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FOR BUSINESS

Plan Benefits Summary

BlueCross BlueShield of Alabama

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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 in these areas. Hospitals designated as Tier 1 are recognized as having attained the highest level of compliance.

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 **www.bcbsal.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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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize 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.		
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health and Substance Abuse)		
Preadmission certification is required for inpatient admissions (except medical emergency services and maternity); notification within 48 hours for emergencies. Call 1-800-248-2342 (toll free) for precertification.		
Inpatient Hospital	**Tier 1:** Covered at 100% of the allowed amount after $200 per day hospital copay days 1-5 for each admission **Tier 2 & Tier 3:** Covered at 100% of the allowed amount after $400 per day hospital copay days 1-5 for each admission	Covered at 80% of the allowed amount after $800 per admission deductible **Note**: In Alabama, available only for medical emergency and accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount subject to calendar year deductible **Mental Health and Substance Abuse Services covered at 100% of the allowed amount; no copay or deductible**	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible **Mental Health and Substance Abuse Services covered at 80% of the allowed amount; no copay or deductible**
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health and Substance Abuse)		
Outpatient Surgery **(Including Ambulatory Surgical Centers)**	**Tier 1:** Covered at 100% of the allowed amount after $200 hospital copay **Tier 2 & Tier 3:** Covered at 100% of the allowed amount after $400 hospital copay	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount after $200 hospital copay	Covered at 100% of the allowed amount after $200 hospital copay and subject to calendar year deductible **Mental Health and Substance Abuse Services covered at 100% of the allowed amount after $200 hospital copay**
Emergency Room (Accident)	Covered at 100% of the allowed amount after $200 hospital copay	Covered at 100% of the allowed amount after $200 hospital copay and subject to calendar year deductible for services within 72 hours; thereafter 80% of the allowed amount subject to calendar year deductible
Emergency Room Physician	Covered at 100% of the allowed amount after $50 physician copay	Covered at 100% of the allowed amount after $50 physician copay and subject to calendar year deductible **Mental Health and Substance Abuse Services covered at 100% of the allowed amount after $50 physician copay**
Outpatient Diagnostic Lab, X-ray & Pathology **Note:** Precertification is required for certain services	**Tier 1:** Covered at 100% of the allowed amount after $200 hospital copay **Tier 2 & Tier 3:** Covered at 100% of the allowed amount after $400 hospital copay	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered
PHYSICIAN BENEFITS (Includes Mental Health and Substance Abuse)		
IN-NETWORK SERVICES *NOT* SUBJECT TO $500 CALENDAR YEAR DEDUCTIBLE		
Office Visits & Consultations	Covered at 100% of the allowed amount after $35 primary care physician copay or $50 specialist physician copay	Covered at 80% of the allowed amount subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount after $50 physician copay	Covered at 80% of the allowed amount subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
CAT Scan, MRI, PET/SPECT, ERCP, angiography/arteriography, cardiac cath/arteriography, UGI endoscopy, muga-gated cardiac scan & colonoscopy **Note:** Precertification is required for certain services	Covered at 100% of the allowed amount after $200 copay per procedure	Covered at 80% of the allowed amount subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy **Note:** Precertification is required for certain services	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible
IN-NETWORK SERVICES SUBJECT TO $500 CALENDAR YEAR DEDUCTIBLE		
Surgery & Anesthesia	Covered at 100% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Maternity Care	Covered at 100% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Note: In Alabama, out-of-network physician services covered at 50% of the allowed amount subject to calendar year deductible		
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **www.bcbsal.com/preventiveservices** for a listing of the specific immunizations and preventive services • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **www.bcbsal.com/pharmacy** for more information.	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Note: In some cases, office visit copays or facility copays may apply		
ROUTINE VISION BENEFITS		
Pediatric Eye Exam Limited to one visit per calendar year up to age 19	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Pediatric Glasses or Contact Lenses Limited to one pair of prescription glasses or contact lenses per calendar year up to age 19	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
PRESCRIPTION DRUG BENEFITS (Includes Mental Health and Substance Abuse)		
Prescription Drug Card • Some drugs require prior authorization • Prescription drugs other than **Specialty Drugs** – 90-day supply may be purchased but copay applies for each 30-day supply; some copays combined for diabetic supplies • Specialty Drugs - up to a 30-day supply • Certain Specialty Drugs can only be dispensed by a Participating Specialty Pharmacy • Specialty Drugs, or biotech drugs, are generally high cost self-administered drugs • View the Standard Prescription Drug Guide at **www.bcbsal.com**	Covered at 100% of the allowed amount after the following copays: **Generic Drugs:** $15 copay per prescription **Preferred Brand Drugs:** $40 copay per prescription **Other Brand Drugs:** $60 copay per prescription **Specialty Drugs:** $100 copay per prescription	Not covered
Mail Order Pharmacy Benefits • Up to 90-day supply with one copay • Mail Order drugs are available through PrimeMail® (Enroll online at **www.bcbsal.com** or call 1-877-579-7627) • Maintenance and Non-Maintenance drugs can be purchased through mail order pharmacy **Note:** If you have less than a 90-day supply, you will pay the same copayment as a 90-day supply when using this mail order program	Covered at 100% of the allowed amount after the following copays: **Generic Drugs*:*** $37.50 copay per prescription **Preferred Brand Drugs:** $100 copay per prescription **Other Brand Drugs:** $150 copay per prescription **Specialty Drugs:** Not covered	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health and Substance Abuse)		
Calendar Year Deductible	$500 per individual; $1,000 aggregate amount per family Calendar year deductible amounts met in-network will not apply to the out-of-network calendar year deductible	$500 per individual; $1,000 aggregate amount per family Calendar year deductible amounts met out-of-network will not apply to the in-network calendar year deductible
Calendar Year Out-of-Pocket Maximum Deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum	$5,000 individual (including calendar year deductible); $10,000 aggregate amount per family (including calendar year deductible) After you reach Calendar Year Out-of-Pocket Maximum, applicable in-network expenses covered at 100% of the allowed amount for remainder of calendar year	There is no out-of-pocket maximum for out-of-network services
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health and Substance Abuse)		
Allergy Testing & Treatment Limited to 6 visits per calendar year for allergy treatment	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Ambulance Service	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Chiropractic Services Limited to 15 visits per calendar year	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible
Occupational, Physical and Speech Therapy • Occupational, physical and speech therapy limited to combined maximum of 30 visits per year • Children ages 0-9 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible
PEDIATRIC DENTAL BENEFITS		
Diagnostic and Preventive Services (up to age 19) **Examples include:** Dental exams, routine cleanings, fluoride treatment, bitewing x-rays, full mouth x-rays and panoramic film, tooth sealants and topical fluoride varnish	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Basic Services (up to age 19) **Examples include:** Tooth color and silver amalgam fillings, simple tooth extractions, non-surgical root canal, emergency treatment for pain and repairs to crowns, inlays, onlays and dentures	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Major Services (up to age 19) **Examples include:** Oral surgery, general anesthesia, periodontic exams, removal of diseased gum tissue and bone, crowns, onlays, core buildup, dentures, implants and bridges	Covered at 50% of the allowed amount subject to calendar year deductible	Not covered
Dentally Necessary Orthodontic Services (up to age 19) **Note:** Benefits subject to a 24-month waiting period	Covered at 50% of the allowed amount subject to calendar year deductible	Not covered
Note: See your benefit booklet for visit and treatment limits		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTH AND HOSPICE BENEFITS (Includes Mental Health and Substance Abuse)		
Home Health and Hospice • Precertification required for visits by home health professionals outside Alabama • For precertification call 1-800-821-7231	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered
HEALTH MANAGEMENT AND ADDITIONAL BENEFITS (Includes Mental Health and Substance Abuse)		
Tobacco Cessation Program	A tobacco cessation program that provides support to participants through telephone-based counseling and nicotine replacement therapy. Call 1-888-768-7848 for participation information.	
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 prenatal wellness program; For more information, please call 1-800-222-4379. You can also enroll online at **www.behealthy.com.**	
Air Medical Services	Air ambulance service to a 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 (**www.bcbsal.com**) or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). In Alabama, in-network services provided by mental health and substance abuse professionals are available through the Blue Choice Behavioral Health Network. 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/or Blue Shield Plans. 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 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, www.bcbsal.com.