THE UNIVERSITY OF ALABAMA IN HUNTSVILLE

Effective January 1, 2017

Group Medical Plan

Group Number: 79912

Divisions: 007, 008, 009, 07S & 09S

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
GENERAL PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar Year Deductible	$100 per person each calendar year	
Annual Out-of-Pocket Maximum	$2,500 individual annual out-of-pocket maximum; $7,500 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 excluding prescription drugs. **Out-of-network**: Only other covered services apply to the out-of-network out-of-pocket maximum. 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 the remainder of the calendar year.	
Baby Yourself®	A maternity program. For more information, call 1-800-222-4379. You can also enroll online at **AlabamaBlue.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 network 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)		
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, subject to $400 per admission copay and the calendar year deductible.	Covered at 80% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries, subject to $400 per admission copay and the calendar year deductible.
	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)		
Precertification is required for some outpatient hospital benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Surgery	Covered at 100% of the allowance subject to the $150 facility copay and the calendar year deductible.	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 and the calendar year deductible.	Covered at 100% of the allowance subject to the $100 facility copay and the calendar year deductible. **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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Accidental Injury **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 allowance subject to the $100 facility copay and the calendar year deductible.	Covered at 100% of the allowance subject to the $100 facility copay and the calendar year deductible within 72 hours of the accident; 80% of the allowance subject to the benefit period deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan.
Diagnostic Lab, X-ray, and Pathology	Covered at 100% of the allowance subject to the calendar year deductible.	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 subject to the calendar year deductible.	Covered at 80% of the allowance subject to the calendar year deductible.
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)	Covered at 100% after $35 daily hospital copay and the calendar year deductible	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)		
Precertification is required for some physician benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits and Outpatient Consultations	Covered at 100% of the allowance subject to a $35 office visit copay and the calendar year deductible.	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 and the calendar year deductible.	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 and the calendar year deductible.	Covered at 100% of the allowance subject to a $50 ER visit copay and the calendar year deductible. **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 subject to the calendar year deductible.	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 subject to the calendar year deductible.	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 subject to the calendar year deductible.	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 subject to the calendar year deductible.	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 or call our Customer Service Department for a printed copy. **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 years beginning at age 40 • Malaria vaccine (when approved)	Not covered.
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.		
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 subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. **Non-PPO in Alabama:** No benefits are available if a non-Preferred provider is used.
Physical Therapy	Covered at 80% of the allowance, subject to the calendar year deductible.	
Rehabilitative Occupational and Speech Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to 20 visits per person per therapy per calendar year.	
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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		
Prescription Drugs	Prescription drug benefits are not administered by Blue Cross and Blue Shield of Alabama.	

Please note: Providers/Specialists may be listed in a PPO directory or on the provider finder website (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 (including your benefit booklet).
Check your benefit booklet for more detailed coverage information.
Please visit our website, AlabamaBlue.com.

Statement of Nondiscrimination

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144（TTY: 711）。