PRemployer
Blue Saver Merit
BlueCard® PPO

Effective January 1, 2016

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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received. Some services require a copay, coinsurance, calendar year deductible or deductible for each admission, visit or service.		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar Year Deductible The in-network and out-of-network calendar year deductibles are separate and do not apply to each other	$3,000 individual; $6,000 family	$3,000 individual; $6,000 family
Calendar Year Out-of-Pocket Maximum (includes calendar year deductible) All 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	$6,000 individual; $12,000 family After you reach your Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year	There is no out-of-pocket maximum for out-of-network services
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services and maternity); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll-free) for precertification.		
Inpatient Hospital	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Inpatient Physician Visits and Consultations	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Emergency Room (Medical Emergency)	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Emergency Room (Accident) **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **Emergency Room (Medical Emergency)** above.	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible for services within 72 hours; not covered, when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Emergency Room Physician	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits, Consultations & Second Surgical Opinions	Covered at 100% of the allowed amount after $30 physician copay for first three illness related office visits; thereafter, covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Surgery & Anesthesia	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Maternity Care	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/preventiveservices** for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/pharmacy** for more information.	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Note: In some cases, office visit copays or facility copays may apply		
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Prescription Drug Card • The pharmacy network for the plan is the **Prime Participating Pharmacy Network** • Prescription drugs (other than Tier 4 (specialty) drugs) can be dispensed for up to a 90-day supply but the copay is applicable for each 30-day supply • Some drugs require precertification • Some copays combined for diabetic supplies • Tier 4 (specialty) drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Prime Therapeutics Specialty Pharmacy™** network. Go to **AlabamaBlue.com/web/pharmacy/druggguide.html** for a list of these Tier 4 (specialty) drugs. • View the **Standard Prescription Drug** list that applies to the plan at **AlabamaBlue.com/web/pharmacy/druggguide.html**	Covered at 100% of the allowed amount after the following copays for a 30-day supply for each prescription: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $50 copay per prescription **Tier 3 Drugs:** $70 copay per prescription **Tier 4 (specialty) Drugs:** $395 copay per prescription **Generic drugs are mandatory when available and may be classified at any Tier.**	Not covered
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
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	Not covered
Ambulance Service	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Participating Chiropractic Services Limited to 15 visits per calendar year	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Occupational, Physical and Speech Therapy • Occupational, physical and speech therapy limited to a combined maximum of 30 visits per calendar 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	Not covered
Home Health and Hospice	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered

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HEALTH MANAGEMENT AND ADDITIONAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
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 maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **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	Air ambulance service to a network 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 Blue Cross and Blue Shield of Alabama or another 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 disorders 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 Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*
- *Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.*

This is not a contract or benefit booklet.
Benefits are subject to the terms, limitations and conditions of your contract with us (including your benefit booklet).
Check your benefit booklet for more detailed coverage information.
Please visit our website, AlabamaBlue.com.