

The University of Alabama System Group Health Plan

(Effective 1-1-10)

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PHYSICIAN SERVICES		
Office Visits, Allergy Treatments & Outpatient Consultations	Covered at 100% of the allowance, subject to a \$25 office visit co-pay.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible.
ER Physician Services	Covered at 100% of the allowance, subject to a \$25 office visit co-pay.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible. Outside Alabama: Covered at 80% 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 \$25 office visit co-pay.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible.
MRIs, CAT scans and certain endoscopies.	Covered at 100% of the allowance, subject to a \$25 office visit co-pay.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible.
Inpatient Visits & Consultations, Surgery, Anesthesia	Covered at 100% of the allowance with no deductible or co-pay.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance with no deductible or co-pay.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible.
Allergy Testing	Covered at 100% of the allowance with no deductible or co-pay.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Lab Exams	Covered at 100% of the allowance with no deductible or co-pay.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible.
Nurse Practitioner/Nurse Midwife Office Visits & Consultations	Covered at 100% of the allowed amount, subject to a \$20 office co-pay. Services must be rendered under the supervision of a PPO doctor.	Not covered.
INPATIENT HOSPITAL FACILITY SERVICES		
Inpatient Facility Coverage	Covered at 100% of the allowance for semi-private room & board, intensive care units, general nursing services & usual hospital ancillaries, subject to a \$250 per admission deductible (maximum of three inpatient per admission deductibles per person per calendar year); 365 days per confinement. Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury.	Covered at 80% of the allowance for semi-private room & board, intensive care units, general nursing services & usual hospital ancillaries, subject to a \$250 per admission deductible (maximum of three inpatient per admission deductibles per person per calendar year); 365 days per confinement.
Preadmission Certification	All hospital admissions except for maternity require preadmission certification. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1 800 248-2342.	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Surgery Facility	Covered at 100% of the allowance, subject to a \$75 facility co-pay.	Covered at 80% of the allowance, subject to a \$75 facility co-pay.
Diagnostic Lab, X-ray & Tests	Covered at 100% of the allowance, no deductible or copay. MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, colonoscopy, endoscopy are subject to a \$75 facility co-pay (one copay per test).	Covered at 80% of the allowance subject to the calendar year deductible. MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, colonoscopy, endoscopy are also subject to \$75 facility co-pay (one copay per test).
Hemodialysis, IV, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance with no deductible or co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
ER - Medical Emergency	Covered at 100% of the allowance, subject to a \$75 facility co-pay.	Covered at 100% of the allowance, subject to a \$75 facility co-pay.
ER - Non-Emergency	Covered at 80% of the allowance, subject to a \$75 facility co-pay & the calendar year deductible.	Covered at 80% of the allowance, subject to a \$75 facility co-pay & the calendar year deductible.
ER - Accidental Injury	Covered at 100% of the allowance, subject to a \$75 facility co-pay.	Covered at 100% of the allowance, subject to a \$75 facility co-pay within 72 hours of the accident. After 72 hours, 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.		

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PREVENTIVE CARE SERVICES		
Inpatient Routine Newborn Care	Covered at 100% of the allowance with no deductible or co-pay.	Not covered.
Well Child Care	Covered at 100% of the allowance, subject to a \$15 office co-pay. Includes 9 visits during the first two years of the child's life & one visit each year thereafter through age 18.	Not covered.
Adult Routine Physical (Includes history, exam, blood pressure, breast exam for females & rectal & prostate digital exam for males)	Covered at 100% of the allowance, subject to a \$15 office co-pay. Limited to one exam each calendar year for members age 19 & over.	Not covered.
Routine Immunizations (Age limitations apply to certain immunizations)	Covered at 100% of the allowance with no deductible or co-pay.	Not covered.
Routine Pap Smears	Covered at 100% of the allowance with no deductible or co-pay. Limited to one per year. Subject to a \$15 office visit co-pay if applicable.	Not covered.
Routine Mammograms	Covered at 100% of the allowance with no deductible or co-pay. Limited to one exam for females between the ages of 35-39 & one per year for females age 40 & above. Subject to a \$15 office visit co-pay if applicable.	Not covered.
Routine Prostate Specific Antigen (PSA)	Covered at 100% of the allowance with no deductible or co-pay. Limited to one per year for males age 40 & over. Subject to a \$15 office visit co-pay if applicable.	Not covered.
Routine Bone Mineral Density Screening	Covered at 100% of the allowance subject to a \$25 co-pay per scan. Limited to one scan every two years for members age 40 & over.	Not covered.
Routine Colorectal Cancer Screening	Covered at 100% of the allowance with no deductible or co-pay for physician charges (outpatient hospital co-pay for surgery/diagnostic services may apply). Limited to the following for members age 50 & over: <ul style="list-style-type: none"> • Fecal occult blood test each year • Flexible sigmoidoscopy every three years • Double-contrast barium enema every five years • Colonoscopy every 10 years 	Not covered.
Other Routine Screening	Covered at 100% of the allowance with no deductible or co-pay when done as part of a routine annual physical. Includes: <ul style="list-style-type: none"> • One CBC & one urinalysis per year • TB skin testing – one per year through age 6; one between ages 7 & 18; one between ages 19 & 34 & one between ages 35 & over • Cholesterol testing (once every 5 years); • Thyroid profile & EKG (annually, beginning at age 50) • Lead screening, one by age 2 or twice by age 4 • Automated multi-channel tests containing up to 22 clinical chemistry tests, one per year beginning at age 19 • Chest x-ray beginning at age 35 • Pneumonia vaccine beginning at age 65, if risk factors warrant • Flu vaccine (one per year per person) for all ages • Rotavirus vaccine for infants • Shingles vaccine for adults age 60 & older • Cervical cancer vaccine for females age 9 to 26 • CA 125 blood test to detect ovarian cancer in women Subject to a \$15 office co-pay if applicable.	Not covered.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient Facility Services	Covered at 100% of the allowance, subject to the \$250 inpatient per admission deductible. (maximum of three inpatient per admission deductibles per person per calendar year); 365 days per confinement. Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury.	Covered at 80% of the allowance, subject to the \$250 inpatient per admission deductible (maximum of three inpatient per admission deductibles per person per calendar year) ; 365 days per confinement.
Inpatient Physician Services	Covered at 100% of the allowance with no deductible or copay.	
Outpatient Physician Services	Covered at 100% of the allowance with no deductible or copay.	
Alcohol & Drug Abuse Rehab Benefits	Covered at 100% of the allowance subject to the \$250 inpatient per admission deductible in Participating Substance Abuse facilities(maximum of three inpatient per admission deductibles per person per calendar year) Note: Benefits available only if services are rendered in the State of Alabama.	
GENERAL PROVISIONS		
Calendar Year Deductible	A \$250 per person per calendar year deductible with a maximum of 3 deductibles per family. Note: All benefits that are applicable to the calendar year deductible are noted as “subject to the calendar year deductible.”	
Annual Out-of-Pocket Maximum	\$1,000 per person plus the \$250 calendar year deductible. Other Covered Expenses are the only expenses applicable to the annual out-of-pocket maximum.	
Comprehensive Lifetime Maximum	\$2,000,000 lifetime maximum for each covered member for covered medical services received on or after 1/1/2008.	
OTHER COVERED SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance, subject to the calendar year deductible when services are provided by a Participating Chiropractor.	In Alabama: Covered at 50% of the allowance, subject to the calendar year deductible when services are provided by a non-Participating Chiropractor. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Note: Limited to a maximum of 24 visits per person each calendar year.
Nutritionist Visits	Covered at 100% of the allowance, subject to a \$20 visit co-pay. Limited to a maximum of eight visits per person each calendar year.	
Routine Vision	Covered 80% of the allowance not subject to the calendar year deductible for one routine eye exam per person each calendar year.	
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 a maximum of 20 visits per person each calendar year.	
Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible for services related to the hand &/or treatment of lymphedema. Limited to a max. of 20 visits per person each 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.	
Preferred Home Health Care	Covered at 100% of the allowance with no deductible or co-pay. Precertification is required for services rendered outside Alabama. Call 1 800 821-7231.	In Alabama: No benefits are available if a non-Preferred provider is used. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required. Call 1 800 821-7231.
Preferred Hospice Care	Covered at 100% of the allowance with no deductible or co-pay. Precertification is required for services rendered outside Alabama. Call 1 800 821-7231.	In Alabama: No benefits are available if a non-Preferred provider is used. Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required. Call 1 800 821-7231.
Baby Yourself	A benefit that offers the opportunity to have a Blue Cross & Blue Shield of Alabama registered nurse case manager monitor a covered member's pregnancy while enrolled in this health plan. Note: The \$250 inpatient hospital deductible per admission will be waived for Baby Yourself participants who enroll within the first trimester of pregnancy & continue participation until the baby is born.	
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.	

Retail Pharmacy Prescription Drug Card Program

- Separate \$50 prescription drug deductible per person per calendar year; 3 member family maximum. Only one deductible will apply if an individual uses a retail pharmacy and/or the mail order program.
- The first prescription for a drug on the maintenance list allows for a 31-day supply with subsequent refills dispensed in a 60-day supply.
- Diabetic supplies are only covered through the Drug Card Program; limited to a 60-day supply at a retail pharmacy or a 90-day supply through mail order.
- Prescription contraceptives are covered subject to the appropriate doctor's office visit or pharmacy co-pay.
- Insulin, insulin needles & syringes purchased on the same day will require only one co-pay.
- Blood glucose strips & lancets purchased on the same day will require only one co-pay.
- Glucose monitors will always require a separate co-pay.

IN-NETWORK (PPO)			OUT-OF-NETWORK (NON-PPO)		
Participating Pharmacy: Prescription drugs will be covered at 100% of the allowed charge after the deductible & subject to the following co-pays:			Non-Participating Pharmacy: Prescription drugs will be covered at 75% of the allowed charge after the deductible & subject to the following co-pays:		
Type of Drugs	1-31 day supply (available for maintenance drugs & non-maintenance drugs)	32-60 day supply (available only for maintenance drugs)	Type of Drugs	1-31 day supply (available for maintenance drugs & non-maintenance drugs)	32-60 day supply (available only for maintenance drugs)
Generic Drugs	\$15 co-pay	\$30 co-pay	Generic Drugs	\$15 co-pay	\$30 co-pay
Preferred Brand Name Drugs	\$30 co-pay	\$60 co-pay	Preferred Brand Name Drugs	\$30 co-pay	\$60 co-pay
Non-Preferred Brand Name Drugs	\$40 co-pay	\$80 co-pay	Non-Preferred Brand Name Drugs	\$40 co-pay	\$80 co-pay
Brand Name Drugs with a Generic Alternative	\$50 co-pay	\$100 co-pay	Brand Name Drugs with a Generic Alternative	\$50 co-pay	Not available
Specialty Drugs (maximum of 1-31 day supply)	\$40 co-pay	Not available	Specialty Drugs (maximum of 1-31 day supply)	\$40 co-pay	Not available
Note: To verify if a drug is on the Preferred Brand Drug List, Maintenance Drug List or Specialty Drug List, call Blue Cross at 800-292-8868.					

Mail Order Prescription Drug Program

- Separate \$50 prescription drug deductible per person per calendar year; 3 member family maximum. Only one deductible will apply if an individual uses a retail pharmacy and/or the mail order program.
- Provided through Caremark. Enroll online at www.bcbsal.com or call (888) 766-5490.

Prescription drugs will be covered at 100% of the allowed charge after the deductible & subject to the following co-pays:

Type of Drugs	1-31 day supply (available for maintenance drugs & non-maintenance drugs)	32-60 day supply (available only for maintenance drugs)	61-90 day supply (available only for maintenance drugs)
Generic Drugs	\$5 co-pay	\$10 co-pay	\$15 co-pay
Preferred Brand Name Drugs	\$20 co-pay	\$40 co-pay	\$60 co-pay
Non-Preferred Brand Name Drugs	\$25 co-pay	\$50 co-pay	\$75 co-pay
Brand Name Drugs with a Generic Alternative	\$40 co-pay	\$80 co-pay	\$100 co-pay

This is not a contract. Benefits are subject to the terms, limitations & conditions of the group contract.

Group #79912
Div 004,005,006 & 05S
Revised 11/19/09