

Group Health Care Plan

University of Alabama in Huntsville

**Group #79912
Divisions 007, 008 & 07S**

Effective January 1, 2008

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL FACILITY SERVICES		
Deductibles and Copay	\$300 per admission deductible. \$10 copay per day for days 2-11.	\$350 per admission deductible.
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	Covered at 80% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
	Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury.	
Preadmission Certification	All hospital admissions require preadmission certification, except maternity. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1 800 248-2342 (toll-free). If preadmission certification is not obtained, no benefits are available.	
Individual Case Management	A program to assist employees and their families in coordinating care in the event of a lengthy illness.	
Baby Yourself	A prenatal wellness program. For more information, call 1 800 222-4379. You can also enroll online at BeHealthy.com .	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Surgery	Covered at 100% of the allowance subject to the \$100 facility copay.	Covered at 80% of the allowance subject to the calendar year deductible.*
Medical Emergency	Covered at 100% of the allowance subject to the \$50 facility copay.	Covered at 80% of the allowance subject to the calendar year deductible.*
Non-Emergency Medical	Covered at 80% of the allowance subject to the \$50 facility copay and the calendar year deductible.	Covered at 80% of the allowance subject to the \$50 facility copay and the calendar year deductible.*
Accidental Injury	Covered at 100% of the allowance subject to the \$50 facility copay.	Covered at 100% of the allowance subject to the \$50 facility copay within 72 hours of the accident. Thereafter, covered at 80% of the allowance, subject to the calendar year deductible.*
Diagnostic Lab, X-ray, and Pathology	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance subject to the calendar year deductible.*
Hemodialysis, IV Therapy, Chemotherapy and Radiation Therapy	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance subject to the calendar year deductible.*
Note: In Alabama, outpatient benefits for non-member hospitals are available only in cases of accidental injury.		
PHYSICIAN SERVICES		
Office Visits and Outpatient Consultations	Covered at 100% of the allowance subject to the \$25 office visit copay.	Covered at 80% of the allowance subject to the calendar year deductible.* Non-PPO in Alabama: Covered at 50% of the allowance subject to the calendar year deductible.*
Emergency Room Physician Fees	Covered at 100% of the allowance subject to the \$50 ER visit copay.	Covered at 80% of the allowance subject to the calendar year deductible.* Non-PPO in Alabama: Covered at 50% of the allowance subject to the calendar year deductible.*
Surgery and Anesthesia	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance subject to the calendar year deductible.* Non-PPO in Alabama: Covered at 50% of the allowance subject to the calendar year deductible.*
Inpatient Visits, Second Surgical Opinions and Inpatient Consultations	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance subject to the calendar year deductible.* Non-PPO in Alabama: Covered at 50% of the allowance subject to the calendar year deductible.*

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Maternity	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance subject to the calendar year deductible.* Non-PPO in Alabama: Covered at 50% of the allowance subject to the calendar year deductible.*
Diagnostic X-rays and Lab Exams	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance subject to the calendar year deductible.* Non-PPO in Alabama: Covered at 50% of the allowance subject to the calendar year deductible.*
ENHANCED PREVENTIVE CARE SERVICES		
Inpatient Visits for Routine Newborn Care	Covered at 100% of the allowance with no deductible or copay.	Not covered.
Well Child Care Exams	Covered at 100% of the allowance subject to the \$25 office visit copay. Includes 9 visits during the first two years of the child's life and one visit each year thereafter through age 6.	Not covered.
Preventive Office Visits	Covered at 100% of the allowance subject to the \$25 office visit copay. Limited to one exam every two years for members age 7-34; one exam annually for members age 35 and over.	Not covered.
Routine Immunizations (Age limitation apply to certain immunizations)	Covered at 100% of the allowance with no deductible or copay.	Not covered.
Routine Pap Smears	Covered at 100% of the allowance with no deductible or copay. Limited to one per year. Subject to the \$25 office visit copay if applicable.	Not covered.
Routine Mammograms	Covered at 100% of the allowance with no deductible or copay. Limited to one exam for females between the ages of 35-39 and one per year for females age 40 and over. Subject to the \$25 office visit copay if applicable.	Not covered.
Routine Prostate Specific Antigen	Covered at 100% of the allowance with no deductible or copay. Limited to one per year for males age 40 and over. Subject to the \$25 office visit copay if applicable.	Not covered.
Other Routine Screening	Covered at 100% of the allowed amount with no deductible or copay. Includes the following: Urinalysis and CBC (when necessary), TB skin testing (when necessary), and Cholesterol testing (once every 5 years). Subject to the \$25 office copay if applicable.	Not covered.
Routine Colorectal Cancer Screening Ages 50 and over <ul style="list-style-type: none"> • Fecal occult blood test each year • Flexible sigmoidoscopy every three years • Double-contrast barium enema every five years • Colonoscopy every 10 years 	Covered at 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay).	Not covered.
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services for Mental Health	Covered at 100% of the allowance subject to the inpatient per admission deductible. Limited to a maximum of 60 days per person per calendar year.	Covered at 80% of the allowance subject to the inpatient per admission deductible.* Limited to a maximum of 60 days per person per calendar year.
Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury.		

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Inpatient Facility Services for Substance Abuse	Covered at 100% of the allowance subject to the inpatient per admission deductible. Limited to a maximum of 28 days per person per calendar year and a lifetime maximum of two admissions.	Covered at 80% of the allowance subject to the inpatient per admission deductible. Limited to a maximum of 28 days per person per calendar year and a lifetime maximum of two admissions.
	Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury.	
Inpatient Physician Services	Covered at 100% of the allowance with no deductible or copay. Physician services are only available as long as inpatient facility services are available.	Covered at 80% subject to the calendar year deductible. Physician services are only available as long as inpatient facility services are available.*
Outpatient Physician Services	Covered at 50% of the allowance subject to the calendar year deductible; limited to 52 visits per person each calendar year and 2,000 visits per lifetime.*	
GENERAL PROVISIONS		
Calendar Year Deductible	\$150 per person each calendar year; \$450 aggregate maximum per family.	
Annual Out-of-Pocket Maximum	\$1,000 individual annual out-of-pocket maximum plus the \$150 calendar year deductible; \$3,000 aggregate maximum per family. Other Covered Services and Point-of-Sale Prescription Drugs are the only expenses applicable to the annual out-of-pocket maximum.	
Lifetime Maximum	\$1,000,000 lifetime maximum for each covered member. Only the following services are applicable to the lifetime maximum: Other Covered Services, non-PPO Physician Services, non-PPO outpatient facility services (excluding care rendered within 72 hours), physician services for the treatment of mental health and substance abuse services, and Point-of-Sale Prescription Drugs.	
OTHER COVERED SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Non-Participating in Alabama: Covered at 50% of the allowance, subject to the calendar year deductible.
	Limited to 24 visits per person per calendar year.	
Preferred Home Health and Hospice	Covered at 100% of the allowance with no deductible or copay. Precertification required for services rendered outside of Alabama. Call 1 800 821-7231.	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification required. Call 1 800 821-7231. Non-PPO in Alabama: No benefits are available if a non-Preferred provider is used.
	Covered PPO and non-PPO expenses for Preferred Home Health Care and covered non-PPO expenses for Preferred Hospice Care apply toward the annual out-of-pocket and lifetime maximums.	
Physical Therapy	Covered at 80% of the allowance, subject to the calendar year deductible.	
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	
Allergy Testing & Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Air Medical Services	Air ambulance service to a hospital near home if hospitalized while traveling more than 200 miles from home. To arrange transportation, call AirMed at 1 877 872-8624.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS		
<p>Prescription Drug Card Preferred Rx Products</p> <ul style="list-style-type: none"> Maintenance drugs may be purchased up to a 90-day supply for 2 copays <p>Diabetic Supplies (Copays apply based on type drug and days supply)</p> <p>Diabetic Supplies are covered only through the Prescription Drug Card Program.</p>	<p>Participating Pharmacy: Separate \$75 prescription drug deductible per person per calendar year (no family maximum). Each prescription purchased from a Participating Pharmacy will be covered at 100% after the deductible subject to the following copays:</p> <p>Generic Drugs : \$10 copay for a 1-31 day supply.</p> <p>Preferred Brand Name Drugs: \$25 copay for a 1-31 day supply.</p> <p>Non-Preferred Brand Name Drugs: \$35 copay for a 1-31 day supply.</p> <p>Brand Name Drugs with a Generic alternative: \$35 copay for a 1-31 day supply. Member will also be responsible for the difference in drug cost between brand name drug and generic drug.</p> <ul style="list-style-type: none"> Insulin, insulin needles and syringes purchased on the same day will require only one copay Blood glucose strips and lancets purchased on the same day will require only one copay Glucose monitors will always require a separate copay 	<p>Non-Participating Pharmacy in Alabama: There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy.</p> <p>Non-Participating Pharmacy Outside Alabama: Benefits are paid at the in-network level. In addition, the member will be responsible for any difference between the agreed- to amount and the actual billed charge.</p>
<p>Note: To view the most current Preferred Brand Drug List, visit our web site at www.bcbsal.com.</p>		

Please note: Providers/Specialists may be listed in a PPO directory or on the provider finder web site (www.bcbs.com), but not covered as PPO benefits by this group health plan (i.e., DME, Ambulance, Midwives, Allergists). Some of these benefits may be covered under Other Covered Services or not at all. Please check your benefit matrix or benefit booklet to determine coverage.

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

***These services do not apply to the out-of-pocket maximums.**

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.

Physician assistants and physician assistants who assist with surgery acting under the supervision of PMD/PPO physicians are eligible providers.