BENEFIT COMPARISON
Blue Cross and Blue Shield of Alabama
Preferred Blue HDHP Plan, 800 Plan, 820 Plan, 860 Healthy Blue, 851 Plan and 879 Plan

	Preferred Blue HDHP Plan **BlueCard PPO** **New Plan Effective 7/1/2010**	**800 Plan** **BlueCard PPO**	**820 Plan** **BlueCard PPO**	**860 Healthy BLUE** **BlueCard PPO**	**851/879 Plan** **BlueCard PPO**
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health and Substance Abuse)					
Preadmission Certification is required for inpatient admissions (except maternity); notification within 48 hours for emergencies. Call 1-800-248-2342 (toll free) for precertification.					
Inpatient Hospital **Note:** In Alabama, inpatient benefits for out-of-network hospitals available only for accidental injury	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network: Tier 1:** 100% after $250 per day hospital copay days 1-6 for each admission **Tier 2 & Tier 3:** 100% after $500 per day hospital copay days 1-6 for each admission **Out-of-Network:** 80% after $1,000 per admission deductible	**In-Network: 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 **Out-of-Network:** 80% after $750 per admission deductible	**In-Network:** 100% after $175 per day hospital copay for days 1-5 for each admission, no deductible per admission **Out-of-Network:** 80% after $750 per admission deductible	**In-Network:** 100% after $250 per admission deductible **Out-of-Network:** 80% after $500 per admission deductible
Inpatient Physician Visits and Consultations	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama covered at 50% subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Mental Health and Substance Abuse Services** **In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% not subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Mental Health and Substance Abuse Services** **In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% not subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Mental Health and Substance Abuse Services** **In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% not subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Mental Health and Substance Abuse Services** **In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% not subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health and Substance Abuse)					
Outpatient Surgery (including Ambulatory Surgical Centers)	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama, not covered	**In-Network: Tier 1:** 100% after $250 hospital copay **Tier 2 & Tier 3:** 100% after $500 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network: Tier 1:** Covered at 100% after $200 hospital copay **Tier 2 & Tier 3:** Covered at 100% after $400 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100% after $175 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100% after $150 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered

	Preferred Blue HDHP Plan **BlueCard PPO** **New Plan Effective 7/1/2010**	**800 Plan** **BlueCard PPO**	**820 Plan** **BlueCard PPO**	**860 Healthy BLUE** **BlueCard PPO**	**851/879 Plan** **BlueCard PPO**
Emergency Room (Medical Emergency)	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama, not covered **Effective 7/1/2010**: **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 80% subject to calendar year deductible; in Alabama, not covered** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 80% subject to calendar year deductible for services within 72 hours of medical emergency or until medically stabilized; thereafter 50% subject to calendar year deductible; in Alabama, not covered** **Mental Health and Substance Abuse Services covered at 80% subject to calendar year deductible; in Alabama, not covered**	**In-Network:** 100% after $250 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered **Effective 7/1/2010**: **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $250 hospital copay; in Alabama, not covered** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $250 hospital copay for services within 72 hours of medical emergency or until medically stabilized; thereafter 80% subject to calendar year deductible; in Alabama, not covered** **Mental Health and Substance Abuse Services covered at 100% after $250 hospital copay; in Alabama, not covered**	**In-Network:** 100% after $200 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered **Effective 7/1/2010**: **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $200 hospital copay; in Alabama, not covered** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $200 hospital copay for services within 72 hours of medical emergency or until medically stabilized; thereafter 80% subject to calendar year deductible; in Alabama, not covered** **Mental Health and Substance Abuse Services covered at 100% after $200 hospital copay; in Alabama, not covered**	**In-Network:** 100% after $175 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered **Effective 7/1/2010**: **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $175 hospital copay; in Alabama, not covered** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $175 hospital copay for services within 72 hours of medical emergency or until medically stabilized; thereafter 80% subject to calendar year deductible; in Alabama, not covered** **Mental Health and Substance Abuse Services covered at 100% after $175 hospital copay; in Alabama, not covered**	**In-Network:** 100% after $150 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered **Effective 7/1/2010**: **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $150 hospital copay; in Alabama, not covered** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $150 hospital copay for services within 72 hours of medical emergency or until medically stabilized; thereafter 80% subject to calendar year deductible; in Alabama, not covered** **Mental Health and Substance Abuse Services covered at 100% after $150 hospital copay; in Alabama, not covered**

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Emergency Room (Accident)	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 80% subject to calendar year deductible for services within 72 hours; thereafter covered at 50% subject to calendar year deductible **Effective 7/1/2010:** **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 80% subject to calendar year deductible** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 80% subject to calendar year deductible for services within 72 hours of accident or until medically stabilized; thereafter 50% subject to calendar year deductible** **Mental Health and Substance Abuse Services covered at 80% subject to calendar year deductible**	**In-Network:** 100% after $250 hospital copay **Out-of-Network:** 100% after $250 hospital copay for services within 72 hours, thereafter 80% subject to calendar year deductible **Effective 7/1/2010:** **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $250 hospital copay** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $250 hospital copay for services within 72 hours of accident or until medically stabilized; thereafter 80% subject to calendar year deductible** **Mental Health and Substance Abuse Services covered at 100% after $250 hospital copay**	**In-Network:** 100% after $200 hospital copay **Out-of-Network:** 80% subject to calendar year deductible **Effective 7/1/2010**: **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $200 hospital copay** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $200 hospital copay for services within 72 hours of accident or until medically stabilized; thereafter 80% subject to calendar year deductible** **Mental Health and Substance Abuse Services covered at 100% after $200 hospital copay**	**In-Network:** 100% after $175 hospital copay **Out-of-Network:** 80% subject to calendar year deductible **Effective 7/1/2010**: **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $175 hospital copay** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $175 hospital copay for services within 72 hours of accident or until medically stabilized; thereafter 80% subject to calendar year deductible** **Mental Health and Substance Abuse Services covered at 100% after $175 hospital copay**	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 100%; no copay or deductible for services within 72 hours; thereafter 80% subject to calendar year deductible **Effective 7/1/2010**: **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% no copay or deductible for services within 72 hours of accident or until medically stabilized; thereafter 100% after $150 hospital copay** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% no copay or deductible for services within 72 hours of accident or until medically stabilized; thereafter 80% subject to calendar year deductible** **Mental Health and Substance Abuse Services covered at 100% no copay or deductible for services within 72 hours of accident or until medically stabilized; thereafter 100% after $150 hospital copay**

	Preferred Blue HDHP Plan BlueCard PPO New Plan Effective 7/1/2010	800 Plan BlueCard PPO	820 Plan BlueCard PPO	860 Healthy BLUE BlueCard PPO	851/879 Plan BlueCard PPO
Emergency Room Physician	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama covered at 50% subject to calendar year deductible **Effective 7/1/2010:** **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 80% subject to calendar year deductible** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 80% subject to calendar year deductible**	**In-Network:** 100% after $50 physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $50 physician copay** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $50 physician copay**	**In-Network:** 100% after $50 physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $50 physician copay** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $50 physician copay**	**In-Network:** 100% after $50 physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $50 physician copay** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $50 physician copay**	**In-Network:** 100% after $30 physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 100% after $30 physician copay** **Effective 10/1/2010:** **Out-of-Network Services Only:** **Covered at 100% after $30 physician copay**
Outpatient Diagnostic Lab & X-ray, Pathology	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama, not covered	**In-Network: Tier 1:** Covered at 100% after $250 hospital copay **Tier 2 & Tier 3:** Covered at 100% after $500 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered **Note**: Laboratory testing performed in the physician's office, but sent to an outpatient hospital facility for processing subject to facility copay. Covered routine mammograms not subject to hospital copay.	**In-Network: Tier 1:** Covered at 100% after $200 hospital copay **Tier 2 & Tier 3:** Covered at 100% after $400 hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered **Note:** The first covered mammogram each calendar year is not subject to the hospital copay	**In-Network:** 100% after $175 hospital copay; covered routine mammograms not subject to hospital copay **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered
Dialysis	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered
IV Therapy, Chemotherapy & Radiation Therapy	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered

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PHYSICIAN BENEFITS (Includes Mental Health and Substance Abuse)					
Office Visits & Outpatient Consultations	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible **Effective 7/1/2010:** **Out-of-Network Services Only:** **Mental Health and Substance Abuse Services covered at 80% subject to calendar year deductible**	**In-Network:** 100% after $35 primary physician copay or $50 specialist physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% after $35 primary physician copay or $50 specialist physician copay **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% after $30 primary physician copay or $50 specialist physician copay **Out-of-Network:** 50% subject to calendar year deductible ***Effective July 1, 2010, the $30 and $50 physician copay will be waived for the first two physician visits for office visits, outpatient consultations, second surgical opinions, routine well child care exams or routine office visits per person in the calendar year. Effective January 1, 2011, only the $30 physician copay will be waived for the first two physician visits for office visits, outpatient consultations, routine well child care exams or routine office visits per person in the calendar year.***	**In-Network:** 100% after $30 physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible
Surgery & Anesthesia	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible **Note: Excludes services related to Bariatrics**
Bariatric Surgery (Surgeon, Assistant Surgeon & Anesthesia)	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	Not covered	Not covered	Not covered	**In-Network:** 80%; no copay or deductible **Out-of-Network:** Not covered **Note:** Bariatric services in Alabama must be performed by Bariatric Surgery Network Provider
Maternity Care	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible
Diagnostic Lab & Pathology	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible

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Diagnostic X-ray	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% after $10 copay per procedure **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible
CAT Scan, MRI, PET/SPECT, ERCP, angiography/arteriography, cardiac cath/arteriography, colonoscopy, UGI endoscopy, muga-gated cardiac scan	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% after $250 copay per procedure **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% after $200 copay per procedure **Out-of-Network:** 50% subject to calendar year deductible **NOTE: All surgeries are subject to the calendar year deductible**	**In-Network:** 100% after $175 copay per procedure **Out-of-Network:** 50% subject to calendar year deductible **NOTE: All surgeries are subject to the calendar year deductible**	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible
Second Surgical Opinions	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% after $50 physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% after $50 physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible	**In-Network:** 100% after $50 physician copay with no deductible **Out-of-Network:** 50% subject to calendar year deductible ***Effective July 1, 2010, the $30 and $50 physician copay will be waived for the first two physician visits for office visits, outpatient consultations, second surgical opinions, routine well child care exams or routine office visits per person in the calendar year. Effective January 1, 2011, only the $30 physician copay will be waived for the first two physician visits for office visits, outpatient consultations, routine well child care exams or routine office visits per person in the calendar year.***	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 50% subject to calendar year deductible
PREVENTIVE CARE BENEFITS					
Routine Newborn Exam (in hospital)	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered

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Routine Well Child Care Exams Nine visits the first 24 months of life and one visit each year thereafter through age six	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $35 copayment for physician office visits.	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $35 copayment for physician office visits.	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $30 copayment for physician office visits. ***Effective July 1, 2010, the $30 and $50 physician copay will be waived for the first two physician visits for office visits, outpatient consultations, second surgical opinions, routine well child care exams or routine office visits per person in the calendar year. Effective January 1, 2011, only the $30 physician copay will be waived for the first two physician visits for office visits, outpatient consultations, routine well child care exams or routine office visits per person in the calendar year.***	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $30 copayment for physician office visits
Routine Developmental Screening Three exams during the first 30 months of life	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered
Routine Immunizations Age limitations apply to certain immunizations	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered

	Preferred Blue HDHP Plan **BlueCard PPO** **New Plan Effective 7/1/2010**	**800 Plan** **BlueCard PPO**	**820 Plan** **BlueCard PPO**	**860 Healthy BLUE** **BlueCard PPO**	**851/879 Plan** **BlueCard PPO**
Routine Office Visit	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $35 copayment for physician office visits. When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $35 copayment for physician office visits. When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $30 copayment for physician office visits. One exam per calendar year ages 7 and over ***Effective July 1, 2010, the $30 and $50 physician copay will be waived for the first two physician visits for office visits, outpatient consultations, second surgical opinions, routine well child care exams or routine office visits per person in the calendar year. Effective January 1, 2011, only the $30 physician copay will be waived for the first two physician visits for office visits, outpatient consultations, routine well child care exams or routine office visits per person in the calendar year.***	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $30 copayment for physician office visits When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam
Routine Pap Smear One per calendar year	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered
Routine Human Papillomavirus (HPV) Testing One routine test every three calendar years for females ages 30 and over	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered
Routine Chlamydia Screening One per calendar year for females ages 15-24	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered
Routine/Screening Mammogram One exam for females ages 35-39 and one per calendar year for females age 40 and over	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered

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Routine Prostate Cancer Screening Males age 40 and over • Prostate Specific Antigen (PSA) each calendar year • Digital Rectal Exam each calendar year	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered
Other Routine Screenings Limited to one of each per person per calendar year • Urinalysis • Complete blood count • TB Skin test • Basic blood glucose test • Cholesterol screening (including lipid panel and HDL)	Not covered	Not covered	Not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	Not covered
Routine Colorectal Cancer Screening Ages 50 and over • Hemocult stool check/ Fecal occult blood test each calendar year • Flexible sigmoidoscopy every three calendar years • Double-contrast barium enema every five calendar years • Colonoscopy every 10 calendar years	**In-Network:** 100%; no copay or deductible **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay) **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay) **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay) **Out-of-Network:** Not covered	**In-Network:** 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay) **Out-of-Network:** Not covered

	Preferred Blue HDHP Plan BlueCard PPO New Plan Effective 7/1/2010	800 Plan BlueCard PPO	820 Plan BlueCard PPO	860 Healthy BLUE BlueCard PPO	851/879 Plan BlueCard PPO
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health and Substance Abuse)					
Calendar Year Deductible	**In-Network:** $1,500 individual; $3,000 aggregate amount per family; calendar year deductible amounts met in-network will not apply to the out-of-network calendar year deductible **Out-of-Network:** $3,000 per individual; $6,000 aggregate amount per family; Calendar year deductible amounts met out-of-network will not apply to the in-network calendar year deductible For individual coverage, no benefits, except preventive care, are paid by the plan until medical expenses paid by the individual equal the deductible amount. For family coverage, no benefits, except preventive care, are paid by the plan to any family member until the total medical expenses paid by the family equal the family deductible amount.	$500 per individual; $1,500 aggregate amount per family	$350 individual; $1,050 aggregate amount per family	$350 individual; $1,050 aggregate amount per family	$200 individual; $600 aggregate amount per family

	Preferred Blue HDHP Plan **BlueCard PPO** **New Plan Effective 7/1/2010**	**800 Plan** **BlueCard PPO**	**820 Plan** **BlueCard PPO**	**860 Healthy BLUE** **BlueCard PPO**	**851/879 Plan** **BlueCard PPO**
Calendar Year Out-of-Pocket Maximum	**In-Network:** $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 expenses covered at 100% for remainder of calendar year. **Out-of-Network:** There is no out-of-pocket maximum for out-of-network services Premiums and amounts paid to out-of-network providers do not apply to the in-network out of pocket maximum	$2,250 individual; $6,750 aggregate amount per family plus calendar year deductible. The following services apply to the out-of-pocket maximum: • In-Network inpatient hospital copay* • In-Network outpatient hospital copay * • Other covered services (except Out-of-Network Physical Therapy, Occupational Therapy and DME services in Alabama) • Home Health and Hospice ***Note: Effective January 1, 2011 In-Network inpatient hospital copay and In-Network outpatient hospital copay will not apply to the calendar year out-of-pocket maximum.**	$1,500 individual, $4,500 aggregate amount per family plus calendar year deductible. The following services apply to the out-of-pocket maximum: • In-Network inpatient hospital copay* • In-Network outpatient hospital copay * • Other covered services (except Out-of-Network Physical Therapy, Occupational Therapy and DME services in Alabama) • Home Health and Hospice ***Note: Effective January 1, 2011 In-Network inpatient hospital copay and In-Network outpatient hospital copay will not apply to the calendar year out-of-pocket maximum.**	$1,500 individual, $4,500 aggregate amount per family plus calendar year deductible. The following services apply to the out-of-pocket maximum: • In-Network inpatient hospital copay* • In-Network outpatient hospital copay * • Other covered services (except Out-of-Network physical therapy, occupational therapy and DME services in Alabama) • Home Health and Hospice ***Note: Effective January 1, 2011 In-Network inpatient hospital copay and In-Network outpatient hospital copay will not apply to the calendar year out-of-pocket maximum.**	$600 individual plus calendar year deductible. The following services apply to the out-of-pocket maximum: • Other Covered Services (except Out-of-Network Physical Therapy, Occupational Therapy and DME services in Alabama) • Home Health and Hospice • In-Network services covered at 80% • Point-of-Sale Prescription Drugs (551 Plan)
Lifetime Maximum	There is no Lifetime Maximum.	$1,000,000 **Note: Effective October 1, 2010 there is no Lifetime Maximum.**	$1,000,000 **Note: Effective October 1, 2010 there is no Lifetime Maximum.**	$1,000,000 **Note: Effective October 1, 2010 there is no Lifetime Maximum.**	$1,000,000 **Note: Effective October 1, 2010 there is no Lifetime Maximum.**

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PRESCRIPTION DRUG BENEFITS (Includes Mental Health and Substance Abuse)						
Prescription Drug Benefits	**Point-of-Sale Drug Program**	**Prescription Drug Card**	**Prescription Drug Card**	**Prescription Drug Card**	**Point-of-Sale Drugs (551 Plan)**	**Prescription Drug Card (579 Plan)**
	Participating Pharmacy: **Generic and Brand Drugs:** Covered at 80% subject to calendar year deductible Must obtain authorization number and file claims **Non-Participating Pharmacy:** Not covered	**Participating Pharmacy:** **Generic Drugs - *mandatory when available:*** $15 copay per prescription **Preferred Brand Drugs:** $50 copay per prescription **Other Brand Drugs:** $75 copay per prescription **Specialty Drugs:** You pay 50% per prescription until you reach $5,000 out-of-pocket per member per calendar year (100% coverage for remainder of year); Specialty Drugs limited to 30 day supply Fertility Drugs are limited to $10,000 contract maximum **Non-Participating Pharmacy:** Not covered	**Participating Pharmacy:** 100%, after the following copays with no claims to file: **Generic Drugs - *mandatory when available*:** $15 copay per prescription **Preferred Brand Drugs:** $40 copay per prescription **Other Brand Drugs:** $60 copay per prescription **Specialty Drugs:** Limited to 30 day supply **Non-Participating Pharmacy:** Not covered	**Participating Pharmacy:** 100%, after the following copays with no claims to file: **Generic Drugs - *mandatory when available*:** $4 copay per prescription **Preferred Brand Drugs:** $40 copay per prescription **Other Brand Drugs:** $75 copay per prescription **Specialty Drugs:** Limited to 30 day supply **Non-Participating Pharmacy:** Not covered	**Participating Pharmacy:** **Generic Drugs and Brand Name Drugs:** 80% subject to calendar year deductible **Specialty Drugs:** Limited to 30 day supply Must obtain authorization number and file claims **Non-Participating Pharmacy:** Not covered	**Participating Pharmacy:** 100%, after the following copays with no claims to file: **Generic Drugs-*mandatory when available*:** $10 copay per prescription **Preferred Brand Drugs:** $35 copay per prescription **Other Brand Drugs:** $50 copay per prescription **Specialty Drugs:** Limited to 30 day supply **Non-Participating Pharmacy:** Not covered
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health and Substance Abuse)						
Allergy Testing & Treatment $200 calendar year maximum per person	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible	

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Ambulance Service	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible
Participating Chiropractic Services $600 calendar year maximum per person	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama, not covered	**In-Network in Alabama and any Chiropractor outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** Not covered	**In-Network in Alabama and any Chiropractor outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** Not covered	**In-Network in Alabama and any Chiropractor outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** Not covered	**In-Network in Alabama and any Chiropractor outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** Not covered
Durable Medical Equipment (DME)	**In-Network in Alabama and any DME Supplier outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible	**In-Network in Alabama and any DME Supplier outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible	**In-Network in Alabama and any DME Supplier outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible	**In-Network in Alabama and any DME Supplier outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible	**In-Network in Alabama and any DME Supplier outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible
Occupational & Physical Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per year	**In-Network in Alabama and any Occupational or Physical Therapist outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible	**In-Network in Alabama and any Occupational or Physical Therapist outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible	**In-Network in Alabama and any Occupational or Physical Therapist outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible	**In-Network in Alabama and any Occupational or Physical Therapist outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible	**In-Network in Alabama and any Occupational or Physical Therapist outside Alabama:** 80% subject to calendar year deductible **Out-of-Network in Alabama:** 50% subject to calendar year deductible
Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per year	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible	80% subject to calendar year deductible
VISION BENEFITS					
Routine Eye Exam Limited to $75 maximum for one exam and refraction every 24 months per person	Not covered	Not covered	Not covered	Covered at 100% no copay or deductible	Not covered
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	**In-Network:** 80% subject to calendar year deductible **Out-of-Network:** 50% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100% subject to calendar year deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered	**In-Network:** 100%; no copay or deductible **Out-of-Network:** 80% subject to calendar year deductible; in Alabama, not covered

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EXPANDED PSYCHIATRIC SERVICES (EPS)					
Expanded Psychiatric Services (EPS) • EPS network available throughout Alabama and in Meridian, Mississippi and Northwest Florida • To find an EPS provider call Customer Service at 1 800 292-8868 or search the online provider finder on our web site at **www.bcbsal.com**	Not Applicable	When care is received or coordinated by an EPS provider, the following mental health 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 and substance abuse benefits available will mirror all other categories of this matrix.			
HEALTH MANAGEMENT BENEFITS (Includes Mental Health and Substance Abuse)					
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury				
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**.				
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	Not Covered	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			