THE UNIVERSITY OF
ALABAMA IN HUNTSVILLE

Group Health Care Plan

University of Alabama in Huntsville

Group #79912
Divisions 007, 008, 009, 07S &09S

Effective January 1, 2015

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
GENERAL PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar Year Deductible	$200 per person each calendar year; $600 aggregate maximum per family.	
Annual Out-of-Pocket Maximum	$2,500 individual annual out-of-pocket maximum; $7,500 aggregate maximum per family. **In-network**: All copays, deductibles and coinsurance including copays for out-of-network mental health/substance abuse ER and ER physican services will apply to the in-network out-of-pocket maximum except for reverse sterilization **Out-of-network**: Only other covered services apply to the out-of-network out-of-pocket maximum.	
Baby Yourself	A prenatal wellness program. For more information, call 1-800-222-4379. You can also enroll online at **www.behealthy.com**.	
American Cancer Society Smoking Quitline	A tobacco cessation program for employees, spouses, and dependents age 18 and over that provides support to participants through telephone-based counseling and nicotine replacement therapy. Call 1-888-768-7848 for participation information.	
Individual Case Management	A program to assist employees and their families in coordinating care in the event of a lengthy illness.	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease.	
Air Medical Services	Air ambulance service to a hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624	
INPATIENT HOSPITAL FACILITY SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Deductible	$400 per admission deductible.	$400 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	Preadmission certification required for all inpatient admissions (except emergency hospital admissions and maternity); notification within 48 hours for emergencies. Call 1-800-248-2342 (toll free) for precertification. If precertification is not obtained, no benefits are available.	
OUTPATIENT HOSPITAL FACILITY SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Surgery	Covered at 100% of the allowance subject to the $150 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 $100 facility copay.	Covered at 100% of the allowance subject to the $100 facility copay. **For mental health disorders and substance abuse services, the copay will apply to the in-network out-of-pocket.**
Non-Emergency Medical	Covered at 80% of the allowance subject to the $100 facility copay and the calendar year deductible.	Covered at 80% of the allowance subject to the $100 facility copay and the calendar year deductible.
Accidental Injury	Covered at 100% of the allowance subject to the $100 facility copay.	Covered at 100% of the allowance subject to the $100 facility copay within 72 hours of the accident; thereafter, covered at 80% of the allowed amount subject to the benefit period 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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) **Note:** Preadmission Certification is required. Call 1-800-248-2342 (toll free). If precertification is not obtained, no benefits are available.	Covered at 100% after $35 daily hospital 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 (Includes Mental Health Disorders and Substance Abuse)		
Office Visits and Outpatient Consultations	Covered at 100% of the allowance subject to a $35 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.
Surgery Performed in a Physician's Office	Covered at 100% of the allowance subject to a $35 office 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 a $50 ER visit copay.	Covered at 100% of the allowance subject to a $50 ER visit copay. **Non-PPO in Alabama:** Covered at 50% of the allowance subject to the calendar year deductible. **For mental health disorders and substance abuse services, the copay, deductible and coinsurance will apply to the in-network out-of-pocket.**
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.
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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
ENHANCED PREVENTIVE CARE SERVICES		
Routine Preventive Services and Immunizations	100% of the allowance, no deductible or co-pay. See AlabamaBlue.com/preventiveservices for a listing of specific covered preventive services and immunizations. **In addition to the standard services, the following are also covered by this plan:** • CBC (when necessary) • Urinalysis (when necessary) • TB skin testing (when necessary) • Cholesterol testing (once every 5 years) • Routine DexaScan-one every two calendar year beginning at age 40 • Malaria vaccine (when approved)	Not covered.
OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
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.	
Speech Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to 20 visits per person per calendar year.	
Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to 20 visits per person per calendar year.	
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 (Includes Mental Health Disorders and Substance Abuse)		
Prescription Drug Card ***Preferred Rx Products*** • Maintenance drugs may be purchased up to a 90-day supply for 2 copays **Diabetic Supplies** (Copays apply based on type drug and days supply) Diabetic Supplies are covered only through the Prescription Drug Card Program.	**Participating Pharmacy:** Separate $100 prescription drug deductible per person per calendar year (no family maximum) for Tier 2 and Tier 3 drugs (generic drugs not subject to deductible). Each prescription purchased from a Participating Pharmacy will be covered at 100% after the deductible subject to the following copays: **Tier 1 Drugs:** $10 copay for a 1-31 day supply. **Tier 2 Drugs:** $30 copay for a 1-31 day supply. **Tier 3 Drugs:** $50 copay for a 1-31 day supply. **Tier 2 or Tier 3 Drugs with a Generic Equivalent:** $50 copay for a 1-31 day supply. Member will also be responsible for the difference in drug cost between the Tier 2 or Tier 3 drug and generic drug. **Note:** Generic drugs may be classified at any Tier. Speciality drugs will only be covered through **Prime Specialty Pharmacy**. Specialty drugs are limited to a 30 day supply per fill. • 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	**Non-Participating Pharmacy in Alabama:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy. **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.
Note: To view the most current Preferred Brand Drug List, visit our web site at AlabamaBlue.com.		

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, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract. Check your benefit booklet for more detailed coverage information.

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