Blue Choice® Platinum FOR BUSINESS

Effective for plan years on and after July 1, 2014



Plan Benefits Summary



AlabamaBlue.com

We cover what matters.

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

Blue Choice[®] Platinum for Business Effective for Plan Years on and after July 1, 2014 BlueCard PPO

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		after \$20 physician copay	subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Surgery & Anesthesia	Covered at 100% of the allowed amount;	Covered at 80% of the allowed amount
	no copay or deductible	subject to calendar year deductible
Bariatric Surgery (Surgeon, Assistant	Covered at 80% of the allowed amount; no	Not covered
Surgeon & Anesthesia)	copay or deductible	
Note: In Alabama, the only in-network providers		
are Bariatric Surgery Network Providers		
Maternity Care	Covered at 100% of the allowed amount;	Covered at 80% of the allowed amount
-	no copay or deductible	subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology,	Covered at 100% of the allowed amount;	Covered at 80% of the allowed amount
Dialysis, IV Therapy, Chemotherapy &	no copay or deductible	subject to calendar year deductible
Radiation Therapy		
Notes Descentification is non-vised for contain		
Note: Precertification is required for certain services		
	services covered at 50% of the allowed amour	t subject to calendar year deductible
	PREVENTIVE CARE BENEFITS	
Routine Immunizations and Preventive	Covered at 100% of the allowed amount;	Not covered
Services	no copay or deductible	
See AlabamaBlue.com/preventiveservices		
for a listing of the specific immunizations and		
preventive services		
Certain immunizations may also be obtained		
through the Pharmacy Vaccine Network. See		
AlabamaBlue.com/pharmacy for more information.		
Note: In some cases, office visit copays or fa	acility conavs may apply	
Note: In some cases, once visit copays of it	ROUTINE VISION BENEFITS	
Adult Eye Exam	Covered at 100% of the allowed amount;	Not covered
Limited to \$75 maximum for exam and refraction	no copay or deductible	Not covered
per calendar year for adults age 19 and over	no copay of deductible	
Pediatric Eye Exam	Covered at 80% of the allowed amount	Not covered
Limited to one visit per calendar year up to age	subject to calendar year deductible	
19		
Pediatric Glasses or Contact Lenses	Covered at 80% of the allowed amount	Covered at 80% of the allowed amount
Limited to one pair of prescription glasses or contact lenses per calendar year up to age 19	subject to calendar year deductible	subject to calendar year deductible
contact lenses per calendar year up to age 19	PRESCRIPTION DRUG BENEFITS	
(Include	s Mental Health Disorders and Substan	ce Abuse)
Prescription Drug Card	Covered at 100% of the allowed amount	Not covered
 Some drugs require prior authorization 	after the following copays:	
• Prescription drugs other than Specialty Drugs	Generic Drugs:	
 90-day supply may be purchased but copay 	\$10 copay per prescription	
applies for each 30-day supply; some copays	Preferred Brand Drugs:	
combined for diabetic suppliesSpecialty Drugs - up to a 30-day supply	\$30 copay per prescription	
 Specially Drugs - up to a 30-day supply Certain Specialty Drugs can only be 	Other Brand Drugs:	
dispensed by a Participating Specialty	\$60 copay per prescription	
Pharmacy	Specialty Drugs:	
 Specialty Drugs, or biotech drugs, are 	\$60 copay per prescription	
generally high cost self-administered drugs		
View the Standard Prescription Drug Guide or locate a Participating Pharmacy at		
locate a Participating Pharmacy at AlabamaBlue.com		
Mail Order Pharmacy Benefits	Covered at 100% of the allowed amount	Not covered
Up to 90-day supply with one copay	after the following copays:	
Mail Order drugs are available through	Generic Drugs:	
PrimeMail [®] (Enroll online at	\$25 copay per prescription	
AlabamaBlue.com or call 1-877-579-7627)	Preferred Brand Drugs:	
Maintenance and Non-Maintenance drugs can	\$75 copay per prescription	
be purchased through mail order pharmacy	Other Brand Drugs:	
Note: If you have less than a 90-day supply, you	\$150 copay per prescription	
will pay the same copay as a 90-day supply	Specialty Drugs: Not covered	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	JMMARY OF COST SHARING PROVISIO	
Calendar Year Deductible	S Mental Health Disorders and Substant \$100 per individual; \$200 aggregate amount per family	\$100 per individual; \$200 aggregate amount per family
	Calendar year deductible amounts met in- network will not apply to the out-of-network calendar year deductible	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 and out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum	\$4,000 individual (including calendar year deductible); \$8,000 aggregate amount per family (including calendar year deductible) After you reach Calendar Year Out-of-Pocket Maximum, applicable 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
	NEFITS FOR OTHER COVERED SERVI s Mental Health Disorders and Substan	
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	Ce Abuse) 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 & 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)	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Examples include: Dental exams, routine cleanings, fluoride treatment, bitewing x-rays, full mouth x-rays and panoramic film, tooth sealants and topical fluoride varnish		
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
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)	Covered at 50% of the allowed amount subject to calendar year deductible	Not covered
Note: Benefits subject to a 24-month waiting period		
Note: See your benefit booklet for visit and tr	eatment limits	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK		
HOME HEALTH AND HOSPICE BENEFITS (Includes Mental Health Disorders 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 Disorders 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 (AlabamaBlue.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.

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, AlabamaBlue.com