BCBS Blue Secure Silver for Business

Benefit	2018
Calendar Year Deductible	$2,600 Individual; $5,200 Family
Calendar Year Out-of-Pocket Maximum	$7,350 Individual; $14,700 Family
Copays	$390

Benefit	2019
Calendar Year Deductible	$3,250 Individual; $6,500 Family
Calendar Year Out-of-Pocket Maximum	$7,900 Individual; $15,800 Family
Copays	$400

Benefit	2020
Calendar Year Deductible	$4,000 Individual; $8,000 Family
Calendar Year Out-of-Pocket Maximum	$8,150 Individual; $16,300 Family
Copays	$450

Benefit	2021
Calendar Year Deductible	$4,000 Individual; $8,000 Family
Calendar Year Out-of-Pocket Maximum	$8,550 Individual; $17,100 Family
Copays	$450

2021 Iron RE Silver

Benefit	2021
Calendar Year Deductible	$2,600 Individual; $5,200 Family
Calendar Year Out-of-Pocket Maximum	$7,350 Individual; $14,700 Family
Copays	$390

THE COWART GROUP
EXECUTIVE BENEFITS FIRM

Iron ReHealth Silver Plan

Comparison To

BlueCross BlueShield Blue Secure Silver Medical Plan

2021

IRON REHEALTH an Arsenal company

Common Services	Blue Secure Silver	Iron ReHealth Silver
CALENDAR YEAR DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical, and Specialty Pharmaceuticals	$4,000 per individual; $8,000 per family	$2,600 per individual; $5,200 per family
CALENDAR YEAR OUT-OF-POCKET MAXIUMUM: The most a Member will pay per Calendar Year for qualified medical, prescription, mental, and substance abuse services, prescription drugs, and specialty drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums, ancillary charges, or out-of-network charges over the maximum payment allowance. If you have a non-calendar plan year, the maximum limit may change during a calendar year period. If the limit increases with a new plan year, you may owe cost-sharing again up to the amount of the increase even if you reached the limit earlier in the Calendar Year. See the Certificate of Coverage for details.	$8,550 per individual; $16,300 per family	$7,350 per individual; $14,700 per family
PREVENTATIVE CARE: • Well Baby Care (Children under age 3) • Routine Physicals (One per Calendar Year for ages 3+) • Covered Immunizations • OBGYN Preventive Visit (One per Calendar Year) • Preventive Prenatal Care (As defined in the Certificate of Coverage) • Other preventive Items and services. See Certificate of Coverage for more Information.	See AlabamaBlue.com/PreventiveServices and AlabamaBlue.com/StandardACAPreventiveDrugList for a listing of specific immunizations and preventive services or call Customer Service for a printed copy. Some immunizations may be obtained through the Pharmacy Vaccine Network. Covered at 100%, no copay or deductible	Covered at 100%, no copay or deductible
OTHER PRIMARY CARE SERVICES: • Medical Physician Office Visit	• $40 Office Visit Copay for Primary Physician	• $40 Office Visit Copay for Primary Physician
SPECIALTY CARE AND SECOND SURGICAL OPINION: (No Primary Care Physician Referral required) • Medical Physician Office Visit	• $70 Office Visit Copay for Specialist	• $65 Office Visit Copay for Specialist
URGENT CARE CENTER SERVICES: • Medical Physician Office Visit	$40 Office Visit Copay	$40 Office Visit Copay
VISION CARE: (NO Primary Care Physician Referral required) • Illness and Injury	(Eyeglasses or contact lenses, One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect) • Covered at 80% *after* calendar year deductible • $70 Office Visit Copay for Specialist	(Eyeglasses or contact lenses, One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect) • Covered at 80% after calendar year deductible • $65 Office Visit Copay for Specialist
ALLERGY SERVICES (No Primary Care Physician Referral required) • Physician Services • Testing and Treatment	$70 office Visit copay for Specialist Covered 80% after calendar year deductible (subject to Medical Guidelines & Limitations)	$65 Office Visit Copay for Specialist Covered at 80% after calendar year deductible (subject to Medical Guidelines & Limitations)
CHRONIC CARE MAINTENANCE: (Including, but not limited to dialysis, IV therapy, chemotherapy, radiation therapy, wound care, wound therapy)	Covered at 100%, no copay or deductible	Covered at 100%, no copay or deductible

PBVERSION 4-2020