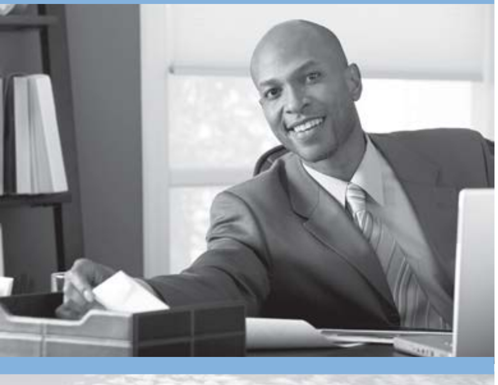
We cover what matters.



BlueCard® PPO Plan Benefits

Dunn Companies

BlueCard® PPO

Effective January 1, 2019

Visit our website at
AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Dunn Companies
BlueCard® PPO
Effective January 1, 2019

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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.***		
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders)		
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 Note: Inpatient hospital deductibles and copays do not apply to the Calendar Year Out-of-Pocket Maximum.	Covered at 100% of the allowed amount after $500 per admission deductible; $100 per day hospital copay days 2-11 for each admission	Covered at 50% of the allowed amount after $500 per admission deductible **Note**: In Alabama, available for only medical emergencies 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 subject to calendar year deductible **Mental Health Disorders covered at 50% of the allowed amount not subject to calendar year deductible**
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders)		
Precertification is required for some outpatient hospital benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount after $250 hospital copay	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount after $250 hospital copay	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered **Mental Health Disorders** covered at 100% of the allowed amount after $250 hospital copay; in Alabama, not covered
Emergency Room (Accident)	Covered at 100% of the allowed amount; no copay or deductible	Covered at 100% of the allowed amount; no copay or deductible for services within 72 hours, thereafter 50% of the allowed amount subject to calendar year deductible
Emergency Room Physician	Covered at 100% of the allowed amount after $30 physician copay	Covered at 50% of the allowed amount subject to calendar year deductible **Mental Health Disorders** covered at 100% of the allowed amount after $30 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	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders	Covered at 100% of the allowed amount after $30 daily hospital copay	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders)		
Precertification is required for some physician benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Office Visits & Consultations	Covered at 100% of the allowed amount after $30 physician copay	Covered at 50% of the allowed amount subject to calendar year deductible
Surgery & Anesthesia	Covered at 100% of the allowed amount; no copay or deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Maternity Care	Covered at 100% of the allowed amount; no copay or deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount; no copay or deductible	Covered at 50% of the allowed amount subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ENHANCED PREVENTIVE CARE BENEFITS		
Routine Newborn Exam (in hospital)	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Well Child Care Exams Nine visits during the first 24 months of life and one visit per year thereafter through age 6	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Developmental Screening Three exams between 9 months and 30 months of life	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Immunizations • Age limitations apply to certain immunizations • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/VaccineNetworkDrugList** for more information.	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Office Visit One visit every two years age 7-34 and one exam annually age 35 and over	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine OB/GYN visit One per calendar year	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Pap Smear One per calendar year	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Human Papillomavirus (HPV) Testing One routine test every three calendar years for females ages 30 and over	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Chlamydia Screening One per calendar year for females ages 15-24	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine/Screening Mammogram One exam for females ages 35-39 and one per calendar year for females ages 40 and over	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Prostate Cancer Screening Males age 40 and over • Prostate Specific Antigen (PSA) each calendar year • Digital Rectal Exam each calendar year	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Colorectal Cancer Screening Ages 50 and over • Hemocult stool check/ Fecal occult blood test one each calendar year • Flexible sigmoidoscopy one every three calendar years • Double-contrast barium enema one every five calendar years • Colonoscopy one every 10 calendar years	Covered at 100% of the allowed amount; no copay or deductible for physician charges and outpatient hospital services.	Not covered
Routine Cholesterol Test One per calendar year (including lipid panel and HDL)	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Blood Sugar Test One per calendar year (no age limit)	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Other Routine Screening Limited to one urinalysis, CBC and TB skin testing when necessary	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Osteoporosis Screening Limited to one bone density test every 24 months for women ages 50 and over	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Routine Venipuncture Limited to one routine venipuncture every calendar year	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. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders)		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available. Separate $150 prescription drug deductible per person per calendar year (no family maximum).		
Participating Retail Pharmacy • Envolve Pharmacy Solutions is your Pharmacy Benefit Manager. You have access to a robust nationwide pharmacy network. To locate a pharmacy, use the pharmacy lookup tool at EnvolveRx.com, on the EnvolveRx app, or contact customer service at 800-460-8988. • AcariaHealth, an Envolve Solution, is your specialty pharmacy that provides medications for complex conditions. For assistance with specialty drugs, please call AcariaHealth at 800-511-5144. • Non-maintenance drugs – up to 34-day supply at retail • Maintenance drugs you take on a regular basis – up to a 60-day supply with one copay • Some copays combined for diabetic supplies	**Tier 1 drugs:** $15 copay per prescription **Tier 2 drugs:** $35 copay per prescription **Tier 3 drugs:** $55 copay per prescription	Not covered

Homescripts Mail Service Pharmacy
• If you take one or more medications on a regular basis, the mail service pharmacy may be the right choice for you. There are two easy ways to enroll:
  • Online at Homescripts.com. Click on Member Enrollment
  • Enroll over the phone. Call 888-239-7690.
• Up to 90-day supply with one copay
• Maintenance drugs can be purchased through mail order pharmacy
• Specialty drugs are not available through mail order
	Tier 1 drugs:
	$15 copay per prescription
	Tier 2 drugs:
	$35 copay per prescription
	Tier 3 drugs:
	$55 copay per prescription
		Not covered

SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders)		
Calendar Year Deductible	$500 individual; 3 member family maximum	
Calendar Year Out-of-Pocket Maximum Applies to: • Other Covered Services • Home Health and Hospice	$2,500 individual plus calendar year deductible; 3 family member maximum Only the coinsurance amounts you pay for the listed services will apply to the maximum. Fixed copays do not apply to the maximum. After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% of the allowed amount for the remainder of the calendar year.	
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders)		
Precertification is required for some other covered services; please see benefit booklet. If precertification is not obtained, no benefits are available.		
Allergy Testing & Treatment	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Ambulance Service	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Participating Chiropractic Services Limited to 20 visits per calendar year	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Physical Therapy	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Home Health and Hospice	Covered at 100% of the allowed amount; no copay or deductible	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Hearing Aids **Includes:** • Hearing Aid Durable Medical Equipment and Fittings • Limited to $2,000 each ear per member each three calendar years	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible

HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders)

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 maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.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.

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, Preferred Care). 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 professionals are available through the Blue Choice Behavioral Health Network.*
- *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.*
- *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.*
- *In-network benefits for Laparoscopic Adjustable Gastric Banding (LAP-BAND®) System, longitudinal gastrectomy and related procedures are covered under this health plan; Out-of-network services not covered. Benefits are not provided for any other type of Bariatric Surgery. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.*
- *Audiologists are eligible providers.*
- *Licensed Mental Health Counselors (LMHC) and Licensed Professional Counselors (LPC) when licensed in the state in which they practice are eligible providers.*

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.

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201,
1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144
(TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。