

University of Alabama in Huntsville
BlueCard PPO

Effective September 1, 2003

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL FACILITY SERVICES		
Deductibles and Copay	\$250 per admission deductible. \$5 copay per day for days 2-11.	\$300 per admission deductible.
Inpatient Facility Coverage (including maternity)	100% coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	80% coverage 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. Reimbursement is \$10 per day for room and board and 75% for covered ancillaries.	
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.	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Surgery	Covered at 100% of the allowance subject to the \$50 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 \$25 facility copay.	Covered at 80% of the allowance subject to the calendar year deductible.*
Accidental Injury	Covered at 100% of the allowance subject to the \$25 facility copay.	Covered at 100% of the allowance with no deductible or 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 \$20 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 \$20 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.*
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.*

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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 \$20 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 \$20 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 \$20 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 \$20 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 \$20 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), Cholesterol testing (once every 5 years), Hemocult (annually ages 50 and over), Sigmoidoscopy (every 3 years, ages 50 and over). Subject to the \$20 office copay if applicable.	
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Covered at 100% of the allowance subject to the inpatient per admission deductible. Allows 365 days of treatment with renewal after 90 days lapse.	Covered at 80% of the allowance subject to the inpatient per admission deductible. Allows 365 days of treatment with renewal after 90 days lapse.*
	Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury. Reimbursement is \$10 per day for room and board and 75% for covered ancillaries.	
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 1,000 visits per person each calendar year and 2,000 visit in lifetime.*	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
GENERAL PROVISIONS		
Calendar Year Deductible	\$100 per person each calendar year; 3 member family maximum.	
Annual Out-of-Pocket Maximum	\$1,000 individual annual out-of-pocket maximum plus the \$100 calendar year deductible; 3 member family maximum. 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		
Chiropractor Services	Covered at 80% of the allowance, subject to the calendar year deductible.	
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 .	
PRESCRIPTION DRUGS		
Point-of-Sale Drug Program (Includes coverage for oral contraceptives)	Participating Pharmacy: Generic drugs and brand name drugs covered at 80% of the allowance, subject to the calendar year deductible.	Non-Participating Pharmacy in Alabama: No benefits are available for prescriptions purchased in a non-Participating Pharmacy in Alabama. 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.

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 Summary Plan Description 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.**

Revised 06/17/03CE
Effective September 1, 2003
Group # 29065