## Blue Choice® Platinum FOR BUSINESS

Effective for plan years on and after July 1, 2014



Plan Benefits Summary



## AlabamaBlue.com

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

## Blue Choice<sup>®</sup> Platinum for Business Effective for Plan Years on and after July 1, 2014 BlueCard PPO

Ambulatory Surgical Centers)         after \$150 hospital copay         subject to calendar year deductible; in Alabama, not covered           Emergency Room (Medical Emergency)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay and subject to calendar year deductible           Emergency Room (Accident)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Emergency Room (Accident)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Emergency Room Physician         Covered at 100% of the allowed amount after \$20 physician copay         Covered at 100% of the allowed amount after \$20 physician copay           Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy         Covered at 100% of the allowed amount after \$20 physician copay         Covered at 100% of the allowed amount after \$20 physician copay           Note: Precentification is required for certain services         Covered at 100% of the allowed amount after \$20 physician copay         Covered at 80% of the allowed amount after \$20 physician copay           Note: Precentification is required. Call 1-800-248-2342 (toil free). If precentification is not obtained but it is later determined that the services services and the atter services and substance Abuses         Covered at 80% of the allowed amount after \$20 physician copay           Vet: Preadmission Certi		Blueoururi o	
The allowed amount may viary depending upon the type provider and where services are received.           Some services requires a copy, colsmance, calendary are deductible or deductible or activity or service.           INPATIENT HOSPITAL AND PHYSICIAN EINEFTS           (Includes Mental Health Disorders and Substance Abuses)           Preadmission certification is required for impationt admissions (except medical emergency services and maternity): notification within 48 hours for each admission.           Covered at 100% of the allowed amount after 51 admission.           Covered at 100% of the allowed amount.           Covered at 100% of the allowed amount. <t< td=""><td>BENEFIT</td><td>IN-NETWORK</td><td>OUT-OF-NETWORK</td></t<>	BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Some services reguine a copay, coinsurance, calendar your deductible for each admission, visit or service.           INPATIENT HOSPITAL AND PHYSICIAN BENEFITS           Consultation is required for inpattent Admission (second at 100% of the allowed amount after 5150 per day hospital copay days 1-5 for each admission)         Some services. Cell 1-800:248-2342 (uil free) for precertification.           Inpatient Hospital         Covered at 100% of the allowed amount.         Covered at 80% of the allowed amount.         Covered at 100% of the allowed amount.         <			
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS           (Includes Mental Health Disorders and Substance Abuses)           Preadmission certification is required for inpatient admissions (except medical emergency services and maternity); notification within 48 hours for emergencies. Call + 500-24324 (oil free) for precentification.           Inpatient Hospital         Covered at 100% of the allowed amount after \$150 per day hospital copay days 1-5           Inpatient Physician Visits and Consultations         Covered at 100% of the allowed amount; no copay of deductible           Inpatient Physician Visits and Consultations         Covered at 100% of the allowed amount; no copay of deductible           Inpatient Physician Visits and Consultations         Covered at 100% of the allowed amount; no copay of deductible           Multicoty Surgical Centers)         Covered at 100% of the allowed amount atupies to calendar year deductible           Mental Health Disorders and Substance Abuses         Covered at 100% of the allowed amount atupies to calendar year deductible           Mubtatory Surgical Centers)         Covered at 100% of the allowed amount atter \$150 hospital copay         Covered at 30% of the allowed amount atter \$150 hospital copay           Emergency Room (Medical Emergency)         Covered at 100% of the allowed amount atter \$150 hospital copay         Covered at 100% of the allowed amount atter \$150 hospital copay           Emergency Room Physician         Covered at 100% of the allowed amount atter \$150 hospital copay         Covered at 100% of the allowed amount att			
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Inpatient Hospital         Covered at 100% of the allowed amount of \$150 per day hospital copay days 1-5 for each admission         Covered at 80% of the allowed amount after \$150 per day hospital copay days 1-5 for each admission         S300 per admission deductible S300 per admission deductible in Alabama, available only for medical emergency and acidental injury           Inpatient Physician Visits and Consultations         Covered at 100% of the allowed amount: no copay or deductible         Covered at 80% of the allowed amount subject to calendary year deductible in Alabama, covered at 50% of the allowed amount subject to calendary year deductible Mental Health Disorders and Substance Abuses           OutTPATIENT HOSPITAL BENEFITS         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 80% of the allowed amount after \$150 hospital copay           Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 80% of the allowed amount after \$150 hospital copay           Emergency Room (Accident)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Emergency Room (Accident)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Emergency Room Physician         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Covered at 100% of the allowed amount after \$150 h			
after \$150 per day hospital copay days 1-5 for each admission       \$300 per admission deductible         Inpatient Physician Visits and Consultations       Covered at 100% of the allowed amount, no copay or deductible       Covered at 50% of the allowed amount, admont subject to calendar year deductible, in Alabama, noured at 50% of the allowed amount subject to calendar year deductible.         OUTPATIENT HOSPITAL BENEFITS       Covered at 80% of the allowed amount, admont subject to calendar year deductible.         Outpatient Surgery (Includes Mental Health Disorders and Substance Abuse)       Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay       Covered at 100% of the allowed amount after \$150 hospital copay         Emergency Room (Medical Emergency)       Covered at 100% of the allowed amount after \$150 hospital copay       Covered at 100% of the allowed amount after \$150 hospital copay         Emergency Room (Accident)       Covered at 100% of the allowed amount after \$150 hospital copay       Covered at 100% of the allowed amount after \$150 hospital copay         Emergency Room Physician       Covered at 100% of the allowed amount after \$150 hospital copay       Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay       Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay       Covered at 100% of the allowed amount ather \$20 physician copay			
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Note: In Albaham, available only for medical emergency and accidental injury           Inpatient Physician Visits and Consultations         Covered at 100% of the allowed amount, no copay or deductible         Covered at 50% of the allowed amount, amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount, subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount, subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount, subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount after \$150 hospital copay           Outpatient Surgery (Including Ambulatory Surgical Centers)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Emergency Room (Medical Emergency)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay and subject to calendar year deductible.           Emergency Room (Accident)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Emergency Room Physician         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay           Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$20 physician copay </td <td></td> <td></td> <td>\$300 per admission deductible</td>			\$300 per admission deductible
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Alabama, not covered           Emergency Room (Medical Emergency)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$150 hospital copay and subject to calendar year deductible           Emergency Room (Accident)         Covered at 100% of the allowed amount after \$150 hospital copay         Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after \$150 hospital copay         Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after \$150 hospital copay           Emergency Room (Accident)         Covered at 100% of the allowed amount after \$150 hospital copay         Covered at 100% of the allowed amount after \$160 hospital copay and subject to calendar year deductible           Emergency Room Physician         Covered at 100% of the allowed amount after \$20 physician copay         Covered at 100% of the allowed amount after \$20 physician copay and subject to calendar year deductible           Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Note: Precertification is required for certain services         Covered at 100% of the allowed amount after \$20 physician copay         Covered at 100% of the allowed amount after \$20 per day hospital copay         Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered           Note: Precentification is required for certain services         Covered at 100% of the allowed amount after \$20 per day hospital copay         Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered           Note: Precatifica	Outpatient Surgery (Including	Covered at 100% of the allowed amount	Covered at 80% of the allowed amount
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after \$150 hospital copay       after \$150 hospital copay and subject to calendar year deductible         Mental Health Disorders and Substance Abuses Services covered at 100% of the allowed amount after \$150 hospital copay       Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after \$150 hospital copay         Emergency Room (Accident)       Covered at 100% of the allowed amount after \$150 hospital copay       Covered at 100% of the allowed amount after \$150 hospital copay and subject to calendar year deductible for services within 72 hours; threafter 80% of the allowed amount after \$20 physician copay         Emergency Room Physician       Covered at 100% of the allowed amount after \$20 physician copay and subject to calendar year deductible         Covered at 100% of the allowed amount after \$20 physician copay and subject to calendar year deductible       Covered at 100% of the allowed amount after \$20 physician copay         Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy       Covered at 100% of the allowed amount, no copay or deductible         Note: Precertification is required for certain services       Covered at 100% of the allowed amount after \$20 physician copay       Covered at 100% of the allowed amount subject to calendar year deductible; in Alabama, not covered         Note: Precertification is required.       Covered at 100% of the allowed amount after \$20 physicain copay       Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered         Note: Precertification is required for certain services       If endote a paredi	Emergency Deam (Medical Emergency)	Covered at 4000/ of the allowed amount	
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amount after \$150 hospital copay           Emergency Room (Accident)         Covered at 100% of the allowed amount after \$150 hospital copay and subject to calendar year deductible for services within 72 hours; thereafter 80% of the allowed amount after \$150 hospital copay and subject to calendar year deductible for services within 72 hours; thereafter 80% of the allowed amount after \$20 physician copay           Emergency Room Physician         Covered at 100% of the allowed amount after \$20 physician copay         Covered at 100% of the allowed amount after \$20 physician copay and subject to calendar year deductible           Outpatient Diagnostic Lab, X-ray, Pathology, 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 Alabarma, not covered           Note: Precetification is required for certain services         Covered at 100% of the allowed amount after \$20 per day hospital copay         Covered at 80% of the allowed amount subject to calendar year deductible; in Alabarma, not covered           Note: Precetification is required. Call 1-800-248-2342 (toli free). If precertification is not obtained but it is later determined that the services were medically necessary, the member will be required to pay a \$250 penalty.         Covered at 100% of the allowed amount after \$20 physician copay           Office Visits & Consultations         Covered at 100% of the allowed amount after \$20 physician copay         Covered at 80% of the allowed amount subject to calendar year deductible; in Alabarma, not covered           Office Visits & Consultations         Cov			
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Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy       no copay or deductible       subject to calendar year deductible; in Alabama, not covered         Note: Precertification is required for certain services       covered at 100% of the allowed amount after \$20 per day hospital copay       Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered         Note: Preadmission Certification is required. Call 1-800-248-2342 (toll free). If precertification is not obtained but it is later determined that the services were medically necessary, the member will be required to pay a \$250 penalty.       Covered at 100% of the allowed amount after \$20 physician copay       Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered         Office Visits & Consultations       Covered at 100% of the allowed amount after \$20 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 \$20 physician copay       Covered at 80% of the allowed amount subject to calendar year deductible			
Chemotherapy & Radiation Therapy       Alabama, not covered         Note: Precertification is required for certain services       Alabama, not covered         Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)       Covered at 100% of the allowed amount after \$20 per day hospital copay       Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered         Note: Preadmission Certification is required. Call 1-800-248-2342 (toll free). If precertification is not obtained but it is later determined that the services were medically necessary, the member will be required to pay a \$250 penalty.       PHYSICIAN BENEFITS         (Includes Mental Health Disorders and Substance Abuse)       Covered at 80% of the allowed amount after \$20 physician copay         Office Visits & Consultations       Covered at 100% of the allowed amount after \$20 physician copay       Covered at 80% of the allowed amount after \$20 physician copay         Second Surgical Opinions       Covered at 100% of the allowed amount after \$20 physician copay       Covered at 80% of the allowed amount after \$20 physician copay			
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Partial Hospitalization Program (PHP)       after \$20 per day hospital copay       subject to calendar year deductible; in Alabama, not covered         Note: Preadmission Certification is required. Call 1-800-248-2342 (toll free). If precertification is not obtained but it is later determined that the services were medically necessary, the member will be required to pay a \$250 penalty.       PHYSICIAN BENEFITS         Office Visits & Consultations         Covered at 100% of the allowed amount after \$20 physician copay       Covered at 80% of the allowed amount subject to calendar year deductible         Second Surgical Opinions       Covered at 100% of the allowed amount       Covered at 80% of the allowed amount		Covered at 100% of the allowed amount	Covered at 80% of the allowed amount
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Second Surgical Opinions Covered at 100% of the allowed amount Covered at 80% of the allowed amount			
after \$20 physician copay subject to calendar year deductible	Second Surgical Opinions	Covered at 100% of the allowed amount	Covered at 80% of the allowed amount
		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		
<b>Note:</b> 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
<ul> <li>Some drugs require prior authorization</li> </ul>	after the following copays:	
• Prescription drugs other than <b>Specialty Drugs</b>	Generic Drugs:	
<ul> <li>90-day supply may be purchased but copay</li> </ul>	\$10 copay per prescription	
applies for each 30-day supply; some copays	Preferred Brand Drugs:	
<ul><li>combined for diabetic supplies</li><li>Specialty Drugs - up to a 30-day supply</li></ul>	\$30 copay per prescription	
<ul> <li>Specially Drugs - up to a 30-day supply</li> <li>Certain Specialty Drugs can only be</li> </ul>	Other Brand Drugs:	
dispensed by a Participating Specialty	\$60 copay per prescription	
Pharmacy	Specialty Drugs:	
<ul> <li>Specialty Drugs, or biotech drugs, are</li> </ul>	\$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 <sup>®</sup> (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
<ul> <li>Occupational, Physical &amp; Speech Therapy</li> <li>Occupational, physical and speech therapy limited to combined maximum of 30 visits per year</li> <li>Children ages 0-9 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy</li> </ul>	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
<b>Examples include:</b> 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)				
<ul> <li>Home Health and Hospice</li> <li>Precertification required for visits by home health professionals outside Alabama</li> <li>For precertification call 1-800-821-7231</li> </ul>	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 <b>www.behealthy.com</b> .			
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