BlueCross BlueShield of Alabama

*We cover what matters.*

# *Plan Benefits Summary*

AlabamaBlue.com

## Blue Secure Silver

FOR BUSINESS

Effective for plan years on and after January 1, 2023

# Hospital Choice Network

The Blue Cross and Blue Shield of Alabama Hospital Choice Network is a local Alabama effort to evaluate cost, quality and patient experience in member hospitals. Hospitals are categorized into either Lower Member Cost Share or Higher Member Cost Share, based on their performance.

Only Alabama general acute care hospitals are eligible for participation in the Hospital Choice Network. Rehabilitation hospitals, psychiatric hospitals, specialty facilities, out-of-state hospitals, VA hospitals and long-term care hospitals are exempt from Hospital Choice Network scoring.

All hospitals are evaluated annually with changes made effective January 1. In addition, reviews are completed on a quarterly basis allowing hospitals to improve their status. To review the evaluation criteria for all hospitals and/or the level of Member Cost Share for a particular hospital, please use the "Find a Doctor" tool on our website at **AlabamaBlue.com.** The Member Cost Share level will be included in the information provided for each hospital that participates in the Hospital Choice Network. For more information on the evaluation criteria, click on the name of the hospital and then click on the "Cost", "Quality" or "Patient Experience" tabs. If you have any questions, please call the Customer Service number on the back of your ID card.

# Prescription Drugs: ValueONE Network

**ValueONE Network Facts:**

- 51,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Retail Network. This includes many national pharmacies you may already be using.
- 50,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Extended Supply Network (ESN). This includes many national pharmacies you may already be using.
- Generally, ValueONE Retail Network pharmacies can fill up to a 30-day supply of retail drugs while ValueONE ESN Network pharmacies can fill up to a 90-day supply of certain medications (prescription must be written for up to a 90-day supply). Refer to your benefit booklet for the specific day supply permitted by your benefit plan. Since the type of pharmacy differs within the ValueONE Network, be sure to check your specific pharmacy.
- If you do not use a ValueONE Network pharmacy, you may be responsible for the full cost of your prescription medication. Benefits may not be provided for out-of-network pharmacies.
- To maximize your pharmacy benefits, you will need to transfer all your prescriptions to a ValueONE Network pharmacy.

**Find a ValueONE Network Pharmacy**

You can locate all of the participating pharmacies in your area at **AlabamaBlue.com/ValueONERetailPharmacyLocator.** Click on "Find a Pharmacy by Name or Location" located under Find a Pharmacy. When searching for a participating pharmacy, make sure either "ValueONE Retail Network" or "ValueONE ESN Network" is listed under "Network Participation" located to the right of the pharmacy address.

# Blue Secure Silver for Business
# Effective for Plan Years on and after January 1, 2023
# BlueCard® PPO

| 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.*** | | |
| **SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.** | | |
| **Calendar Year Deductible**<br><br>The in-network and out-of-network deductibles are separate and do not apply to each other | $4,000 Individual; $8,000 Family | $4,000 Individual; $8,000 Family |
| **Calendar Year Out-of-Pocket Maximum** (including in-network calendar year deductible)<br><br>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 | $8,550 Individual; $17,100 Family<br><br>After you reach your individual 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, maternity admissions and as required by Federal law); 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** | **Lower Member Cost Share:** Covered at 100% of the allowed amount after $550 per day hospital copay days 1-5 for each admission<br>**Higher Member Cost Share:** Covered at 100% of the allowed amount after $950 per day hospital copay days 1-5 for each admission | Covered at 50% of the allowed amount after $1,500 per admission deductible<br><br>**Note**: In Alabama, available only for medical emergency services and accidental injury |
| **Inpatient Physician Visits and Consultations** | Covered at 100% of the allowed amount subject to calendar year deductible<br><br>**Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount; no copay or deductible** | Covered at 50% of the allowed amount subject to calendar year deductible<br><br>**Mental Health Disorders and Substance Abuse Services covered at 50% of the allowed amount; no copay or deductible** |
| **OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Precertification is required for some outpatient hospital benefits. Precertification is also required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.** | | |
| **Outpatient Surgery (Including Ambulatory Surgical Centers)** | **Lower Member Cost Share:** Covered at 100% of the allowed amount after $550 hospital copay<br>**Higher Member Cost Share:** Covered at 100% of the allowed amount after $950 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 $550 hospital copay | Covered at 100% of the allowed amount after $550 hospital copay<br><br>**Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after $550 hospital copay** |
| **Emergency Room (Accident)**<br><br>**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 100% of the allowed amount after $550 hospital copay | Covered at 100% of the allowed amount after $550 hospital copay when services are rendered within 72 hours of the accident; 50% of the allowed amount subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Emergency Room Physician** | Covered at 100% of the allowed amount after $80 physician copay | Covered at 100% of the allowed amount after $80 physician copay<br><br>**Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after $80 physician copay** |
| **Outpatient Diagnostic Lab, X-ray & Pathology** | **Lower Member Cost Share:** Covered at 100% of the allowed amount after $550 hospital copay<br>**Higher Member Cost Share:** Covered at 100% of the allowed amount after $950 hospital copay | Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered |
| **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 and Substance Abuse** | Covered at 100% of the allowed amount after $80 per day hospital copay | Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered |
| **PHYSICIAN BENEFITS<br>(Includes Mental Health Disorders and Substance Abuse)** | | |
| **Precertification is required for some physician benefits. Precertification is also required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList.<br>If precertification is not obtained, no benefits are available.** | | |
| **IN-NETWORK SERVICES *NOT* SUBJECT TO $4,000 CALENDAR YEAR DEDUCTIBLE** | | |
| **Office Visits, Consultations & Psychotherapy** | Covered at 100% of the allowed amount after $40 primary care physician copay or $80 specialist physician copay | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Telephone and Online Video Physician Consultations Program**<br><br>To enroll in the telephone and online video consultations program, go to AlabamaBlue.com/Teleconsultation or call 1-855-477-4549.<br><br>Telephone and online video consultations are available to diagnose, treat and prescribe medication (when necessary) for certain medical issues. | Covered at 100% of the allowed amount subject to a $40 copayment per consultation | Not covered |
| **Second Surgical Opinion** | Covered at 100% of the allowed amount after $80 physician copay | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Diagnostic X-ray** | Covered at 100% of the allowed amount after $10 copay per procedure | Covered at 50% of the allowed amount subject to calendar year deductible |
| **CAT Scan, MRI, PET/SPECT, ERCP, angiography/arteriography, cardiac cath/arteriography, UGI endoscopy, muga-gated cardiac scan & colonoscopy** | Covered at 100% of the allowed amount after $550 copay per visit | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Diagnostic Lab, 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-NETWORK SERVICES SUBJECT TO $4,000 CALENDAR YEAR DEDUCTIBLE** | | |
| **Surgery & Anesthesia** | Covered at 100% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Maternity Care** | Covered at 100% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PREVENTIVE CARE BENEFITS** | | |
| **Routine Immunizations and Preventive Services**<br>• See **AlabamaBlue.com/PreventiveServices** and **AlabamaBlue.com/StandardACAPreventiveDrugList** for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy.<br>• 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 |
| **Note**: In some cases, office visit copays or facility copays may apply | | |
| **PEDIATRIC VISION BENEFITS** | | |
| **Pediatric Eye Exam**<br>Limited to one exam (including refraction) per member per calendar year up to the end of the month in which the member turns 19. | Covered at 80% of the allowed amount subject to calendar year deductible | Not covered |
| **Pediatric Glasses or Contact Lenses**<br>Limited to one pair of prescription glasses per member per calendar year; contact lenses are limited to one 12-month supply per calendar year. Benefits are available up to the end of the month in which the member turns 19. | Covered at 80% of the allowed amount subject to calendar year deductible | Covered at 80% of the allowed amount subject to calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Precertification is required for some drugs; if no precertification is obtained, no benefits are available.** | | |
| **Retail Prescription Prepaid Drug Card**<br><br>The retail pharmacy network for the plan is the **ValueONE Retail Network**.<br>• Locate a ValueONE Reatil Network Pharmacy at **AlabamaBlue.com/ValueONERetailPharmacyLocator**<br><br>Prescription drugs can be dispensed for up to a 30-day supply.<br>• View the **Source+Rx 1.0 Drug** list that applies to the plan at **AlabamaBlue.com/2023SourcePlusRx1DrugList**<br><br>Maintenance prescription drugs can be dispensed for up to a 30-day supply<br>• View the Maintenance Drug List that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList**<br>• Some copays may be combined for diabetic supplies<br><br>Tier 5 and 6 (Specialty) drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Tier 5 and 6 (Specialty) drugs is the **Pharmacy Select Network**.<br>• View the Specialty Drug List that applies to the plan at **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList**<br><br>Some immunizations may be received from an in-network pharmacy that participates in the **Pharmacy Vaccine Network.**<br>• A list of the eligible vaccines these pharmacies may provide can be found at **AlabamaBlue.com/VaccineNetworkDrugList** | Covered at 100% of the allowed amount after the following copays:<br><br>**Tier 1 Drugs:**<br>$15 copay per prescription<br><br>**Tier 2 Drugs:**<br>$30 copay per prescription<br><br>**Tier 3 Drugs:**<br>$75 copay per prescription<br><br>**Tier 4 Drugs:**<br>$100 copay per prescription<br><br>**Tier 5 (Preferred Specialty) Drugs:**<br>$250 copay per prescription<br><br>**Tier 6 (Non-Preferred Specialty) Drugs:**<br>Covered at 60% of the allowed amount<br><br>**Covered Insulin Products:** $99 maximum cost share per 30-day supply | Not covered |
| **Extended Supply Prescription Prepaid Drug Benefits**<br><br>The extended supply pharmacy network for the plan is the **ValueONE ESN Network**<br>• Locate a ValueONE ESN Pharmacy at **AlabamaBlue.com/ValueONEESNPharmacyLocator**<br><br>Only maintenance prescription drugs can be purchased through this extended supply pharmacy service - up to a 90-day supply with one copay for each 30 day supply<br>• View the Maintenance Drug List that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList**<br>• View the **Source+Rx 1.0** Drug list that applies to the plan at **AlabamaBlue.com/2023SourcePlusRx1DrugList** | Covered at 100% of the allowed amount after the following copays:<br><br>**Tier 1 Drugs:**<br>$15 copay per prescription<br><br>**Tier 2 Drugs:**<br>$30 copay per prescription<br><br>**Tier 3 Drugs:**<br>$75 copay per prescription<br><br>**Tier 4 Drugs:**<br>$100 copay per prescription<br><br>**Tier 5 (Preferred Specialty) Drugs:**<br>Not covered<br><br>**Tier 6 (Non-Preferred Specialty) Drugs:**<br>Not covered<br><br>**Covered Insulin Products:** $99 maximum cost share per 30-day supply | Not covered |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Select Generic Specialty and Biosimilar Drugs**<br><br>Generic specialty and biosimilar drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some generic specialty and biosimilar drugs is the **Pharmacy Select Network**.<br><br>• View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at **AlabamaBlue.com/SelectGenericSpecialtyandBiosimilarDrugList.**<br><br>Generic specialty and biosimilar drugs are not available through the **Home Delivery Network**. | Covered at 100% of the allowed amount; no copay or deductible | Not covered |
| **Mail Order Pharmacy Service**<br>• Up to 90-day supply with one copay<br>• Mail Order drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/HomeDeliveryNetwork**<br><br>**Note:** If you have less than a 90-day supply, you will pay the same copay as a 90-day supply when using this mail order service. | Covered at 100% of the allowed amount after the following copays:<br><br>**Tier 1 Drugs:**<br>$37.50 copay per prescription<br><br>**Tier 2 Drugs:**<br>$75 copay per prescription<br><br>**Tier 3 Drugs:**<br>$187.50 copay per prescription<br><br>**Tier 4 Drugs:**<br>$250 copay per prescription<br><br>**Tier 5 (Preferred Specialty) Drugs:**<br>Not covered<br><br>**Tier 6 (Non-Preferred Specialty) Drugs:**<br>Not covered<br><br>**Covered Insulin Products:** $99 maximum cost share per 30-day supply | Not covered |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **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** | Covered at 80% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Ambulance Service** | Covered at 80% of the allowed amount subject to calendar year deductible | Covered at 80% of the allowed amount subject to calendar year deductible |
| **Chiropractic Services**<br>Limited to 15 visits per member per calendar year | Covered at 80% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered |
| **Durable Medical Equipment (DME)** | Covered at 80% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Rehabilitative Occupational, Physical and Speech Therapy**<br><br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year | Covered at 80% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Habilitative Occupational, Physical and Speech Therapy**<br><br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year | Covered at 80% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Autism-Related Rehabilitative and Habilitative Occupational and Speech Therapy**<br><br>Children ages 0-18 with an autism diagnosis are allowed unlimited visits for occupational and speech therapy | Covered at 80% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible |
| **Home Health and Hospice** | Covered at 100% of the allowed amount subject to calendar year deductible | Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered |
| **Home Infusion** | 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 |
| **Medical Nutrition Therapy Services**<br><br>For adults and children, 6 hours each calendar year | Covered at 100% of the allowed amount after $40 physician copay | Covered at 50% of the allowed amount subject to calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PEDIATRIC DENTAL BENEFITS** | | |
| **Benefits are available up to the end of the month in which the member turns 19. See your benefit booklet for visit and treatment limits.** | | |
| **Diagnostic and Preventive Services**<br><br>**Examples include:**<br>Dental exams, routine cleanings, fluoride treatment, bitewing x-rays, full mouth x-rays and panoramic film, tooth sealants and topical fluoride varnish | Covered at 100% of the allowed amount; no copay or deductible | Not covered |
| **Basic Services**<br><br>**Examples include:**<br>Tooth color and silver amalgam fillings, simple tooth extractions, non-surgical root canal, emergency treatment for pain and repairs to crowns, inlays, onlays and dentures | Covered at 80% of the allowed amount; no copay or deductible | Not covered |
| **Major Services**<br><br>**Examples include:**<br>Oral surgery, general anesthesia, periodontic exams, removal of diseased gum tissue and bone, crowns, onlays, core buildup, dentures, implants and bridges | Covered at 50% of the allowed amount subject to calendar year deductible | Not covered |
| **Medically Necessary Orthodontic Services** | Covered at 50% of the allowed amount subject to calendar year deductible | Not covered |
| **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**. | |
| **Chronic Condition Management** | Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions. | |
| **Baby Yourself®** | A maternity program; For more information, please call **1-800-222-4379**. You can also enroll online at **AlabamaBlue.com/BabyYourself**. | |
| **Air Medical Transport** | Air medical transportation 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 a 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/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, the average charge for care in the area, or in accordance with applicable Federal law.*
- *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.*
- *Please refer to your benefit book or contact Blue Cross directly about coverage for your hospital charges and other related medical services. Approval for air medical transportation does not mean that hospitalization and other medical expenses will be covered. All coverage determinations for medical benefits are subject to the terms, conditions, limitations and exclusions of the health plan. Air medical transportation services are provided through a contract with AirMed International, LLC, an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical transportation services terminate if coverage by your health plan ends.*

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