25 miles of your home. If a mandatory outpatient procedure is performed on an inpatient basis without QCP precertification, MAP will cover only the expenses that would have been paid if the procedure had been performed on an outpatient basis.

Surgical Opinions

When you or a covered dependent need surgery, and the procedure is on the Mandatory Second Surgical Opinion List (see following section), contact QCP. QCP will review your medical circumstances and will determine if a second surgical opinion is required or if it can be waived as a condition to receiving maximum MAP benefits.

If you do not obtain the required second opinion and you proceed with surgery, the QCP penalty will be applied. If QCP waives the second opinion and you still obtain one, it will not be covered.

When a required second opinion does not agree with your physician's recommended treatment, the following options are available to you:

- You, your physician, or a family member may contact QCP to discuss alternatives to surgery.
- You may contact QCP to obtain a third opinion from another physician by following the same procedure as for a second opinion. The same benefit levels will apply.
- You may choose not to obtain a third opinion and proceed with the surgery; however:
  - If Blue Cross and Blue Shield of Alabama determines that the surgery was not medically necessary, the expenses will not be covered, or
  - If determined to be medically necessary, your MAP payment will be subject to the QCP penalty.

When a required third opinion does not confirm the need for surgery, and you proceed with the surgery:

- If Blue Cross and Blue Shield of Alabama determines that the surgery was not medically necessary, the expenses will not be covered, or
- If determined to be medically necessary, your MAP payment will be subject to the QCP penalty.

If you choose to proceed with surgery on an inpatient basis when there is no confirming opinion, and QCP does not certify the confinement, more than one QCP penalty will be applied.

Remember, it is up to you and your physician whether or not you have the surgery.

Surgical Opinion Payments

MAP pays for required second or third surgical opinions as follows:

- If a QCP-listed physician is used, the opinion is paid in full;
- If a QCP-approved, but not listed, physician is used, the opinion is paid at 100 percent of R&C;
- If the opinion is obtained without QCP authorization or from a physician who is not approved by QCP, the cost of the opinion is not a covered expense. No payment will be made by the plan.
- For QCP-listed and approved physicians, do not make a payment. Ask the physician to forward the bill directly to QCP (see inside front cover for address).

In addition, if the physician rendering the second or third opinion performs the surgery, the charge for the services, including the cost of the opinion, will not be a covered expense.

Procedures Requiring a Confirming Second Opinion

For maximum MAP benefits, the following procedures require QCP contact and a confirming second surgical opinion unless waived by QCP.

Mandatory Second Surgical Opinion List

Procedure	Description
Chemonucleolysis	Treatment of herniated disc
Hallux Valgus Procedures	Surgery of big toe to correct deformity, including bunionectomy
Knee Operations	Elective knee operations only
Rhinoplasty	Surgical reconstruction of the nose, including submucous resection
Varicose Veins of Legs	Removal of varicose veins

Obtaining a Second/Third Opinion

If QCP requires you to obtain a second or third surgical opinion, a QCP representative will provide you with the names of board-certified or board-eligible physicians (three or more whenever possible) from which you may select to provide the surgical opinion. "Board-certified" means that the physician has taken and successfully completed the necessary examinations for certification in his/her area of specialty. "Board-eligible" means that the physician meets board requirements but has not yet taken the examinations required for certification.

25-Mile Waiver

If there is no board-certified physician within 25 aerial miles of your home, the second surgical opinion may be waived by QCP, or you may be asked to obtain a second surgical opinion from a board-eligible physician.

Paid Time Off

When QCP requires and precertifies a second or third surgical opinion, the company will allow you paid time off to see the physician for that opinion. Paid time off applies only when the required second or third opinion is for your illness or injury - not your dependent's.

When QCP is Not Contacted

If QCP is not contacted, or a confirming second or third surgical opinion is not obtained when required:

- If it is determined by Blue Cross and Blue Shield of Alabama that the surgery was not medically necessary, MAP will not cover the expenses; **or**
- If determined to be medically necessary, the QCP penalty will apply.

Remember, the decision to have surgery is up to you and your physician.

Mental and Nervous Care Benefits

For purposes of MAP, the term "mental/nervous" includes alcoholism and drug addiction, referred to in this booklet as substance abuse.

Benefit Limitations

MAP will pay an individual lifetime maximum benefit of up to $150,000 for covered expenses due to inpatient, partial hospitalization, and outpatient mental/nervous care. Once a participant reaches this limit, additional mental/nervous expenses incurred during the remainder of that year will not be covered and will not count toward the participant's deductible or out-of-pocket limit.

Effective Jan. 1, 1993, when a MAP participant reaches or has reached the $150,000 mental health maximum lifetime benefit, the plan will provide an additional $1,000 in benefits each year, after the deductible, for covered mental/nervous care. MAP participants will become eligible for this $1,000 annual benefit in the year following the calendar year in which the $150,000 maximum lifetime benefit is reached. Unused benefits will not be carried over to the following year.

This $1,000 annual benefit cannot be applied to create a new inpatient or partial hospitalization substance abuse benefit when the lifetime limits have been reached.

MAP pays for two substance abuse rehabilitation benefits per lifetime – one inpatient benefit and one partial hospitalization benefit. To be considered separate, the second benefit must start at least 180 days after the first one ends.

In addition, specific benefits have special limits as described in this section.

Special Rules for PPO And Non-PPO Hospital Benefits

Lower benefit levels will be paid for non-PPO hospital charges that are incurred in a PPO area, regardless of where the participant lives. This rule applies to all mental/nervous confinements, including confinements for substance abuse. In other words, if you live outside the PPO area but receive treatment within a PPO area, you must use a PPO facility to obtain maximum MAP benefits.

Benefits for Medicare-primary participants are the same as the PPO hospital benefits, whether or not a PPO hospital is used.

The amount you pay does not apply to the out-of-pocket limit. In addition, once the out-of-pocket limit is reached, benefits will not increase to 100 percent.

Inpatient Benefits

All inpatient confinements for mental/nervous conditions (including those for Medicare-primary participants) must be precertified by QCP. If QCP does not certify the admission, the inpatient expenses are not covered and do not apply toward the out-of-pocket limit.

Effective Jan. 1, 1993, if QCP does not precertify a hospital admission for mental/nervous care when notified of the hospital admission, and the admission meets medical necessity guidelines for inpatient care, MAP will provide benefits on a prospective basis. This means that MAP will now pay for the period of time spent in the hospital **after QCP is contacted and if medically necessary.**

Covered hospital services for inpatient care will be eligible for MAP benefits beginning on the date QCP is actually contacted. Any subsequent inpatient treatment following that date will also be eligible, subject to all MAP provisions in effect at the time of the admission. The patient may be required to relocate to a PPO facility and use PPO mental health care physicians to receive maximum MAP benefits.

The following MAP benefits for physician services related to inpatient mental/nervous care are effective Jan.1, 1993:

- If a participant is admitted to a non-PPO facility inside a PPO network area by either a PPO or a non-PPO physician, MAP will pay up to $75 per visit — limited to two visits per week and a maximum of 52 visits per calendar year — after the deductible is met.
- If a PPO participant is admitted to a PPO facility by a non-PPO physician in a PPO physician network, MAP will pay up to $75 per visit — limited to two visits per week and a maximum of 52 per year after the deductible is met.
- If a participant is admitted to a PPO facility by a PPO physician, MAP will pay 90 percent of the covered charges, after the deductible is met.
- If a non-PPO participant is admitted to a non-PPO facility outside of a PPO network area, MAP benefits will be paid at 90 percent of covered charges, after the deductible is met.
- MAP substance abuse rehabilitation benefit limitations still apply, including the requirement that physician fees are part of the facility charges.

Mental/nervous confinements will be reviewed to determine the portion of care that is medically necessary versus that which is maintenance or custodial and not covered under MAP.

Hospital Benefits Other Than For Substance Abuse Care

After QCP has certified the confinement and the deductible has been met, MAP pays inpatient hospital benefits for mental/nervous conditions as follows:

Number of Days in the Hospital	PPO Hospital or No PPO Hospital Available in Area	Non-PPO Hospital within any PPO Area
Less than 30	100% of covered charges	90% of payment allowance
30-59	95% of covered charges	85% of payment allowance
60-89	90% of covered charges	80% of payment allowance
90 or more	85% of covered charges	75% of payment allowance

Each admission must be separated by 60 days to be considered a separate admission. Physician benefits are the same as for other inpatient illnesses; however, covered charges apply to the $150,000 mental/nervous lifetime maximum.

Hospital Benefits: Substance Abuse Care

Once certified by QCP, benefits for substance abuse care are paid as follows after the deductible has been met:

- 100 percent of covered inpatient hospital charges from a PPO hospital;
- 90 percent of the PPO area payment allowance for covered inpatient hospital charges from a non-PPO hospital located inside a PPO area;
- 100 percent of covered inpatient hospital charges from a non-PPO hospital if the participant does not live in a PPO area, and the hospital is not located in a PPO area.

Inpatient Detoxification Benefits

MAP covers hospital and physician charges for up to 30 days for each detoxification benefit. No more than two detoxifications during a five-year period are covered. The second benefit must start at least 180 days after the first one ended to be considered separate.

Inpatient Substance Abuse Rehabilitation Benefits

MAP covers hospital charges for one inpatient rehabilitation program per lifetime for up to 30 days for active and retired employees, surviving spouses and Class I dependents. Class II and sponsored dependents are not eligible for this benefit. Any fees, including physician fees, billed separately from the inpatient facility program charge are not covered under MAP.

Partial Hospitalization/Substance Abuse Rehabilitation Program Benefits (Alternate Benefit)

"Partial hospitalization" is when a patient is admitted to the hospital under an approved treatment or rehabilitation program and the daily stay is for less than 24 hours. To be eligible for reimbursement under MAP, QCP must precertify partial hospitalization.

Any fees, including physician fees, billed separately from the inpatient facility program charge are not covered under MAP.

Expenses from an approved day or evening rehabilitation program are paid as follows:

- 100 percent of covered charges from a PPO hospital, deductible required;
- If you live in a PPO area, non-PPO hospital at 90 percent of the payment allowance, deductible required;
- If you do not live in a PPO area, services from a non-PPO hospital located outside the PPO area are paid at 100 percent of covered charges, deductible required.
- If you do not live in a PPO area but come inside a PPO area, you must use a PPO hospital.

Benefits are limited to one partial hospitalization per lifetime, up to 30 treatment days.

An approved partial hospitalization/substance abuse rehabilitation program is one that is:

- Approved by the Joint Commission on Accreditation of Health Care Organizations;

- Usually four to six weeks in duration, either day or evening;
- Specifically designed for the treatment of addictions;
- Specifically tailored to address the problem of substance abuse.

Outpatient Mental/Nervous Benefits

Effective Jan. 1, 1993, MAP benefits for physician services related to outpatient mental/nervous care will be 90 percent of covered charges, up to a maximum of $55 per visit, after the deductible is met. Visits are limited to two per calendar week, not to exceed 52 visits per year. This benefit will increase to $57 per visit on Jan. 1, 1995.

MAP will allow the first outpatient visit to a mental health care physician to be billed as two visits equal to the weekly limit, or up to a maximum benefit of $110. This allowance will be made only once each year and must involve a new provider. This benefit will increase to $114 on Jan. 1, 1995.

Services must be provided by a Doctor of Medicine (M.D.) or an individual who possesses a Doctorate degree (Ph.D., Ed.D. or Psy.D.) and is licensed and certified as a clinical psychologist. Services provided by an individual other than those identified above are not covered under MAP.

Remember, all mental/nervous treatment decisions are up to you and your physician.

Prescription Drug Benefits

Generic Versus Brand Name

A generic drug is one that uses its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When authorized by your physician and permitted by applicable law, a pharmacy is able to dispense a generic drug. You will find that using generic drugs will save you money.

To maximize your benefits, you should always purchase generics when permitted by your physician.

If your doctor allows a generic drug but you choose the brand name drug, you will pay the difference between the generic copayment amount and the price of the brand name drug.

Over-the-Counter and Legend Drugs

Drugs that may be purchased without a prescription (over-the-counter) are not covered by MAP – even if your physician "prescribes" them – except for prenatal vitamins.

Certain "legend" drugs, obtained by prescription only, are considered exclusions and are never covered under MAP. These include, but are not limited to:

- Investigational drugs;
- Infertility drugs;
- Nicorette/Nicoderm or any smoking cessation drug/supply;
- Vitamins (except prenatal);
- Drugs for the purpose of weight loss.

Other prescription drugs are covered only when supported by documentation of medical necessity. These drugs include, but are not limited to: Accutane/Retin-A, oral contraceptives for dependents, and growth hormones. For female spouses or employees, oral contraceptives are covered under MAP up to a 12-month supply per year.

New Prescription Drug Card Program

A new prescription drug card program became effective Jan. 1, 1993, for all participants who have primary coverage under MAP* and live within a three-digit zip code area that has a BellSouth PPO pharmacy. These participants must use the PPO network or the Mail Order Prescription Drug Program to receive benefits. BellSouth has retained PCS, Inc. to administer the prescription drug card program. MAP participants may also use the PCS prescription drug card at any pharmacy that participates in the PCS electronic filing system network.

* For Medicare primary covered participants, MAP is considered the primary plan for prescription drug benefits. Therefore, in order to receive prescription drug benefits, Medicare primary covered participants, like all other MAP primary covered participants, must use the Prescription Drug Card Program or the Mail Order Prescription Drug Program.

Prescription drug claims for MAP primary and Medicare primary covered participants can no longer be filed with Blue Cross and Blue Shield of Alabama.

When you obtain a prescription from a pharmacy that submits claims through the PCS electronic network but is not a BellSouth PPO pharmacy, you will pay the regular PPO copayment plus an additional $3 per prescription.

You may call 1-800-228-5739 for the location of PPO pharmacies in your area if you have questions relating to the program, or to obtain a PCS card.

The following charts show what your copayments will be under the new prescription drug card program.

Effective January 1, 1993 through December 31, 1994

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

Effective January 1, 1995

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

A 90-day supply or 200 unit doses is allowed, whichever is greater. (Copayments are not eligible for reimbursement by MAP.)

If the cost of the drug is less than the copayment, you pay the actual cost. This cost is not eligible for reimbursement through Blue Cross and Blue Shield of Alabama.

Remember, if you choose a brand name drug when a generic is allowed, you pay the difference between the generic copayment and the cost of the brand name drug.

If you live in a three-digit zip code area where there is a PPO pharmacy, expenses for prescription drugs purchased in a pharmacy, physician's office, hospital pharmacy, clinic, etc., will not be covered unless that provider is a member of the BellSouth PPO or PCS network of pharmacies and cannot be filed with Blue Cross and Blue Shield of Alabama for reimbursement.

If you live in a zip code area where there is not a participating BellSouth PPO pharmacy, you may use the PCS network and pay the PCS non-PPO copayments, or you may file a manual prescription drug claim form under MAP with Blue Cross and Blue Shield of Alabama with annual deductible and coordination of benefits (COB) rules applying.

All of the prescription drug card copayments you and your covered dependents pay that are related to the BellSouth PPO and PCS will be applied to the family $350 annual out-of-pocket limit for prescription drug expenses only. This $350 family out-of-pocket limit is separate from the annual out-of-pocket limit under MAP. When you reach the $350 annual family maximum, your prescription drug copayment will be reduced to $3 per prescription for the rest of that year. If you use a PCS network pharmacy, the additional copayment in the amount of $3 will also be charged – for a total of $6.

NOTE: MAP participants with secondary coverage, except those covered by Medicare, must continue to file claim forms with Blue Cross and Blue Shield of Alabama to be reimbursed for covered prescription drug expenses, subject to the MAP deductible and out-of-pocket limit. After the deductible is met, covered expenses will be reimbursed up to 90 percent of reasonable and customary (R&C) charges, or 100 percent of R&C after you reach the annual out-of-pocket limit minus the primary plan payments.

There are several other prescription drug benefits effective Jan. 1, 1993:

- Insulin syringes and any other covered prescription diabetic supplies will be covered under all prescription drug programs.
- Birth control pills will be covered under the prescription drug programs, limited to an annual maximum of a 12-month supply (except for a diagnosed condition) for the female employee or covered female spouse. Birth control pills for other eligible participants with a diagnosed medical condition will continue to be a covered expense.
- All prescription drug benefits will continue to be applied toward the MAP $1 million maximum lifetime benefit for retirees, and the STAP $500,000 lifetime maximum, if appropriate.

Mail Order Prescription Drug Program

If you take prescribed drugs on a regular or maintenance basis, you may order the medication through the Mail Order Prescription Drug Program. Your covered dependents may use this program only if:

- MAP is their primary plan, or
- Primary coverage is provided by Medicare, and MAP is the secondary plan.

Rules for determining when MAP is the primary plan are explained in the section "Coordination of Benefits" on page 51.

How the Program Works

The Mail Order Prescription Drug Program is administered by National Rx Services, Inc., a subsidiary of Medco Containment Services, Inc. Through this program, no deductible is required. Your copayment for each covered prescription is $7. The copayment is not eligible for reimbursement by Blue Cross and Blue Shield of Alabama.

National Rx Services, Inc. will fill your covered prescriptions only for the amount prescribed by your physician, up to a 90-day supply or 200 unit doses, whichever is greater. For certain controlled substance drugs, the amount dispensed may be less than the amount prescribed by your physician. Your medication will be mailed to you via U.S. Mail or United Parcel Service (UPS) along with instructions for future refills. For each drug, your first order will require a new/original prescription. Refill prescriptions originally filled by another pharmacy are unacceptable.

All prescription orders will be filled with a generic drug when a generic substitution is available and permissible by law, unless you or your physician require the use of a brand name drug. However, if the prescription is for a brand name drug, and a generic is available and allowed by your physician, but you choose the brand name drug, you must pay the difference between the cost of the brand name drug and the $7 copayment. The company only reimburses $7. National Rx Services, Inc. will notify you of the additional cost and the method for paying. If your physician requires a brand name drug, you pay only the $7 copayment.

Your Cost

Your cost for each prescription drug is either a $7 copayment or a $4 copayment plus a $3 coupon.

When a generic drug is sent to you, a $3 coupon will be included with your order. This $3 coupon may be used as a credit against the required $7 copayment for your next prescription order or refill. Only one coupon may be used for each drug; therefore, you will always pay at least $4 for each prescription drug ordered.

Again, if you choose a brand name drug when a generic is allowed, you pay the difference between the $7 copayment and the cost of the brand name drug.

How to Order a Prescription Drug

To order a prescription drug, simply mail your new/original prescription(s), your completed Prescription Order Claim Form, and the appropriate copayment(s) in a pre-addressed envelope to National Rx Services, Inc.

Prescription drug order inquiries or requests for National Rx Services, Inc.'s Prescription Order Forms should be directed to the Customer Service Department at 1-800-447-7856, Monday through Friday between 8 a.m. and 8 p.m., or Saturday from 8 a.m. to noon, Eastern Standard Time (EST).

General Prescription Drug Benefits for Secondary Coverage

You may submit your covered secondary prescription expenses to Blue Cross and Blue Shield of Alabama for reimbursement. MAP will pay 90 percent of R&C minus the primary payment for generic drugs or for brand name drugs when required by your physician. If you insist on receiving a brand name drug and it is not required by your physician, MAP will pay the generic copayment amount only and you will pay the difference between the cost of the drug and the generic copayment amount.

To receive MAP benefits, you must submit a completed MAP Drug Claim Form to Blue Cross and Blue Shield of Alabama along with the purchase receipts. For more information, see page 58.

Additional Plan Provisions

Remember, to maximize your benefits you should use a PPO physician/hospital whenever possible.

Accidental Injury and Sudden/Serious Illness

If you or a covered dependent have an accidental injury or a sudden/serious illness, MAP covers the related facility and physician charges as follows.

Emergency Conditions

Emergency conditions are conditions resulting in hospitalization, bone fractures, abrasions, lacerations, poisoning, rape or sudden/serious illness.

Facility Charges

If you are treated within 72 hours of occurrence, facility charges will be paid in full with no deductible.

Physician/Surgeon Charges

- PPO physician charges will be paid at 90 percent of covered charges.
- Non-PPO physician charges will be paid at 90 percent of R&C with no deductible.

Note: The only services not subject to the deductible are those received within 72 hours of the emergency.

Non-Emergency Conditions

Facility Charges

When you use an emergency room for non-emergency conditions, or for emergency conditions treated after 72 hours of occurrence, there are no benefits for the emergency room (facility) fee.

The remaining covered charges for ancillary fees, such as lab, X-ray, etc., will be paid as follows:

- PPO hospital services will be paid at 100 percent of covered charges after a $25 copayment, deductible required.
- If you live in a PPO area, non-PPO hospital covered charges will be paid at 90 percent of the payment allowance after a $50 copayment, deductible required.
- If you do not live in a PPO area, covered charges from a non-PPO hospital located outside the PPO area will be paid at 90 percent of the allowable expense after a $25 copayment, deductible required.
- If you do not live in a PPO area, but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO hospital charges will be paid at 90 percent of the payment allowance after a $50 copayment, deductible required.

Copayments for non-emergency conditions do not apply to the deductible or out-of-pocket limit.

Physician/Surgeon Charges

Physician/Surgeon charges will be paid at normal physician benefit levels with the PPO provision applied. (See the section "Physician/Surgeon Care Benefits" on page 31.)

If the emergency/non-emergency condition requires hospitalization and the admission is approved by QCP, MAP pays benefits as described in the sections "Hospital Care Benefits" on page 27and "Physician/Surgeon Care Benefits" on page 31.

Maternity Care

It is required that you contact QCP for precertification during the first trimester of pregnancy. This will allow QCP to assist you in maximizing your benefits and lowering your out-of-pocket expenses.

QCP also administers the Healthy Happy Babies Program that provides a voluntary health risk screening for pregnant MAP participants.

The obstetrician's global fee for prenatal and postnatal care is paid as follows:

- PPO physician services will be paid at 100 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, no deductible required.
• If you do not live in a PPO area, services from a non-PPO physician located outside the PPO area will be paid at 100 percent of covered charges, no deductible required.
• If you do not live in a PPO area, but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services will be paid at 80 percent of the payment allowance, no deductible required.

Coverage for nurse midwives is provided under Alternate Benefits and must be precertified by QCP (see the section "The Quality Care Program" on page 24).

Prenatal vitamins are covered by MAP up to Well Child Care annual limits.

If you are considering a sterilization procedure following your child's delivery, see the Multiple Surgical Procedure provisions on page 32. Inpatient hospital expenses for maternity care are covered as any other illness or injury (see page 27). **Remember, because maternity admissions are not considered emergencies, you must contact QCP for precertification.**

Amniocentesis

Effective Jan. 1, 1993, MAP will provide coverage for amniocentesis for women who will be age 35 or older on the estimated date of delivery. MAP PPO guidelines apply.

Well Baby Pediatric Examination

MAP pays benefits for one "well baby" pediatric examination of a newborn child during the mother's hospital confinement.
• 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, no deductible required.
• If you do not live in a PPO area, services from a non-PPO physician located outside the PPO area will be paid at 90 percent of R&C, no deductible required.
• If you do not live in a PPO area but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services will be paid at 80 percent of the payment allowance, no deductible required.

Routine nursery charges are covered under the Hospital Care Benefits provisions of MAP with no deductible required (see "Hospital Care Benefits" on page 27).

Well Child Care

MAP covers routine exams and immunizations to age 6 and annual screenings for ages 6 to 12 up to $250 per child and $400 per family during any calendar year. Amounts not paid due to the annual limit being met and the $5 copayment do not apply to the deductible or out-of-pocket limit.

• PPO physician services will be paid at 90 percent of covered charges after a $5 copayment, deductible not required.
• If you live in a PPO area, non-PPO physician services will be paid at 80 percent of the pay-

ment allowance after a $5 copayment, no deductible required.
• If you do not live in a PPO area, services from a non-PPO physician located outside the PPO area will be paid at 90 percent of R&C after a $5 copayment, no deductible required.
• If you do not live in a PPO area but come into a PPO area for services, 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 a $5 copayment, no deductible required.

Mammography

Prior to age 40, routine mammogram screenings are not covered. For women under age 40, mammograms for a diagnosed condition are covered under MAP 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 by a non-PPO physician 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 services, 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 has been met.

For women ages 40-49, the first mammogram performed either due to a diagnosed condition or a routine screening is paid as follows:
• PPO physician services will be paid at 100 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, no deductible required.
• If you do not live in a PPO area, services by a non-PPO physician located outside the PPO area will be paid at 100 percent of R&C, no deductible required.
• If you do not live in a PPO area but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services will be paid at 80 percent of the payment allowance, no deductible required.

Thereafter, one routine mammogram will be covered every two years for women age 40 through 49.

All other subsequent mammograms are covered only if performed for a diagnosed condition and will be paid 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 by a non-PPO physician 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 services, 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 has been met.

For women age 50 and over, one mammogram performed either for a diagnosed condition or as a routine screening is covered per calendar year as follows:

• PPO physician services will be paid at 100 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, no deductible required.
• If you do not live in a PPO area, services by a non-PPO physician located outside the PPO area will be paid at 100 percent of R&C, no deductible required.
• If you do not live in a PPO area but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services will be paid at 80 percent of the payment allowance, no deductible required.

Within that year, subsequent mammograms for a diagnosed condition will be paid 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 by a non-PPO physician 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 services, 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 has been met.

Physician X-Ray and Lab Benefits

Covered X-ray and lab services are paid 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 by a non-PPO physician 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 services, 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 has been met.

However, if X-ray and lab services are performed for pre-admission or pre-surgical testing, the benefits are as follows:
• PPO physician services will be paid at 100 percent of covered charges, no deductible required.
• If you live in a PPO area, non-PPO physician services will be paid at 100 percent of the payment allowance, no deductible required.
• If you do not live in a PPO area, services by a non-PPO physician located outside the PPO area will be paid at 100 percent of R&C, no deductible required.
• If you do not live in a PPO area but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services will be paid at 100 percent of the payment allowance, no deductible required.

Pap Smears

The laboratory (facility) fee is paid as follows:
• PPO hospital services are paid at 100 percent of covered charges, no deductible required.
• If you live in a PPO area, non-PPO hospital services are paid at 100 percent of the payment allowance, no deductible required.

• If you do not live in a PPO area, services by a non-PPO hospital located outside the PPO area will be paid at 100 percent of covered charges, no deductible required.
• If you do not live in a PPO area but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO hospital services are paid at 100 percent of the payment allowance, no deductible required.

Physician charges for the Pap smear are paid as follows:
• PPO physician services are paid at 100 percent of covered charges, no deductible required.
• If you live in a PPO area, non-PPO physician services are paid at 80 percent of the payment allowance, no deductible required.
• If you do not live in a PPO area, services by a non-PPO physician located outside the PPO area will be paid at 100 percent of R&C, no deductible required.
• If you do not live in a PPO area but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services are paid at 80 percent of the payment allowance, no deductible required.

Effective Jan. 1, 1993, MAP will provide an annual scheduled benefit of up to $30 for routine gynecological office visits and associated expenses when in conjunction with a Pap smear test. The scheduled benefit is not subject to the MAP deductible and represents total plan coverage for the office visit to obtain a Pap smear and associated expenses.

Gynecological visits with a diagnosed condition will continue to be covered under regular MAP provisions, including application of the deductible. The benefit for a diagnosed condition applies regardless of whether or not associated with a Pap smear test.

Chemotherapy, Electroshock and Radiation Therapy

MAP covers the cost of chemotherapy, electroshock and radiation therapy (for the agent/drug and its administration but not the hospital charges) with no deductible required. The agent/drug is paid at 100 percent of R&C.

Physicians' administration charges are paid as follows:
• PPO physician services will be paid at 100 percent of the 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, no deductible required.
• If you do not live in a PPO area, services by a non-PPO physician located outside the PPO area will be paid at 100 percent of R&C, no deductible required.
• If you do not live in a PPO area but come into a PPO area for services, you must use a PPO provider to obtain maximum benefits. Non-PPO physician services will be paid at 80 percent of the payment allowance, no deductible required.

Human Organ Transplants

MAP coverage for human organ transplants is provided only under the circumstances described in this section and is limited to the following procedures:
• Bone marrow, for specific diagnoses
• Cornea
• Heart
• Kidney

Bone marrow, heart, and kidney transplants must meet all of the following criteria before being covered under MAP:

• The patient must have no other terminal disease requiring treatment that would not be affected by the transplant;
• The procedure must be performed in approved facilities which have demonstrated a high degree of success. The names of these facilities are available from QCP;
• The patient must satisfy the selection criteria of the facility to which he/she has been referred.

In addition, bone marrow and heart transplants must meet all of the following requirements before they will be covered under MAP:
• The patient must be faced with a life-threatening illness, and all alternative conventional therapies must have been performed without having cured or lessened the medical situation; and
• The transplant must have a reasonable probability of success which will lead to a higher quality of life.

Subject to the foregoing requirements, autologous bone marrow transplants are covered under MAP for only the following conditions:
• Advanced Hodgkin's Disease in individuals for whom conventional treatment has failed and who have no compatible donor;
• Acute leukemia in remission in individuals who have a high probability of relapse and no compatible donor;
• Specific resistant non-Hodgkin's lymphomas.

Services or supplies for or related to human organ or autologous bone marrow transplant procedures that are not listed above as being covered under the MAP likewise are not covered. Related services or supplies include the administration of high dose chemotherapy and in-patient care associated with such chemotherapy when supported by transplant procedures.

Certain transplants not covered under MAP may be eligible for benefits if the active participant elected coverage under the Supplemental Transplant Assistance Plan (STAP). Please refer the summary plan description for the Supplemental Transplant Assistanct Plan for more information.

Additional MAP Benefits

MAP pays 90 percent of the R&C charges once the deductible has been met for the following:
• Physical therapy/physiotherapy, (must be precertified by QCP) if prescribed by a physician and performed by a registered physical therapist (RPT), or when performed by a licensed physical therapy assistant (LPTA) when supervised and billed by an RPT;
• Blood, if not donated or otherwise replaced;
• Initial placement of artificial limbs and eyes, but not their replacements;
• Certain prescribed durable medical equipment, e.g., wheelchairs;
• Local ambulance service to the nearest hospital where treatment is first given (benefits increase to 100 percent for a transfer from a non-PPO hospital to a PPO hospital when precertified by QCP); and
• Private duty nursing, if precertified by QCP; however, the following criteria apply:
  - Expenses incurred for the professional services of a registered nurse (RN) or a licensed practical nurse (LPN) – other than a nurse who is a member of the immediate family and resides in the covered individual's home – may be covered, and
  - Payment will be made for only that portion of the nurse's services that are determined to be medically necessary by Blue Cross and Blue Shield of Alabama, and then only upon receipt of a physician's written documentation of such need. A listing of the special care services should be provided.

Exclusions (Not Covered under MAP)

Although MAP covers a broad range of services and supplies, there are some items, as in all plans of this type, that are excluded and are not covered. These include but are not limited to:

- Saturday and Sunday hospital room and board charges for non-emergency Friday and Saturday admissions, except as explained under "Special Limitations" on page 29;
- Expenses due to a pre-existing condition, (see page 23);
- Charges for any services received before coverage under MAP began;
- Expenses due to an occupational illness or injury covered by Workers' Compensation;
- Routine health check-ups or examinations unless specifically stated under MAP's provisions;
- Diagnostic tests (unless specifically stated under MAP's provisions) which do not reveal either an illness or injury, unless you submit satisfactory proof that you had specific symptoms of a condition requiring medical attention;
- Charges paid or payable under the laws of any country or for which you have no legal obligation to pay;
- Brand name prescription drug charges in excess of the cost for generic drug substitutes when a generic drug is available and allowed by the prescribing physician;
- Over-the-counter drugs, even if prescribed, except prenatal vitamins;
- Charges in excess of R&C limits;
- Charges in excess of payment allowance limits;
- Hospitalization for dental care unless required due to an accident or to safeguard your health (see "Special Limitations" on page 29);
- Charges for any dental work or treatment except to the extent specifically provided under MAP's provisions;
- Outpatient facility charges from other than an ambulatory surgical facility or an outpatient department of a hospital;
- Charges for any surgery or medical treatment, including drugs, that are considered experimental, investigative or exploratory;
- Charges for in-hospital personal services, e.g., radio and television rentals, guest meals, barber, etc.;
- Mail Order Prescription Drug Program copayments (see page 42);
- PPO Pharmacy copayments;
- Physician copayments, such as the $5 copayment for the well child care benefits, (see page 45), and the PPO physician copayments;
- Amounts (other than any covered expenses applied to the deductible) in excess of limits for mental/nervous care and chiropractic benefits;
- Charges for vision therapy, eyeglasses, or hearing aids and related examinations or prescriptions for them, except initially due to surgery;
- Speech therapy is not covered for self-correcting articulation problems;
- Charges for therapies (physical, rehabilitation) that are determined to be maintenance treatment;
- Charges for care in a nursing or convalescent home (unless approved by QCP);
- Charges for custodial care or rest cures;
- Services or expenses related to the non-surgical management of Temporomandibular Joint Dysfunction (TMJ);
- Charges above MAP coverage limits;
- Cosmetic surgery or treatment unless required because of an accident which occurred after coverage under MAP began or to correct a birth defect, if such correction results in an improvement of bodily function;
- Expenses for an illness or injury caused by an act of war – declared or undeclared;
- Charges from a social worker or counselor;

- Charges billed independently by a Certified Registered Nurse Anesthetist (CRNA) when the services are provided in facilities inside the BellSouth PPO areas;
- Expenses primarily for the purpose of weight loss;
- Durable Medical Equipment and medical supplies that can be purchased over the counter, such as blood pressure monitors and glucometers;
- Food and food supplements, such as vitamins, unless administered by nasogastric or gastrostomy tubes;
- Charges primarily for the purpose of education rather than treatment, e.g., diabetic dietary counseling;
- Flu shots;
- Nicorette/Nicoderm or any smoking cessation program;
- Charges for dental implants.

MAP is intended to reimburse you for medically necessary expenses incurred for the care and treatment of a non-occupational illness or injury. Therefore, any charges for care, treatment, services or supplies that are not determined to be medically necessary for the treatment of a non-occupational illness or injury or which are provided solely for your convenience are considered exclusions and will not be covered by MAP.

Remember, you and your physician are responsible for making all decisions regarding your medical treatment.

Coordination of Benefits

With the growing number of medical plans and the increasing number of two-income families, many people are covered or have the opportunity to be covered under more than one group plan. For this reason, MAP contains a Coordination of Benefits (COB) provision which is designed to ensure benefits up to your MAP benefit levels on each claim while preventing duplication of payment.

NOTE: There is no coordination of benefits between plans provided by BellSouth Corporation or its subsidiaries.

COB applies when an employee or dependent is covered, or in certain circumstances eligible for coverage, by more than one group plan or by Medicare (see "Medicare" on page 56). Under MAP, a group plan is a medical plan offered by an employer (business, partnership, individual owner, etc.) to its employees at no cost or at a cost subsidized by the employer. For example, multiple-choice, flexible benefit plans, ERISA-type plans, federal/state/local government plans, and certain church plans are considered group plans. (This excludes coverage provided by HMOs. See page 52.)

If an employer simply offers a plan for the convenience of its employees by collecting the premiums but does not contribute to its cost, the plan is not considered a group plan.

The COB provision does not apply to any individual or personal policies of insurance.

Keep in mind, MAP PPO hospital and physician provisions apply even if MAP is the secondary plan.

It is your responsibility to notify your benefit office of any additions/changes in your and

your dependents' eligibility for other insurance coverage.

When Coordination of Benefits Does Not Apply

When a person is covered under a Health Maintenance Organization (HMO), BellSouth does not provide secondary coverage. In addition, there is no COB between BellSouth participating companies covered under MAP or other BellSouth provided plans. (For a list of participating companies, see the inside front cover of this booklet.)

Primary/Secondary Coverage

The plan that considers expenses first is the primary plan. The plan that waits for the primary plan to consider expenses is the secondary plan.

When MAP is the secondary plan, combined benefits from both the primary and secondary plans may not total more than the amount MAP would have paid alone. In other words, MAP will coordinate benefits up to MAP benefit levels. Also, MAP will pay only benefits for expenses covered by MAP.

MAP coordinates with other group health plans according to the following rules:

- A plan that has no rules for coordinating benefits with other plans is primary.
- A plan that has a secondary-only rule for its employees when other coverage is available will be primary.
- A plan that covers a person as an employee or in some capacity other than as a dependent is primary.
- The plan of the parent or sponsor whose birthday comes first in the year will be the primary plan for children and other dependents. This is the "birthday rule." If a plan has not adopted the "birthday rule," that plan's rules will determine which plan is primary. However, if your spouse works and declines dependent coverage because contributions are required, MAP will provide full plan benefits for your dependent children.
- For children whose parents are divorced or separated, the following rules apply:
  - If there is a court order establishing which parent has financial responsibility for the child's health care expenses, that parent's plan will be primary.
  - If there is no court order, and the parent with custody has not remarried, that parent's plan is primary.
  - If there is no court order and the parent with custody has remarried, plans covering the child will pay benefits in the following order:
    1) The plan of the parent with custody;
    2) The plan of the step-parent with custody;
    3) The plan of the parent without custody.
- If none of the rules listed above establish an order of payment, the plan which has covered the person the longest will be primary.

Example #1: Spouse's Expenses

Assume: Your spouse is an active employee of AB & Company (ABC) and is covered by its plan; therefore, ABC's plan is primary. Your spouse has surgery on March 1, 1991, and the non-PPO surgeon's fees of $1,000 are within R&C limits and covered under both ABC's and BellSouth's plans. Deductibles under both plans have been met. You reside in a non-PPO area.

MAP's benefit level is 90 percent. ABC's benefit level is 80 percent. As the primary plan,

ABC considers the expense first and pays $800 (80 percent of $1,000).

Since MAP is the secondary plan, it pays the difference between ABC's plan payment and MAP's benefit:

MAP benefit	***(90% of $1,000)***	***$900***
ABC pays	***(80% of $1,000)***	***-800***
MAP pays		***$100***

The $800 paid by ABC's plan does not apply toward MAP's deductible or out-of-pocket limit.

COB Rules: When Your Spouse is Employed

If Your Spouse Declines His/Her Employer's Group Plan

COB rules affect you if your spouse works and declines his/her employer's group plan coverage when the employer contributes:

- All or any part of the cost of the coverage for its employees (if your spouse works 30 or more hours per week);
- The full cost of coverage for its employees, even when your spouse works less than 30 hours per week; or
- The full cost of dependent coverage if it would be primary according to COB rules.

MAP will pay normal benefits minus the benefits that would have been paid by your spouse's employer's plan if your spouse had elected coverage, assuming that your spouse met that plan's deductible. In other words, MAP benefits are reduced by benefits that were available even if they were not elected.

Should the COB rules apply to your working spouse, you may elect to purchase MAP primary coverage for your spouse, unless your spouse works more than 30 hours and his/her employer pays the full cost of coverage. In that case, you cannot purchase MAP coverage for your spouse. Please contact your benefit office for rates and to see if they qualify.

However, if you retired prior to Jan. 1, 1988, and your spouse declines his/her current or former employer's coverage because employee contributions are required, MAP will provide full plan benefits. If you retired on or after Jan. 1, 1988, and your spouse is employed, COB rules apply.

Example #2: Spouse's Expenses

Assume: You are an active employee. Your spouse is an active employee of AB & Company (ABC) and works more than 30 hours per week. ABC pays a portion of the cost for medical coverage, but your spouse declined. ABC's plan is still considered primary for your spouses expenses.

Your spouse has surgery on March 1, 1991, and non-PPO surgeon's fees of $1,000 are within R&C limits and covered under both ABC's and BellSouth's plans. Your MAP deductible has been met. You do not live in a PPO area.

MAP's benefit level is 90 percent. ABC's plan benefit level is 80 percent; therefore, it would have paid $800 (80 percent of $1,000). Since ABC sponsors a medical plan and makes contributions toward its costs, the COB rules apply. ABC's plan benefits will be taken into account when determining MAP's benefit payment.

If MAP were the primary plan, it would have paid $900 (90 percent of $1,000). Since it is

secondary, it pays the difference between its normal payment and ABC's plan benefit, as determined as follows:

MAP benefit	***(90% of $1,000)***	***$900***
ABC benefit	***(80% of $1,000)***	***-800***
MAP pays		***$100***

MAP pays only $100 even though the ABC plan did not actually pay the $800, and the $800 does not apply toward MAP's deductible or out-of-pocket limit.

Example #3: A Dependent Child's Expenses
Make the same assumptions as in Example #2, except: The $1,000 medical claim is for your child's surgery. The claim is submitted to MAP. ABC's plan is primary and provides dependent coverage at no cost to your spouse; however, your spouse declined coverage.

According to MAP's COB rules, ABC's plan benefits would be taken into account when determining MAP's benefit. If MAP was primary, it would have paid $900 (90 percent of $1,000) for this claim. Since it is secondary it would pay the difference between its normal payment and ABC's plan benefit (see Example 2).

MAP pays $100 even though the ABC plan did not actually pay the $800, and the $800 does not apply toward MAP's deductible or out-of-pocket limit.

If Your Spouse is Self-Employed

Special COB rules apply if your spouse:
- Is eligible for group medical coverage through a professional association but declines it, or
- Has employees and provides group medical coverage to them.

MAP will pay normal benefits minus the benefits that would have been paid by your spouse's plan if he/she had elected coverage, assuming that he/she met that plan's deductible. <u>In other words, MAP benefits are reduced by benefits that were available, even if they were not elected.</u>

As an alternative, you may purchase MAP primary coverage for your self-employed spouse. Please contact your Benefit Office for rates and to see if your spouse qualifies.

COB Rules for "Multiple Choice" Medical Benefits

If your spouse works 30 or more hours a week and his/her employer or former employer offers a cafeteria-style, flexible benefits program or any type of multiple-choice benefit group plan, regardless of the cost to your spouse (and your spouse either elects or declines medical coverage), BellSouth will coordinate benefits as follows:
- The mid-priced option will be used, even if your spouse chooses a less expensive option or declines coverage.
- If your spouse elects the mid-priced option or one more expensive, the option selected will be used to coordinate benefits with MAP.

If the mid-priced option cannot be determined, the most popular option will be used instead of the mid-priced option. The most popular option is determined by participants' elections in the group eligible for the options at your spouse's employer or former employer.

Once it has been determined which medical option to apply, benefits will be coordinated according to MAP's COB provisions.

Example #4: Flexible Benefits
Assume: Your spouse is an active employee of AB & Company (ABC) and works more than 30 hours per week. ABC's plan, therefore, is the primary plan.

Your spouse has surgery on March 1, 1991, and non-PPO surgeon's fees of $1,000 are within R&C limits and covered under both plans. Your MAP deductible has been met. You do not live in a PPO area.

MAP's benefit level is 90 percent. ABC offers your spouse three different medical options. Each one covers the same expenses but at different rates:
- *Option 1 pays 70 percent of the covered expenses;*
- *Option 2 pays 80 percent of the covered expenses;*
- *Option 3 pays 90 percent of the covered expenses.*

Your spouse declines coverage under any option.

According to COB rules, MAP coverage is secondary. The mid-priced option, Option 2, will be used to determine MAP benefits as follows:

MAP benefit	***(90% of $1,000)***	***$900***
ABC's Option 2 benefit	***(80% of $1,000)***	***-800***
MAP pays		***$100***

MAP pays only $100 even though ABC's plan did not actually pay the $800, and the $800 does not apply toward the MAP deductible or out-of-pocket limit.

If your spouse had not declined coverage but had elected Option 1 or 2, MAP's benefit would still be $100 (according to the mid-priced option rule). If Option 3 had been elected, no MAP benefits would have been paid since Option 3's benefit level is the same as MAP's. ***According to COB rules, MAP coordinates benefits only up to MAP levels.***

COB Rules for Surviving Spouse Contracts

A surviving spouse who becomes employed is not required to elect coverage paid for in part or in full by his/her employer. However, if the surviving spouse elects coverage through his/her employer, coverage through MAP will be secondary.

The surviving spouse may elect to continue primary coverage for the dependents on his/her MAP contract, if they are not covered under any other group plan, regardless of whether the surviving spouse chooses to be secondary under MAP.

COB Rules for Retirees Who Become Employed

See, "When You Retire" and "Competitor Rule and Benefit Forfeiture" on pages 61 and 62.

Medicare

There are two parts to Medicare: **Part A** provides benefits for hospital care, and **Part B** provides benefits toward physician's fees and certain other covered medical expenses.

Based on current federal law, you and your dependents may become eligible for both parts of Medicare upon reaching age 65, or before age 65 if you are disabled and have received 24 months of disability payments from Social Security. Medicare is also available at any age if the participant has End-Stage Renal Disease.

You should contact your local Social Security office for information on how to enroll in Medicare. Part A is paid in full by Medicare. For Part B, the government charges a monthly premium. However, the company currently reimburses Part B premiums, up to the 1990 premium amount ($28.60). That reimbursement excludes any special coverage premiums that you and your eligible Class I dependents who were covered under MAP on your retirement effective date pay to the government for Part B coverage, unless the company provides primary medical coverage. You must be pension-eligible to receive Part B reimbursement. Long term disability (LTD) participants who are not service or disability pension eligible do not qualify for Part B reimbursement.

To apply for reimbursement, contact your Benefit Office. If the company provides primary coverage, Part B premiums are not reimbursed.

It is your responsibility to notify your Benefit Office of any change in Medicare eligibility for you and your dependents.

Once you or your dependents meet the criteria for Medicare eligibility, MAP will not reimburse any benefits payable under the law regardless of your enrollment status. MAP will subtract any benefits available under Medicare from the MAP benefits you can receive. In combination with Medicare, MAP currently provides the same level of coverage you had under MAP alone. Remember, the MAP deductible must be satisfied each calendar year. Expenses applied to the Medicare deductible may also be used to satisfy the MAP deductible. Medicare will be primary except as explained below.

In states where appropriate agreements are in place, Medicare carriers will electronically file your claim for secondary coverage directly with MAP.

Coverage for Active Employees and Their Medicare-Eligible Dependents

For active employees who have a disabled dependent (for reasons other than End-Stage Renal Disease), MAP will provide primary coverage for the disabled dependent until he/she reaches age 65. At age 65, Medicare becomes the primary plan for any disabled dependent other than the spouse. The disabled spouse's coverage under MAP will remain primary as long as the participant is an active employee.

If a participant requires treatment for End-Stage Renal Disease, MAP will provide primary coverage for the first 18 months but will be secondary to Medicare thereafter. However, when MAP becomes secondary, the participant may be eligible for Part B reimbursement.

If you work beyond age 65, MAP will continue to be primary for you and your spouse. If either you or your spouse reject, in writing, primary coverage under MAP and choose Medicare as your primary coverage, MAP coverage will end for the person making the election until the BellSouth employee retires.

Coverage for Spouses and Class II Dependents Not Eligible for Medicare

For retirees whose retirement date is prior to Jan. 1, 1988, spouses who have to pay for Medicare coverage due to their insufficient work record will not be carved-out under MAP. BellSouth will continue to provide primary MAP coverage until the dependent is eligible for Medicare coverage on the retiree's work records. Then, MAP will provide secondary coverage.

For retirees whose retirement date is on or after Jan. 1, 1988, spouses who have to pay for Medicare coverage will be carved out under MAP. Only secondary MAP benefits will be provided, even though the spouse has to pay for Medicare coverage due to an insufficient work history.

The carve-out will apply to all Class II dependents who become eligible for Medicare, regardless of their work history or the retiree's retirement date.

No reimbursement for Part B Medicare premiums will be made for Class II dependents.

The company reserves the right to modify coverage, including reduction, elimination of coverage, or requiring employees or dependents to pay all or a portion of coverage costs, at its discretion, subject to applicable collective bargaining agreements.

How to File a Claim

When to File

Once coverage begins, you may apply for benefits as soon as you incur a covered expense. However, it is recommended that all requests for benefit payments be submitted to Blue Cross and Blue Shield of Alabama within 90 days after the medical expenses are incurred. For hospitalization, the hospital and physician will normally file your claims. (Separate claims must be filed for each covered dependent.)

The provider or participant must file the claims no later than 12 months from the date of the service. Claims received after one year from the date the expenses were incurred will not be covered or paid.

Filing Claims When COB Applies

Requests for benefit payments should always be filed with the primary plan first. When COB rules determine that MAP is secondary, MAP payments will be delayed until you provide information on your other available group plan coverage. It is your responsibility to keep enrollment information for yourself and your dependents current on your company enrollment records. To make changes, please call your Benefit Office. If you fail to do so, payments may be delayed, reduced or denied. In some situations, refunds may be requested for previous MAP payments.

Retired employees enrolled in Medicare should always file with Medicare first, then attach their Explanation of Medicare Benefits (EOMB) Form and itemized bill to the Medical Plan Claim Form. Timely filing provisions apply to all MAP claims, even if Medicare or another insurance is primary.