BlueCard® PPO

Public Education Employees' Health Insurance Plan (PEEHIP)

Children's Health Insurance Plan (CHIP)

Group 81000

Effective October 1, 2010

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PLAN BENEFITS

Visit our web site at www.bcbsal.com

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BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL FACILITY SERVICES		
Copay	$5 inpatient copay per admission	$5 inpatient copay per admission
Inpatient Facility Coverage (excluding 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. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1 800 248-2342. 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. This includes a Care Management program for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Surgery	Covered at 100% of the allowance subject to a $5 facility copay.	Covered at 80% of the allowance subject to a $5 facility copay.
Medical Emergency & Hemodialysis	Covered at 100% of the allowance subject to a $5 facility copay.	Covered at 80% of the allowance subject to a $5 facility copay.
Accidental Injury	Covered at 100% of the allowance subject to a $5 facility copay.	Covered at 100% of the allowance subject to a $5 facility copay if within 72 hours of the accident. Thereafter, covered at 80% of the allowance subject to a $5 facility copay.
Diagnostic Lab & Pathology	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Diagnostic X-ray	Covered at 100% of the allowance subject to a $3 facility copay.	Covered at 80% of the allowance subject to a $3 facility copay.
IV Therapy, Chemotherapy and Radiation Therapy	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
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 a $3 office visit copay.	Covered at 80% of the allowance subject to a $3 office visit copay.
Emergency Room Physician Fees	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Surgery and Anesthesia	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
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 with no deductible or copay.
Diagnostic Lab & Pathology Exams	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Diagnostic X-ray	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
ENHANCED PREVENTIVE CARE SERVICES		
Routine Physical Exams	Covered at 100% of the allowance with no deductible or copay. Limited to the following: 6 visits during the first year; 3 visits during the second year; one annual exam for ages 2-6; one exam every two years for ages 7-18.	Not covered.
Routine Immunizations (Age limitations apply to certain immunizations)	Covered at 100% of the allowance with no deductible or copay.	Not covered.
Human Papilloma Virus (HPV) Vaccine	Covered at 50% of the allowance with no deductible or copay for females age 9 and over.	Not covered.
Routine Pap Smears	Covered at 100% of the allowance with no deductible or copay. Limited to one per year.	Not covered.

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Other Routine Screening	Covered at 100% of the allowance with no deductible or copay. Includes lead screening once by age 2; urinalysis once by age 5, then once between ages 12-18; TB skin testing once before age 1, once between ages 1-4 and once between ages 14-18; CBC or components annually; cholesterol testing (once every 5 years).	Not covered.
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Covered at 100% of the allowance subject to a $5 inpatient copay per admission.	Covered at 80% of the allowance subject to a $5 inpatient copay per admission.
	Limited to 30 days of inpatient care per plan year for mental health and substance abuse services combined. Inpatient substance abuse limited to one admission per plan year and a maximum of two admissions per lifetime.	
Inpatient Physician Services	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Outpatient Physician Services	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
	Limited to 20 visits per plan year for mental health and substance abuse services combined.	
GENERAL PROVISIONS		
Annual Out-of-Pocket Maximum	$500 individual annual out-of-pocket maximum. Other Covered Services are the only expenses applicable to the annual out-of-pocket maximum. Member is responsible for expenses above the allowed amount.	
OTHER COVERED SERVICES		
Participating Chiropractor Services	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Physical Therapy	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Durable Medical Equipment	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Occupational Hand Therapy	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
Speech Therapy	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance with no deductible or copay.
	Limited to 30 sessions per person per calendar year.	
Ambulance Services	Covered at 100% of the allowance subject to a $5 copay per occurance.	
Allergy Testing	Covered at 100% of the allowance subject to a $5 copay per visit.	Covered at 80% of the allowance subject to a $5 copay per visit.
Allergy Treatment	Covered at 100% of the allowance subject to a $3 copay per visit.	Covered at 80% of the allowance subject to a $3 copay per visit.
HOME HEALTH AND HOSPICE		
Preferred Home Health and Hospice	Covered at 100% of the allowance with no deductible or copay. Home health care limited to 60 days per calendar year combined for both in-network and out-of-network. Precertification required for services rendered outside of Alabama. Call 1 800 821-7231.	Covered at 80% of the allowance with no deductible or copay. Home health care limited to 60 days per calendar year combined for both in-network and out-of-network. Precertification required for services rendered outside of Alabama. Call 1 800 821-7231. **Non-Preferred 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.	
Dental and Vision Care	Not covered.	Not covered.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS		
Prescription Drug Plan • A copay will be charged for each 30 day supply. **Diabetic Supplies** (copays apply)	**Participating Pharmacy:** Each prescription purchased from a Participating Pharmacy will be covered at 100% subject to the following copays: **Generic Drugs:** $1 copay per prescription **Preferred Brand Name Drugs:** $3 copay per prescription **Other Brand Name Drugs:** $5 copay per prescription Generic drugs are mandatory when generic equivalents are available. If a member chooses to purchase a brand name drug when an equivalent generic is available, the member will be responsible for the entire cost of the drug. Diabetic Supplies are covered only through the Prescription Drug Card Program.	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy.
Note: To view the most current Preferred Brand Drug List or Maintenance Drug List, visit our web site at www.bcbsal.com.		

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

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, Allergists). Please check your benefit matrix or benefit booklet to determine coverage.

PEEHIP covers Nurse Practitioners and Midwives if they are in the PEEHIP PPO network.

PEEHIP members who use non-participating hospitals, providers or outpatient facilities will incur additional out-of-pocket costs. To maximize your benefits, always use network providers.

If you have any questions concerning your PEEHIP benefits or a claim, call 1 800 327-3994.
To certify emergency admission, call 1 800 354-7412.
To certify home health and hospice services, call 1 800 821-7231.
Visit our web site at www.bcbsal.org/peehip1/

Your group believes this plan is a "grandfathered heath plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, this plan does not have to include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans. Benefits are subject to the terms, limitations and conditions of the group contract.
Check your benefit booklet for more detailed coverage information.