

Special Open Enrollment Plan Details

Effective January 1, 2013

Hospital Tiered Network

Blue Cross and Blue Shield of Alabama has developed a Hospital Tiered Network within the state of Alabama. Hospitals are categorized into one of three “tiers”, based on their performance in primary areas of interest. Hospitals designated as Tier 1 are recognized as having attained the highest level of compliance across these areas.

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 Health Provider” tool on our web site 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.

SPECIAL OPEN ENROLLMENT PLAN DETAILS

The following summarizes the benefits of the Special Open Enrollment Plan.

Benefits are subject to all terms and conditions described in the certificate for this plan. This is not a contract or certificate.

Please be aware that most benefits are limited to those services or supplies furnished by physicians, hospitals or other Health care providers or facilities in Alabama with whom Blue Cross and Blue Shield of Alabama has a contract.

GENERAL PROVISIONS	
Calendar Year Deductible*	The first \$2,500 of covered expenses per person each calendar year \$7,500 family maximum per year
Prescription Drug Deductible	The first \$350 of covered prescriptions per person each calendar year
Calendar Year Out-of-Pocket Maximum**	\$7,500 individual calendar year out-of-pocket maximum including the \$2,500 calendar year deductible
Lifetime Maximum	Unlimited
Mental and Nervous Disorders and Substance Abuse	Benefits are only available when using an Expanded Psychiatric Services (EPS) provider; benefit details to follow later in this matrix.

* Deductibles are applied to claims in the order in which they are processed regardless of the order in which they are received. Deductible is not applicable to all services (see specific categories).

** The Out-of-Pocket Maximum does not include the inpatient hospital daily copay, outpatient hospital copay, copays to PMD Physicians, coinsurance to Non-Participating and Non-Preferred providers, prescription drug deductible and copays, or non-covered expenses. After the out-of-pocket maximum is met, services which are applicable to the out-of-pocket maximum will be paid at 100% of the Allowed Amount for the remainder of the year.

INPATIENT HOSPITAL BENEFITS		
BENEFIT	PARTICIPATING HOSPITAL*	NON-PARTICIPATING HOSPITAL
Inpatient Hospital Coverage 365 days of care during each hospital confinement	Tier 1: 100% of the allowed amount, subject to a \$300 copayment for each of the 1 st through the 5 th days Tier 2 and 3: 100% of the allowed amount, subject to a \$600 copayment for each of the 1 st through the 5 th days 100% coverage after daily copay for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries**	Not covered Exception: Accidental Injury and Medical Emergency covered as follows: Covered at 80% of the Allowed Amount subject to the \$2,500 calendar year deductible
Preadmission Certification	Required for all hospital admissions except emergency hospital admissions and maternity. Emergency admissions require notification within 48 hours of admission. For precertification, call 1 800-248-2342 toll-free.	

* Participating hospitals are those facilities contracted to do business with Blue Cross and Blue Shield of Alabama.

** If you are discharged and readmitted to a hospital within 90 days, the days of each stay will apply toward your 365 day maximum; Inpatient hospital days are limited to combined maximum of days in Participating and Non-Participating Hospitals.

OUTPATIENT HOSPITAL BENEFITS*		
(Facility charges only – benefit charges for physician and other medical expenses may apply as detailed in the following sections.)		
BENEFIT	PREFERRED OUTPATIENT FACILITY	NON-PREFERRED OUTPATIENT FACILITY
Surgery, Diagnostic Lab and X-Ray	Tier 1: 100% of the allowed amount, subject to a \$300 copayment Tier 2 and 3: 100% of the allowed amount, subject to a \$600 copayment	Not Covered
Dialysis, IV Therapy, Chemotherapy and Radiation Therapy	Covered at 100% of the Allowed Amount, No copay required	Not Covered
Accidental Injury and Medical Emergency	Covered at 100% of the Allowed Amount, subject to \$300 facility copay	Covered at 100% of the allowed amount, subject to the \$2,500 calendar year deductible after payment of a \$300 facility copay

* Benefits will be determined under "Major Medical Benefits" for (1) services in the emergency room if the patient's condition does not meet the definition of a Medical Emergency, and (2) outpatient hospital services not listed in this table. Outpatient benefits in Non-Participating Hospitals are available only in cases of Accidental Injury and Medical Emergency.

PHYSICIAN BENEFITS		
Includes the following when licensed and acting within the scope of that license at the time and place you are treated or receive services: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic (D.C.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), and Psychologist (Ph.D., Psy.D. or Ed.d), Certified Registered Nurse Practitioners (CRNP); Certified Nurse Midwives (CNM), licensed physician assistant (P.A.) or surgeon assistant (S.A) acting under the direct supervision of an M.D. who is a preferred provider.		
BENEFIT	PMD PHYSICIAN**	NON-PMD PHYSICIAN***
Office Visits and Outpatient Consultations	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount after \$50 office visit copay*	Subject to \$2,500 calendar year deductible In Alabama: Covered at 50% of the Allowed Amount Outside Alabama: Not Covered

BENEFIT	PMD PHYSICIAN**	NON-PMD PHYSICIAN***
Emergency Room Physician Care	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount, after the \$75 ER visit copay*	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount, after the \$75 ER visit copay*
Surgery and Assistant Surgery Anesthesia Laboratory and Pathology X-Rays Chemotherapy and Radiation Therapy Second Surgical Opinions In-Hospital Physician Care In-Hospital Physician Consultations Maternity	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount	Subject to \$2,500 calendar year deductible In Alabama: Covered at 50% of the Allowed Amount Outside Alabama: Not Covered
Inpatient Physician Care for Accidental Injury and Medical Emergency	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount	Subject to \$2,500 calendar year deductible In Alabama: Covered at 50% of the Allowed Amount Outside Alabama: Covered at 80% of the Allowed Amount

* PMD copays required for each office visit per person; PMD copays do not count toward your calendar year out-of-pocket maximum.

** Your 20% PMD coinsurance counts toward your calendar year out-of-pocket maximum.

*** The amount you must pay a Non-PMD physician does not count toward your calendar year out-of-pocket maximum. If you use a Non-PMD provider, you may have to file your claim, and you will be responsible for charges in excess of the Allowed Amount, applicable deductible, and coinsurance.

PREVENTIVE BENEFITS		
BENEFIT	PMD PHYSICIAN	NON-PMD PHYSICIAN
Routine preventive services and immunizations • See www.bcbsal.com/preventiveservices for a listing of the specific preventive services and immunizations • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See www.bcbsal.com/pharmacy for more information.	100% of the allowed amount, no deductible or coinsurance	Not covered
Note: In some cases, office visit copays or facility copays may apply		

MAJOR MEDICAL BENEFITS*		
BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Chiropractor Services Limited to a maximum payment of \$600 per person each calendar year	Subject to \$2,500 calendar year deductible Covered at 80% of Allowed Amount	Not covered
Home Health and Hospice Care	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount	Not covered
Occupational Therapy Services for the Hand and/or Treatment of Lymphedema; Physical Therapy Limited to a combined maximum of 15 visits per person each calendar year	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount	Subject to \$2,500 calendar year deductible In Alabama: Covered at 50% of the Allowed Amount Outside Alabama: Not Covered
Durable Medical Equipment	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount	Subject to \$2,500 calendar year deductible Covered at 80% of the Allowed Amount

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Ambulance Services	Subject to \$2,500 calendar year deductible Covered at 80% of Allowed Amount	
Allergy Testing & Treatment Limited to a combined maximum of \$200 per person each calendar year	Subject to \$2,500 calendar year deductible Covered at 80% of Allowed Amount	

* When using a Preferred or Participating Provider, the provider will bill us and we will pay him or her directly. You will be responsible for applicable deductibles, copays, and coinsurance. If you use a Non-Preferred or Non-Participating provider, you may have to file your claim, and you will be responsible for charges in excess of the Allowed Amount, applicable deductible, and coinsurance.

Benefits for Mental and Nervous Disorders and Substance Abuse			
Note: Benefits are available only when using an Expanded Psychiatric Services (EPS) Provider. There are a limited number of EPS providers. They are listed on www.bcbsal.com under <i>Find a Doctor</i> . You may also call Customer Service for a listing.			
BENEFIT	Maximum Benefit Amounts	Deductible	Copay
Facility Inpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage up to 30 days of inpatient care each calendar year when a member is admitted by an EPS Provider	No deductible	No Copay
Physician Inpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage up to 30 days of inpatient care each calendar year when a member is treated by an EPS Provider	No deductible	No Copay
Outpatient Treatment for Mental and Nervous Disorders and Substance Abuse	100% coverage, no visit limit when treated by an EPS Provider	No deductible	No Copay

PRESCRIPTION DRUG BENEFITS	
Prescription Drugs Copays apply for each 30 day supply for all drugs Some drugs require prior authorization Certain Specialty Drugs can only be dispensed by a Specialty Participating Pharmacy. Specialty Drugs, or biotech drugs, are generally high cost self-administered drugs Copays are combined for some diabetic supplies	Subject to a \$350 prescription drug deductible per person each calendar year \$20 copay for generic; \$60 copay for Preferred brand; \$80 copay for Non-Preferred brand No benefits are available for drugs purchased at a Non-Participating Pharmacy or for brand name drugs for which there is a generic equivalent available. Note: To view the most current prescription drug lists, visit our web site at www.bcbsal.com .
HEALTH MANAGEMENT	
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
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.

Important Note: This plan does not pay supplemental benefits to Medicare; you should consider enrolling in Medicare and purchasing a Medicare supplement contract when you become eligible for Medicare (generally upon attaining age 65). Medicare supplements - unlike this plan - are designed to fill in most of the gaps in coverage left by Medicare.

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