

**University of North Alabama**  
**BlueCard PPO**

Effective March 1, 2009

**University of North Alabama  
BlueCard PPO  
Effective March 1, 2009**

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<p style="text-align: center;"><i>Benefit payments are based on the amount of the provider's charge that Blue Cross and Blue Shield recognizes for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received. Some services require a copay, coinsurance, calendar year deductible or deductible for each admission, visit or service.</i></p>		
<b>INPATIENT HOSPITAL AND PHYSICIAN BENEFITS</b>		
<p>Preadmission Certification required for all inpatient admissions (except maternity); notification within 48 hours for emergencies. Call 1 800 248-2342 (toll free) for precertification.</p>		
<b>Inpatient Hospital</b> Note: Inpatient hospital deductibles and copays do not apply to the Calendar Year Out-of-Pocket Maximum. See special provisions for mental health and substance abuse benefits	Covered at 100% after \$300 per admission deductible; no copay required	Covered at 80% after \$600 per admission deductible Note: In Alabama, available only for accidental injury
<b>Inpatient Physician Visits and Consultations</b>	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
<b>OUTPATIENT HOSPITAL BENEFITS</b>		
<b>Outpatient Surgery (Including Ambulatory Surgical Centers)</b>	Covered at 100% after \$150 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
<b>Emergency Room (Medical Emergency)</b>	Covered at 100% after \$150 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
<b>Emergency Room (Accident)</b>	Covered at 100%; no copay or deductible	Covered at 100%; no copay or deductible for services within 72 hours, thereafter 80% subject to calendar year deductible
<b>Emergency Room Physician</b>	Covered at 100% after \$25 physician copay	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
<b>Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy &amp; Radiation Therapy</b>	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
<b>PHYSICIAN BENEFITS</b>		
<b>Office Visits &amp; Consultations</b>	Covered at 100% after \$25 physician copay	Covered at 80% subject to calendar year deductible
<b>Surgery &amp; Anesthesia</b>	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible
<b>Maternity Care</b>	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible
<b>Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy &amp; Radiation Therapy</b>	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible
<b>Note: In Alabama, Out-of-Network physician services covered at 50% subject to calendar year deductible</b>		
<b>PREVENTIVE CARE BENEFITS</b>		
<b>Routine Newborn Care (in hospital)</b>	Covered at 100%; no copay or deductible	Not covered
<b>Routine Well Child Care Exams</b> Nine visits during first 24 months of life and one visit per calendar year thereafter through age six	Covered at 100% after \$25 physician copay	Not covered
<b>Routine Immunizations</b> Age limitations apply to certain immunizations	Covered at 100%; no copay or deductible	Not covered
<b>Routine Office Visit</b> When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam	Covered at 100% after \$25 physician copay	Not covered
<b>Routine Pap Smear</b> One per calendar year	Covered at 100%; no copay or deductible	Not covered
<b>Routine Human Papillomavirus (HPV) Testing</b> One routine test every three calendar years for females ages 30 and over	Covered at 100%; no copay or deductible	Not covered
<b>Routine/Screening Mammogram</b> One routine mammogram per calendar year for females ages 35 and over	Covered at 100%; no copay or deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Prostate Cancer Screening</b> Males age 40 and over <ul style="list-style-type: none"> <li>Prostate Specific Antigen (PSA) each calendar year</li> <li>Digital Rectal Exam each calendar year</li> </ul>	Covered at 100%; no copay or deductible	Not covered
<b>Routine Colorectal Cancer Screening</b> Ages 50 and over <ul style="list-style-type: none"> <li>Hemocult stool check/Fecal occult blood test each calendar year</li> <li>Flexible sigmoidoscopy every three calendar years</li> <li>Double-contrast barium enema every five calendar years</li> <li>Colonoscopy every 10 calendar years</li> </ul>	Covered at 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay)	Not covered
<b>Note: In case of illness or family history of cancer, services generally are not considered preventive and may be covered by other plan provisions</b>		
PRESCRIPTION DRUG BENEFITS		
<b>Point-of-Sale Drug Program</b> <ul style="list-style-type: none"> <li>Member must file claim with authorization number for reimbursement</li> <li>Some drugs may require prior authorization</li> <li>In-Network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or Preferred Care Services, Inc.</li> </ul>	<b>Generic Drugs:</b> Covered at 100%; no deductible <b>Brand Drugs:</b> Covered at 80% subject to the calendar year deductible	Not covered
SUMMARY OF COST SHARING PROVISIONS		
<b>Calendar Year Deductible</b>	\$250 individual; \$750 aggregate maximum per family	
<b>Calendar Year Out-of-Pocket Maximum</b> <b>Applies to:</b> <ul style="list-style-type: none"> <li>Other Covered Services</li> <li>In-Network inpatient physician services for mental health and substance abuse treatment</li> <li>Home Health and Hospice</li> <li>Point-of-Sale Prescription Drugs</li> </ul>	\$400 individual plus calendar year deductible After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% for the remainder of the calendar year.	
<b>Lifetime Maximum</b> <b>Applies to:</b> <ul style="list-style-type: none"> <li>Other Covered Services</li> <li>Out-of-Network physician services</li> <li>Out-of-Network hospital services (excluding outpatient accident care rendered within 72 hours)</li> <li>Physician services for the treatment of mental health and substance abuse</li> <li>Point-of-Sale Prescription Drugs</li> </ul>	\$1,000,000 per member  After you reach the Lifetime Maximum, In-Network hospital services, In-Network physician services and In-Network hospice services may be covered (subject to plan benefits).	
BENEFITS FOR OTHER COVERED SERVICES		
<b>Allergy Testing &amp; Treatment</b> \$400 calendar year maximum per person	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
<b>Ambulance Service</b>	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
<b>Participating Chiropractic Services</b> \$1,000 maximum per person per calendar year	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
<b>Durable Medical Equipment (DME)</b>	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
<b>Occupational and Physical Therapy</b> Occupational, physical and speech therapy limited to a combined maximum of 30 visits per year	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
<b>Speech Therapy</b> Occupational, physical and speech therapy limited to a combined maximum of 30 visits per year.	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
VISION BENEFITS		
<b>Routine Vision</b> Limited to \$250 maximum per person every two calendar year Benefits limits start new each even year	Covered at 100%; no copay or deductible	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>HOME HEALTH AND HOSPICE BENEFITS</b>		
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>Precertification required for visits by home health professionals outside Alabama</li> <li>For precertification call 1 800 821-7231</li> </ul>	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
<b>MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS</b>		
<b>Inpatient Hospital</b> Up to 15 days of inpatient treatment during any 12 consecutive months; no coverage after 15 days	Covered at 100% after \$300 per admission deductible; no copay required	Covered at 80% after \$600 per admission deductible <b>Note:</b> in Alabama, not covered
<b>Inpatient Physician</b> Up to 15 days of inpatient treatment during any 12 consecutive months; no coverage after 15 days	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible
<b>Outpatient Hospital &amp; Physician</b> Up to 20 visits per calendar year	Covered at 50% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
<b>Expanded Psychiatric Services (EPS)</b> <ul style="list-style-type: none"> <li>EPS network available throughout Alabama and in Meridian, Mississippi and Pensacola, Florida.</li> <li>To find an EPS provider call Customer Service at 1 800 292-8868 or search the online provider finder on our web site <a href="http://www.bcbsal.com">www.bcbsal.com</a></li> </ul>	<b>Care must be coordinated by EPS provider</b> Covered at 100%; no copay or deductible <b>Inpatient:</b> Up to 30 days each year; includes hospital, physician and therapy expenses <b>Outpatient:</b> Includes office visits, therapy, counseling and testing	
<b>HEALTH MANAGEMENT BENEFITS</b>		
<b>Individual Case Management</b>	Coordinates care in event of catastrophic or lengthy illness or injury; For more information, please call 1-800-821-7231	
<b>Disease Management</b>	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
<b>Baby Yourself</b>	A prenatal wellness program; For more information, please call 1 800 222-4379. You can also enroll online at <a href="http://www.behealthy.com">www.behealthy.com</a> .	
<b>Contraceptive Management</b>	Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.	
<b>Air Medical Services</b>	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	

**Useful Information to Maximize Benefits**

- To maximize your benefits, always use In-network providers for services covered by your health benefit plan. To find In-Network providers, check a provider directory, provider finder web site ([www.bcbsal.com](http://www.bcbsal.com)) or call 1 800 810-BLUE (2583).
- In-network hospitals, physicians and other health care providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing health care services at a reduced price (examples: BlueCard PPO, PMD, Preferred Care). In-Network Pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or Preferred Care Services, Inc.
- Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use Out-of-Network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to In-Network providers in the same area or the average charge for care in the area.
- Please be aware that providers/specialists may be listed in a PPO directory or provider finder web site, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.
- In-network Certified Registered Nurse Practitioners (CRNPs) /Certified Nurse Midwives (CNMs) are considered eligible providers; no coverage out-of-network for services provided by CRNPs and CNMs.
- Physician assistants and physician assistants who assist with surgery acting under the supervision of PMD/PPO physicians are eligible providers.

**This is not a contract, benefit booklet or a Summary Plan Description.  
Benefits are subject to the terms, limitations and conditions of the group contract.  
Please visit our web site, [www.bcbsal.com](http://www.bcbsal.com).**