

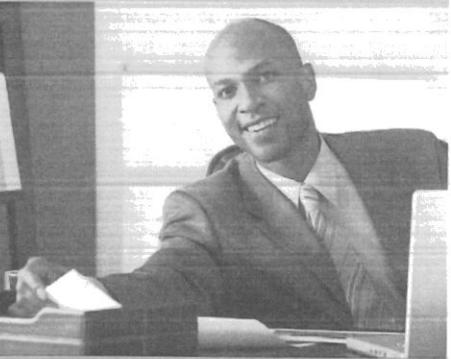
*We cover what matters.*

# BlueCard<sup>®</sup> PPO

## Plan Benefits

### Cullman County Commission BlueCard<sup>®</sup> PPO

Effective October 1, 2015



Visit our website at  
[AlabamaBlue.com](http://AlabamaBlue.com)



**BlueCross BlueShield  
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

**Cullman County Commission**  
**BlueCard® PPO**  
**Effective October 1, 2015**

| BENEFIT   | IN-NETWORK  | OUT-OF-NETWORK   |
|---|---|--|
| <i>Benefit payments are based on the amount of the provider's charge that Blue Cross and Blue Shield recognizes 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.</i> |   |  |
| <b>INPATIENT HOSPITAL AND PHYSICIAN BENEFITS</b><br><b>(Includes Mental Health Disorders and Substance Abuse)</b>   |   |  |
| 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  | Covered at 100% after \$100 per admission deductible; No copay required | Covered at 70% after \$200 per admission deductible; no copay required<br><br><b>Note:</b> In Alabama, Out-of-Network benefits available only for accidental injury  |
| Inpatient Physician Visits and Consultations  | Covered at 100%; no copay or deductible                                 | Covered at 70% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible<br><br><b>Mental Health Disorders and Substance Abuse Services covered at 70% not subject to calendar year deductible</b> |
| <b>OUTPATIENT HOSPITAL BENEFITS</b><br><b>(Includes Mental Health Disorders and Substance Abuse)</b>  |   |  |
| Precertification is required for some outpatient hospital benefits; please see benefit booklet. Precertification is also required for physician-administered specialty drugs; visit <a href="http://AlabamaBlue.com/DrugList">AlabamaBlue.com/DrugList</a> . If precertification is not obtained, no benefits are available.  |   |  |
| Outpatient Surgery (Including Ambulatory Surgical Centers)  | Covered at 100% after \$50 hospital copay                               | Covered at 70% subject to calendar year deductible; in Alabama, not covered  |
| Emergency Room (Medical Emergency)  | Covered at 100% after \$50 hospital copay                               | Covered at 70% subject to calendar year deductible; in Alabama, not covered<br><br><b>Mental Health Disorders and Substance Abuse Services covered at 100% after \$50 hospital copay; in Alabama, not covered</b>                            |
| Emergency Room (Accident)   | Covered at 100%; no copay or deductible                                 | Covered at 100% no copay or deductible for services within 72 hours; thereafter 70% subject to calendar year deductible.   |
| Emergency Room Physician  | Covered at 100% after \$20 physician copay                              | Covered at 70% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible<br><br><b>Mental Health Disorders and Substance Abuse Services covered at 100% after \$20 physician copay</b>             |
| Outpatient Diagnostic Lab, X-ray, Pathology   | Covered at 100%; no copay or deductible                                 | Covered at 70% subject to calendar year deductible; in Alabama, not covered  |
| Dialysis, IV Therapy, Chemotherapy & Radiation Therapy  | Covered at 100%; no copay or deductible                                 | Covered at 70% subject to calendar year deductible; in Alabama, not covered  |
| Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)  | Covered at 100% after \$20 daily hospital copay                         | Covered at 70% subject to calendar year deductible; in Alabama, not covered  |
| <b>PHYSICIAN BENEFITS</b><br><b>(Includes Mental Health Disorders and Substance Abuse)</b>  |   |  |
| Precertification is required for some physician benefits; please see benefit booklet. Precertification is also required for physician-administered specialty drugs; visit <a href="http://AlabamaBlue.com/DrugList">AlabamaBlue.com/DrugList</a> . If precertification is not obtained, no benefits are available.  |   |  |
| Office Visits & Outpatient Consultations  | Covered at 100% after \$20 physician copay                              | Covered at 70% subject to calendar year deductible   |
| Surgery & Anesthesia  | Covered at 100%; no copay or deductible                                 | Covered at 70% subject to calendar year deductible   |
| Maternity Care  | Covered at 100%; no copay or deductible                                 | Covered at 70% subject to calendar year deductible   |
| Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy  | Covered at 100%; no copay or deductible                                 | Covered at 70% subject to calendar year deductible   |
| <b>Note:</b> In Alabama, Out-of-Network physician services covered at 50% subject to calendar year deductible   |   |  |

| BENEFIT  | IN-NETWORK  | OUT-OF-NETWORK |
|--|---|----------------|
| <b>PREVENTIVE CARE BENEFITS</b>  |   |                |
| <b>Routine Newborn Exam (in hospital)</b>  | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine Well Child Care Exams</b><br>Nine visits during first 24 months of life and one visit each calendar year thereafter through age six   | Covered at 100% after \$20 physician copay  | Not covered    |
| <b>Routine Developmental Screening</b><br>Three exams between 9 months and 30 months of life   | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine Immunizations</b><br>• Age limitations apply to certain immunizations<br>• Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See <a href="http://AlabamaBlue.com/pharmacy">AlabamaBlue.com/pharmacy</a> for more information.  | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine Office Visit</b><br>When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam   | Covered at 100% after \$20 physician copay  | Not covered    |
| <b>Routine Pap Smear</b><br>One per calendar year  | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine Human Papillomavirus (HPV) Testing</b><br>One routine test every three calendar years for females ages 30 and over  | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine Chlamydia Screening</b><br>One per calendar year for females ages 15-24   | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine/Screening Mammogram</b><br>One exam for females ages 35-39 and one per calendar year for females ages 40 and over   | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine Hepatitis C Screening</b><br>Once in a lifetime for members born between 01/01/1945 and 12/31/1965  | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine Prostate Cancer Screening</b><br>Males age 40 and over<br>• Prostate Specific Antigen (PSA) each calendar year<br>• Digital Rectal Exam each calendar year  | Covered at 100%; no copay or deductible   | Not covered    |
| <b>Routine Colorectal Cancer Screening</b><br>Ages 50 and over<br>• Hemocult stool check/ Fecal occult blood test each calendar year<br>• Flexible sigmoidoscopy every three calendar years<br>• Double-contrast barium enema every five calendar years<br>• Colonoscopy every 10 calendar years   | Covered at 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay)  | Not covered    |
| <b>Note:</b> In case of illness or family history of cancer, services generally are not considered preventive and may be covered by other plan provisions  |   |                |
| <b>PRESCRIPTION DRUG BENEFITS<br/>(Includes Mental Health Disorders and Substance Abuse)</b>   |   |                |
| <b>Prescription Drug Card</b><br>• The pharmacy network for the plan is the <b>Prime Participating Pharmacy Network</b><br>• Some drugs require prior authorization<br>• Some copays combined for diabetic supplies<br>• Prescription drugs (other than specialty drugs) can be dispensed for up to a 90-day supply but the copayment is applicable for each 30-day supply<br>• Specialty Drugs, or biotech drugs, are generally high cost self-administered drugs<br>• View the <b>Standard Prescription Drug</b> list that applies to the plan at <a href="http://AlabamaBlue.com/web/pharmacy/drugguide.html">AlabamaBlue.com/web/pharmacy/drugguide.html</a> | Separate \$150 prescription drug deductible per person per calendar year (\$300 family maximum) applies to Brand Name Drugs; each prescription purchased from Participating Pharmacy covered 100% after deductible subject to the following:<br><b>Tier 1 Drugs:</b><br>Covered at 70% with no deductible<br><b>Tier 2 Drugs:</b><br>Covered at 70% subject to pharmacy deductible<br><b>Tier 3 Drugs:</b><br>Covered at 70% subject to pharmacy deductible | Not covered    |

| BENEFIT  | IN-NETWORK   | OUT-OF-NETWORK   |
|--|--|--|
| <b>Mail Order Pharmacy Benefits</b> <ul style="list-style-type: none"> <li>Up to 90-day supply with one copay</li> <li>Mail Order drugs are available through PrimeMail<sup>®</sup> (Enroll online at <a href="http://AlabamaBlue.com">AlabamaBlue.com</a> or call 1-877-579-7627)</li> <li>Maintenance and Non-Maintenance drugs can be purchased through mail order pharmacy</li> <li>Specialty Drugs are not available through mail order</li> </ul>                                    | <b>Tier 1 Drugs:</b><br>Covered at 70% with no deductible<br><b>Tier 2 Drugs:</b><br>Covered at 70% subject to pharmacy deductible<br><b>Tier 3 Drugs:</b><br>Covered at 70% subject to pharmacy deductible  | Not covered  |
| <b>SUMMARY OF COST SHARING PROVISIONS<br/>(Includes Mental Health Disorders and Substance Abuse)</b>   |  |  |
| <b>Calendar Year Deductible</b>  | \$50 individual; 3 member family maximum.<br><br>4 <sup>TH</sup> Quarter Carryover Deductible: Any covered expenses incurred in the last 3 months of any benefit period which have been allocated toward all <u>or</u> a portion of the Calendar year Deductible for that year may also be allocated toward next years Calendar year Deductible.   |  |
| <b>Calendar Year Out-of-Pocket Maximum Applies to:</b> <ul style="list-style-type: none"> <li>Other Covered Services</li> <li>Out-of-Network physician services outside of Alabama</li> </ul>  | \$1,500 individual plus \$50 calendar year deductible<br><br>After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% for the remainder of the calendar year.  |  |
| <b>BENEFITS FOR OTHER COVERED SERVICES<br/>(Includes Mental Health Disorders and Substance Abuse)</b>  |  |  |
| Precertification is required for some other covered services; please see benefit booklet.<br>If precertification is not obtained, no benefits are available.   |  |  |
| <b>Allergy Testing &amp; Treatment</b><br>Limited to 6 visits per person per calendar year   | Covered at 70% subject to calendar year deductible   | Covered at 70% subject to calendar year deductible   |
| <b>Ambulance Service</b>   | Covered at 70% subject to calendar year deductible   | Covered at 70% subject to calendar year deductible   |
| <b>Cancer Diagnosed Treatment</b>  | Covered at 100%; no copay or deductible  | Covered at 70% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible |
| <b>Participating Chiropractic Services</b><br>Limited 12 visits per person per calendar year   | Covered at 70% subject to calendar year deductible   | Covered at 70% subject to calendar year deductible; in Alabama, not covered  |
| <b>Durable Medical Equipment (DME)</b>   | Covered at 70% subject to calendar year deductible   | Covered at 70% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible |
| <b>Occupational and Physical Therapy</b><br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per year  | Covered at 70% subject to calendar year deductible   | Covered at 70% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible |
| <b>Speech Therapy</b><br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per year   | Covered at 70% subject to calendar year deductible   | Covered at 70% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible |
| <b>Home Health and Hospice</b>   | Covered at 100%; no copay or deductible  | Covered at 70% subject to calendar year deductible; in Alabama, not covered  |
| <b>VISION BENEFITS</b>   |  |  |
| <b>Routine Vision</b> <ul style="list-style-type: none"> <li>Routine vision exams and refractions, limited to a \$50 maximum per person age 19 and over. No dollar maximum for members up to age 19.</li> <li>One exam per member under age 19 every 12 months; one exam per member age 19 and older every 24 months</li> <li>Conventional lenses, frames and contact lenses limited to a \$350 maximum per member every 24 months. No dollar maximum for members up to age 19.</li> </ul> | Routine Vision Exams and Refractions covered at 100% after \$25 copay.<br><br>Conventional Lenses, Frames, and Contact Lenses covered at 100% of the allowed amount.   |  |
| <b>EXPANDED PSYCHIATRIC SERVICES (EPS)</b>   |  |  |
| <b>Expanded Psychiatric Services (EPS)</b> <ul style="list-style-type: none"> <li>EPS network available throughout Alabama and in Meridian, Mississippi and Northwest Florida</li> <li>To find an EPS provider call Customer Service at 1-800-292-8868 or search the online provider finder on our website at <a href="http://AlabamaBlue.com">AlabamaBlue.com</a></li> </ul>  | When care is received or coordinated by an EPS provider, the following mental health disorders and substance abuse benefits are available:<br><br>Covered at 100%; no copay or deductible<br><b>Inpatient:</b> Includes hospital, physician and therapy expenses<br><b>Outpatient:</b> Includes office visits, therapy, counseling and testing<br><br>When care is not received or coordinated by an EPS provider, the mental health disorders and substance abuse benefits available will mirror all other categories of this matrix. |  |

| BENEFIT   | IN-NETWORK   | OUT-OF-NETWORK |
|---|--|----------------|
| <b>HEALTH MANAGEMENT BENEFITS</b><br>(Includes Mental Health Disorders 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 <sup>®</sup>  | A prenatal wellness program; For more information, please call 1-800-222-4379. You can also enroll online at <a href="http://Behealthy.com">Behealthy.com</a> .  |                |
| 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 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](http://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, Preferred Care). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s).
- 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.
- In-Network Certified Registered Nurse Practitioners (CRNPs) /Certified Nurse Midwives (CNMs) are considered eligible providers; no coverage out-of-network for services provided by CRNPs and CNMs.

**Your group believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, this plan does not have to include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans. This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract. Please visit our website, [AlabamaBlue.com](http://AlabamaBlue.com).**