



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at AlabamaBlue.com or by calling 1-800-292-8868.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$500 person / \$1500 family. Does not apply to preventive services, inpatient, drugs, noncovered services, most copays, physician outpatient, balance-billed charges and pre-certification penalties.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$750 person per admission for out-of-network. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$5000 person / \$10000 family.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premium, balance-billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits and pre-certification penalties.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes, this plan uses in-network providers. For a list of in-network providers, see AlabamaBlue.com or call 1-800-810-BLUE.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-292-8868 or visit us at AlabamaBlue.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-292-8868 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance & \$35 copay	50% coinsurance	Subject to overall deductible for out-of-network
	Specialist visit	0% coinsurance & \$50 copay	50% coinsurance	Subject to overall deductible for out-of-network
	Other practitioner office visit	20% coinsurance for chiropractor	20% coinsurance for chiropractor	Subject to overall deductible; in Alabama, out-of-network not covered
	Preventive care/screening/immunization	No Charge	Not Covered	Please see AlabamaBlue.com/preventiveservices
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	Benefits listed are physician services; subject to overall deductible for out-of-network; facility benefits are also available
	Imaging (CT/PET scans, MRIs)	0% coinsurance & \$200 copay per procedure	50% coinsurance	Benefits listed are physician services; subject to overall deductible for out-of-network; precertification may be required for coverage; facility benefits are also available

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at AlabamaBlue.com/pharmacy .	Tier 1 drugs	0% coinsurance & \$15 copay	Not Covered	Prior authorization required for specific drugs; generic drugs mandatory when available; mail order is available through PrimeMail®
	Tier 2 drugs	0% coinsurance & \$40 copay	Not Covered	Prior authorization required for specific drugs; generic drugs mandatory when available; mail order is available through PrimeMail®
	Tier 3 drugs	0% coinsurance & \$60 copay	Not Covered	Prior authorization required for specific drugs; generic drugs mandatory when available; mail order is available through PrimeMail®
	Tier 4 drugs	0% coinsurance & \$100 copay	Not Covered	Prior authorization required for specific drugs; generic drugs mandatory when available; mail order is available through PrimeMail®
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance & \$400 copay	20% coinsurance	Benefits listed are Tier 1; Tier 2 and Tier 3 facilities in Alabama will have higher copay; subject to overall deductible for out-of-network; in Alabama, out-of-network not covered
	Physician/surgeon fees	0% coinsurance	50% coinsurance	Subject to overall deductible
If you need immediate medical attention	Emergency room services	0% coinsurance & \$400 copay	0% coinsurance & \$400 copay	Subject to overall deductible for out-of-network; physician charges may apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to overall deductible
	Urgent care	0% coinsurance & \$50 copay	50% coinsurance	Subject to overall deductible for out-of-network

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance & \$200 copay days 1-5	20% coinsurance & \$750 per admission	Benefits listed are Tier 1; Tier 2 and Tier 3 facilities in Alabama will have higher copay; in Alabama, out-of-network benefits are only available for accidental injury; precertification is required for coverage
	Physician/surgeon fee	0% coinsurance	50% coinsurance	Subject to overall deductible

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	50% coinsurance	Benefits listed are outpatient physician services; in-network benefits listed are coordinated by Expanded Psychiatric Services (EPS); non-EPS benefits are also available with higher patient responsibility; subject to overall deductible for out-of-network; some services require precertification
	Mental/Behavioral health inpatient services	No Charge	20% coinsurance	Benefits listed are inpatient physician services; in-network benefits listed are coordinated by Expanded Psychiatric Services (EPS); non-EPS benefits are also available with higher patient responsibility; precertification is required
	Substance use disorder outpatient services	No Charge	50% coinsurance	Benefits listed are outpatient physician services; in-network benefits listed are coordinated by Expanded Psychiatric Services (EPS); non-EPS benefits are also available with higher patient responsibility; subject to overall deductible for out-of-network; some services require precertification
	Substance use disorder inpatient services	No Charge	20% coinsurance	Benefits listed are inpatient physician services; in-network benefits listed are coordinated by Expanded Psychiatric Services (EPS); non-EPS benefits are also available with higher patient responsibility; precertification is required
If you are pregnant	Prenatal and postnatal care	0% coinsurance	50% coinsurance	Benefits listed are outpatient physician services; subject to overall deductible; physician copay may apply

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	0% coinsurance	50% coinsurance	Benefits listed are inpatient physician services; subject to overall deductible
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Subject to overall deductible; in Alabama, out-of-network not covered; precertification may be required for coverage
	Rehabilitation services	20% coinsurance	20% coinsurance	Subject to overall deductible; limited to a combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year; in Alabama, out-of-network coinsurance is 50%
	Habilitation services	20% coinsurance	20% coinsurance	Subject to overall deductible; limited to a combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year; in Alabama, out-of-network coinsurance is 50%
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	20% coinsurance	Subject to overall deductible; in Alabama, out-of-network coinsurance is 50%
	Hospice service	0% coinsurance	20% coinsurance	Subject to overall deductible; in Alabama, out-of-network not covered; precertification may be required for coverage
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Please see AlabamaBlue.com/preventiveservices
	Glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Dental check-up	No Charge	Not Covered	Please see AlabamaBlue.com/preventiveservices

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|------------------------|----------------------------|
| • Acupuncture | • Glasses, child | • Routine eye care (Adult) |
| • Bariatric surgery | • Hearing aids | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Skilled nursing care |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|--|--|
| • Chiropractic care | • Infertility treatment (Assisted Reproductive Technology not covered) | • Non-emergency care when traveling outside the U.S. |
|---------------------|--|--|

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan administrator at the phone number listed in your benefit booklet. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the plan administrator at 1-800-292-8868. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have healthcare coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% health coverage. **This plan does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-292-8868.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,430
- Patient pays \$1,110

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Copays	\$460
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$1,110

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: AlabamaBlue.com.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,790
- Patient pays \$1,610

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$20
Copays	\$1220
Coinsurance	\$0
Limits or exclusions	\$370
Total	\$1,610

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: AlabamaBlue.com.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

Questions: Call 1-800-292-8868 or visit us at AlabamaBlue.com.

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**PRemployer
BlueCard[®] PPO**

Effective January 1, 2016



Hospital Tiered Network

The Blue Cross and Blue Shield of Alabama Hospital Tiered Network is a local Alabama effort to ensure fiscal responsibility, quality and patient safety in member hospitals. Hospitals are categorized into one of three “tiers”, based on their performance. Hospitals designated as Tier 1 are recognized as having attained the highest level of performance.

Copay amounts for inpatient and outpatient services will vary between tiers with Tier 1 having the lowest copay. The Tier 1 level includes all PPO facilities (including PPO facilities outside Alabama) other than Tier 2 and Tier 3. Only Alabama general acute care hospitals are eligible for tiering within the Hospital Tiered Network. Rehabilitation hospitals, psychiatric hospitals, specialty facilities, out of state hospitals, VA hospitals and long term care hospitals are exempt from participating. All facilities not included on this list are subject to standard in-network benefit design.

All hospitals are evaluated annually with changes made effective January 1. In addition, reviews are completed on a quarterly basis allowing hospitals to improve tier status. To review the evaluation criteria for all hospitals and/or the tier level of a particular hospital, please use the “Find a Doctor” tool on our website at **AlabamaBlue.com**. The tier level will be included in the information provided for each hospital that participates in the Hospital Tiered Network. For more information on the evaluation criteria, click on the name of the hospital and then click on the “Credentials” tab. If you have any questions, please call the Customer Service number on the back of your ID card.

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Effective January 1, 2016**

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<i>Benefit payments are based on the amount of the provider's charge that Blue Cross and Blue Shield recognizes for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received. Some services require a copay, coinsurance, calendar year deductible or deductible for each admission, visit or service.</i>		
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services and maternity); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll-free) for precertification.		
Inpatient Hospital	Tier 1: Covered at 100% after \$200 per day hospital copay days 1-5 for each admission Tier 2 & Tier 3: Covered at 100% after \$400 per day hospital copay days 1-5 for each admission	Covered at 80% after \$750 per admission deductible Note: In Alabama, available only for medical emergency and accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 100% not subject to calendar year deductible	Covered at 50% subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 80% not subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Tier 1: Covered at 100% after \$400 hospital copay Tier 2 & Tier 3: Covered at 100% after \$800 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% after \$400 hospital copay	Covered at 100% after \$400 hospital copay and subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 100% after \$400 hospital copay; copay applies to the out-of-pocket maximum
Emergency Room (Accident) Note: If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to Emergency Room (Medical Emergency) above.	Covered at 100% after \$400 hospital copay	Covered at 100% after \$400 hospital copay and subject to calendar year deductible for services within 72 hours; 80% of the allowed amount, subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Emergency Room Physician	Covered at 100% after \$50 physician copay	Covered at 100% after \$50 physician copay and subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 100% after \$50 physician copay; copay applies to the out-of-pocket maximum
Outpatient Diagnostic Lab, X-ray & Pathology Note: The first covered mammogram each calendar year is not subject to the hospital copay	Tier 1: Covered at 100% after \$400 hospital copay Tier 2 & Tier 3: Covered at 100% after \$800 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)	Covered at 100% after \$50 daily hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
IN-NETWORK SERVICES NOT SUBJECT TO \$500 CALENDAR YEAR DEDUCTIBLE		
Office Visits & Consultations	Covered at 100% after \$35 primary physician copay or \$50 specialist physician copay	Covered at 50% subject to calendar year deductible
Second Surgical Opinions	Covered at 100% after \$50 physician copay	Covered at 50% subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%; no copay or deductible	Covered at 50% subject to calendar year deductible
CAT Scan, MRI, PET/SPECT, ERCP, angiography/arteriography, cardiac cath/arteriography, colonoscopy, UGI endoscopy, muga-gated cardiac scan	Covered at 100% after \$200 copay per procedure	Covered at 50% subject to calendar year deductible
IN-NETWORK SERVICES SUBJECT TO \$500 CALENDAR YEAR DEDUCTIBLE		
Surgery & Anesthesia	Covered at 100% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
Maternity Care	Covered at 100% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services <ul style="list-style-type: none"> See AlabamaBlue.com/preventiveservices for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See AlabamaBlue.com/pharmacy for more information 	Covered at 100%; no copay or deductible	Not covered
Note: In some cases, office visit copays or facility copays may apply		
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Prescription Drug Card <ul style="list-style-type: none"> The pharmacy network for the plan is the Prime Participating Pharmacy Network Some drugs require precertification Some copays combined for diabetic supplies Prescription drugs (other than specialty drugs) can be dispensed for up to a 90-day supply but the copay is applicable for each 30-day supply Tier 4 (specialty) drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Prime Therapeutics Specialty Pharmacy network. Go to AlabamaBlue.com/web/pharmacy/drugguide.html for a list of these specialty drugs. View the Standard Prescription Drug list that applies to the plan at AlabamaBlue.com/web/pharmacy/drugguide.html 	Covered at 100% subject to the following copays for a 30-day supply for each prescription: Tier 1 Drugs: \$15 copay per prescription Tier 2 Drugs: \$40 copay per prescription Tier 3 Drugs: \$60 copay per prescription Tier 4 (specialty) Drugs: \$100 copay per prescription Generic drugs are mandatory when available and may be classified at any Tier.	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Mail Order Pharmacy Benefits <ul style="list-style-type: none">Up to 90-day supply with one copayMail Order drugs are available through PrimeMail® (Enroll online at AlabamaBlue.com or call 1-877-579-7627)Maintenance and Non-Maintenance drugs can be purchased through mail order pharmacySpecialty Drugs are not available through mail order	Covered at 100% subject to the following copays for a 90-day supply for each prescription: Tier 1 Drugs: \$45 copay per prescription Tier 2 Drugs: \$100 copay per prescription Tier 3 Drugs: \$180 copay per prescription Generic drugs are mandatory when available and may be classified at any Tier.	Not covered
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar Year Deductible	\$500 individual; \$1,500 aggregate amount per family	
Calendar Year Out-of-Pocket Maximum	\$5,000 individual; \$10,000 aggregate amount per family All deductibles, copays and coinsurance for in-network services and all deductibles, copays and coinsurance for out-of-network mental health disorders/substance abuse emergency services apply to the out-of-pocket maximum. Coinsurance for out-of-network Home Health, Hospice, and Other Covered Services (excluding occupational therapy, physical therapy, speech therapy and DME in Alabama) applies to the out-of-pocket maximum. After you reach Calendar Year Out-of-Pocket Maximum, applicable expenses covered at 100% for remainder of calendar year.	
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Allergy Testing & Treatment	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Ambulance Service	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Participating Chiropractic Services	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Durable Medical Equipment (DME)	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
Occupational, Physical and Speech Therapy <ul style="list-style-type: none">Occupational, physical and speech therapy limited to combined maximum of 30 visits per yearChildren ages 0-9 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
Home Health and Hospice	Covered at 100% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
EXPANDED PSYCHIATRIC SERVICES (EPS)		
Expanded Psychiatric Services (EPS) <ul style="list-style-type: none">EPS network available throughout Alabama and in Meridian, Mississippi and Northwest FloridaTo find an EPS provider call Customer Service at 1-800-292-8868 or search the online provider finder on our website at AlabamaBlue.com	When care is received or coordinated by an EPS provider, the following mental health disorders and substance abuse benefits are available: Covered at 100%; no copay or deductible Inpatient: Includes hospital, physician and therapy expenses Outpatient: Includes office visits, therapy, counseling and testing When care is not received or coordinated by an EPS provider, the mental health disorders and substance abuse benefits available will mirror all other categories of this matrix.	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
Baby Yourself[®]	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at BeHealthy.com .	
Contraceptive Management	Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.	
Air Medical Services	Air ambulance service to a network hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624.	

Useful Information to Maximize Benefits

- To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website (**AlabamaBlue.com**) or call 1-800-810-BLUE (2583).
- In-network hospitals, physicians and other healthcare providers have a contract with Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard PPO, PMD, Preferred Care). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.
- Out-of-network providers generally do not contract with Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area.
- Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.
- Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.

This is not a contract, benefit booklet or a Summary Plan Description.

Benefits are subject to the terms, limitations and conditions of the group contract (including your benefit booklet).

Check your benefit booklet for more detailed coverage information.

Please visit our website, AlabamaBlue.com.