The University of Alabama at Huntsville
Effective January 01, 2024

BENEFIT	IN-NETWORK (79912)	IN-NETWORK (97368)
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Medical Deductible	$150 per individual per calendar year	$1,600 self-only coverage; $3,200 family coverage For family coverage, no benefits, except preventive care, are paid by the plan to any family member until the total medical expenses paid by the family equal the family deductible amount.
Calendar Year Pharmacy Deductible	$150 per individual per calendar year	Not applicable
Calendar Year Out-of-Pocket Maximum	$2,500 individual; $7,150 family **In-network:** All copays, deductibles and coinsurance including copay for out-of-network mental health and substance abuse ER and ER physician services will apply to the in-network out-of-pocket maximum excluding prescription drugs; Payments made by drug manufacturer assistance programs may not apply towards the deductible or out-of-pocket maximum. There is a separate $2,500 individual; $7,150 family prescription drug 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 allowance for the remainder of the calendar year In-network and out-of-network out-of-pocket amounts apply to each other	$3,500 self-only coverage; $7,000 family coverage All deductibles, copays and coinsurance for in-network services and out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum including prescription drugs The dollar amount of any specialty drug financial assistance provided by providers or manufacturers will not apply to the in-network out-of-pocket maximum Once the family Calendar Year Out-of-Pocket Maximum is met, applicable expenses will pay at 100% of the allowed amount for the remainder of the year
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services, maternity and as required by Federal law); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll-free) for precertification.		
Inpatient Hospital and Residential Treatment Facilities	Covered at 100% of the allowed amount for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries, subject to $400.00 per admission copay and subject to calendar year deductible; 365 days per confinement.	Covered at 80% of the allowed amount, subject to calendar year deductible 365 days per confinement
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible

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Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Emergency Room Non-Emergency	Covered at 80% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible	Covered at 60% of the allowed amount, subject to calendar year deductible
Emergency Room (Accident)	Covered at 100% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Emergency Room (Physician)	Covered at 100% of the allowed amount, subject to $55.00 physician copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Chemotherapy, Hemodialysis, IV Therapy & Radiation Therapy	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Diagnostic Lab & X-ray	Covered at 100% of the allowed amount, subject to calendar year deductible MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 100% of the allowed amount, subject to $125.00 copay and subject to calendar year deductible **Note**: If there is more than one procedure done on the same date of service there will be **only** one copayment taken for the facility and **only** one copayment taken for the physician.	Covered at 80% of the allowed amount, subject to calendar year deductible
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowed amount, subject to $55.00 daily hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits and Outpatient Consultations Rendered by a Primary Care Physician (Includes: Internist, Family & General Practitioner, Pediatrician, OB/GYN & Geriatrician)	Covered at 100% of the allowed amount, subject to $35.00 physician copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Office Visits and In-Person Consultations Rendered by a Specialist	Covered at 100% of the allowed amount, subject to $55.00 physician copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible

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Nurse Practitioner/Nurse Midwife/Clinical Nurse Specialist/Mental Health Nurse Practitioner/Mental Health Clinical Nurse Specialist and Physician Assistant's Office Visits and Consultations	Covered at 100% of the allowed amount, subject to $20.00 physician copay and subject to calendar year deductible Services must be rendered under the supervision of a PPO doctor.	Covered at 80% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program A service, through Teladoc™ to diagnose, treat and prescribe medication (when necessary) for certain medical issues. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4549	Covered at 100% of the allowed amount, subject to $20.00 payment per consultation	Covered at 80% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program – Dermatology A service, through Teladoc™ to diagnose, treat and prescribe medication (when necessary) for certain dermatology issues. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4549	Covered at 100% of the allowed amount, subject to $55.00 payment per consultation and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program – Behavioral Health Services A service available to diagnose, treat and prescribe medication (when necessary) for certain behavioral health conditions is available through TeladocTM. To schedule an appointment with a TeladocTM behavioral health provider, go to **Teladoc.com/Alabama** or call 1-855-477-4549	Covered at 100% of the allowed amount, $55.00 initial consult fee and subject to calendar year deductible with MD; $55.00 ongoing consult fee and subject to calendar year deductible with MD; $35.00 consult fee and subject to calendar year deductible with non-MD provider	Covered at 80% of the allowed amount, subject to calendar year deductible initial consult with MD; at 80% of the allowed amount, subject to calendar year deductible ongoing consult with MD; covered at 80% of the allowed amount, subject to calendar year deductible with MD; covered at 80% of the allowed amount, subject to calendar year deductible with non-MD provider
Surgery Performed in a Physician's Office	Covered at 100% of the allowed amount, subject to $35.00 office visit copay and subject to calendar year deductible if performed by a Primary Care Physician Covered at 100% of the allowed amount subject to $55.00 office visit copay and subject to calendar year deductible if performed by a Specialist	Covered at 80% of the allowed amount, subject to calendar year deductible
Surgery & Anesthesia	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Maternity Care	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Hemodialysis, Chemotherapy, Radiation Therapy & IV Therapy	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Diagnostic Lab & X-ray	Covered at 100% of the allowed amount, subject to calendar year deductible However MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 100% of the allowed amount, subject to a $35.00 copay and subject to calendar year deductible. **Note**: If there is more than one procedure done on the same date of service there will be **only** one copayment taken for the facility and **only** one copayment taken for the physician.	Covered at 80% of the allowed amount, subject to calendar year deductible

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Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorder. Ages 0-9 limited to an annual maximum of $20,000, ages 10-13 limited to an annual maximum of $15,000 and ages 14-18 limited to an annual maximum of $10,000.	Covered at 100% of the allowed amount after $55 copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for In-network and Out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
PREVENTIVE CARE BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Routine Immunizations and Preventive Services See **AlabamaBlue.com/PreventiveServices** and **AlabamaBlue.com/ NetResultsACAPreventiveDrugList** for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/VaccineNetworkDrugList** for more information	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.		
Retail Prescription Drug Card Benefits • The pharmacy network for the plan is **Prime Participating Network** • Some copays combined for diabetic supplies • Fertility medications are covered • Prescription drugs - up to a 31-Day supply • The only in-network pharmacy for someTier 4 (specialty) drugs is the **Pharmacy Select Network**; view the Specialty Drug Lists at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList** • View the **NetResults 1.0 (Up to 4 Tier)** drug lists that apply to the plan at **AlabamaBlue.com/NetResults1 DrugList4T** • Certain specialty drugs are listed on the Specialty Drug Coupon Program List at **AlabamaBlue.com/ specialtycouponprogramdruglist** • Locate a **Prime Participating Network** pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocator** Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network. A list of the eligible vaccines these pharmacies may provide can be found at: **AlabamaBlue.com/ VaccineNetworkDrugList**.	Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 drugs subject to separate $150 prescription drug deductible per person per calendar year. **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $45 copay per prescription **Tier 3 Drugs:** $65 copay per prescription **Tier 4 (specialty) Drugs:** $125 copay per prescription Drugs on the Specialty Drug Coupon Program List must be purchased at a pharmacy in the Select Pharmacy network and are subject to the greater of the applicable Tier copay or the full amount of the available manufacturer cost share assistance program payments. **Separate Annual Out-of-Pocket Maximum:** $2,500 per person $7,150 per family If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay	Covered at 80% of the allowed amount subject to calendar year deductible **Tier 1 Drugs:** Member pays 20% of the allowed amount **Tier 2 Drugs:** Member pays 20% of the allowed amount **Tier 3 Drugs:** Member pays 20% of the allowed amount **Tier 4 (specialty) Drugs:** Member pays 20% of the allowed amount

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Extended Supply Prescription Drug Card Benefits • The extended supply pharmacy network for the plan is the **Prime Participating Network ESN Network** • Prescription drugs-up to 31 day supply (other than maintenance) • Maintenance only-up to 90 days with two copays • Tier 4 (specialty) drugs are not available through extended supply pharmacy service • View the **NetResults 1.0 (Up to 4 Tier)** and maintenance drug lists that apply to the plan at **AlabamaBlue.com/AlabamaBlue.com/NetResults1DrugList4T** • Locate a **Prime Participating Network ESN Network** pharmacy at **AlabamaBlue.com/PrimeParticipatingPharmacyLocator**	Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 subject to separate $150 prescription drug deductible per person per calendar year. **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $45 copay per prescription **Tier 3 Drugs:** $65 copay per prescription **Tier 4 (specialty) Drugs:** Not Covered **Separate Annual Out-of-Pocket Maximum:** $2,500 per person $7,150 per family If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay	Covered at 80% of the allowed amount subject to calendar year deductible **Tier 1 Drugs:** Member pays 20% of the allowed amount **Tier 2 Drugs:** Member pays 20% of the allowed amount **Tier 3 Drugs:** Member pays 20% of the allowed amount **Tier 4 (specialty) Drugs:** Not covered
Select Generic Specialty and Biosimilar Drugs Generic specialty and biosimilar drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some generic specialty and biosimilar drugs is the **Pharmacy Select Network.** • View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at **AlabamaBlue.com/SelectGenericSpecialtyandBiosimilarDrugList**. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, subject to calendar year deductible
Mail Order Pharmacy Benefits • Prescription drugs-up to 31 day supply (other than maintenance) • Maintenance only-up to 90 days with two copays • Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com** or call 1-855-793-5326) • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/Maintenance DrugList** • View the NetResults 1.0 (Up to 4 Tier) drug lists that apply to the plan at **AlabamaBlue.com/NetResults 1DrugList4T**	Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 subject to separate $150 prescription drug deductible per person per calendar year. **Tier 1 Drugs:** $10 copay per prescription **Tier 2 Drugs:** $35 copay per prescription **Tier 3 Drugs:** $55 copay per prescription **Tier 4 (specialty) Drugs:** Not covered **Separate Annual Out-of-Pocket Maximum:** $2,500 per person $7,150 per family If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay	Covered at 80% of the allowed amount subject to calendar year deductible **Tier 1 Drugs:** Member pays 20% of the allowed amount **Tier 2 Drugs:** Member pays 20% of the allowed amount **Tier 3 Drugs:** Member pays 20% of the allowed amount **Tier 4 (specialty) Drugs:** Not covered

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BENEFITS FOR 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.		
Allergy Testing & Treatment	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Ambulance Service	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services Limited to a maximum of 24 visits per person each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible when services are provided by a participating in network chiropractor	Covered at 80% of the allowed amount, subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational and Speech Therapy Occupational and speech therapy limited to a maximum of 35 visits per person per therapy each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Habilitative Occupational and Speech Therapy Occupational and speech therapy limited to a maximum of 35 visits per person per therapy each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Not applicable
Rehabilitative Physical Therapy Limited to a maximum of 35 visits per person each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Not applicable
Habilitative Physical Therapy Limited to a maximum of 35 visits per person each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Not applicable
Rehabilitative Occupational, Physical and Speech Therapy Limited to a maximum of 35 visits per person per therapy each calendar year	Not applicable	Covered at 80% of the allowed amount, subject to calendar year deductible
Habilitative Occupational, Physical and Speech Therapy Limited to a maximum of 35 visits per person per therapy per calendar year	Not applicable	Covered at 80% of the allowed amount, subject to calendar year deductible
Occupational and Speech Therapy for Autism Diagnosis ages 0-18	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Nutritionist Visits Limited to a maximum of eight visits per person each calendar year. Note: Employee is also responsible for any charges above the allowance.	Covered at 100% of the allowed amount, subject to $20.00 physician copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Preferred Home Health and Hospice	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Home Infusion	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible