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BlueCard® PPO
Plan Benefits

University Of North Alabama
BlueCard® PPO

Effective March 01, 2024

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BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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BlueCard® PPO
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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 Deductible	$500 individual; $1,050 family	
Calendar Year Out-of-Pocket Maximum **Applies to:** • Other Covered Services (excluding out-of-network occupational therapy, physical therapy, speech therapy and DME in Alabama) • Home Health and Hospice • Point-of-Sale Prescription Drugs	$600 individual plus calendar year deductible Only the coinsurance amounts you pay for the listed services will apply to the maximum. Fixed copays do not apply to the maximum. After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% of the allowed amount for the remainder of the calendar year.	
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services and 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 Note: Inpatient hospital deductibles and copays do not apply to the Calendar Year Out-of-Pocket Maximum.	Covered at 100% of the allowed amount, after $75.00 daily hospital copay days 2-6 for each admission and $450.00 per admission deductible	Covered at 80% of the allowed amount, after $600.00 per admission deductible **Note:** In Alabama, available only for medical emergency services and accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 80% of the allowed amount, no copay or deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits; please see benefit booklet. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, after $300.00 hospital copay	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount, after $300.00 hospital copay	Covered at 100% of the allowed amount, after $300.00 hospital copay **Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, after $300.00 hospital copay
Emergency Room (Accident)	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Emergency Room (Physician)	Covered at 100% of the allowed amount, after $50.00 physician copay	Covered at 100% of the allowed amount, after $50.00 physician copay **Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, after $50.00 physician copay
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray **Note:** The first covered mammogram each calendar year is not subject to the hospital copay	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowed amount, after $50.00 daily hospital copay	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits; please see benefit booklet. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Office Visits and Consultations	Covered at 100% of the allowed amount, after $35.00 primary care physician copay or $50.00 specialist physician copay	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** covered at 50% 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 **In Alabama,** covered at 50% 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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 100% of the allowed amount, after $35.00 copay	Covered at 80% of the allowed amount, subject to calendar year deductible
PREVENTIVE CARE BENEFITS		
Routine Newborn Exam (in hospital)	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Well Child Care Exams Nine visits during first 24 months of life and one visit each year thereafter through age six	Covered at 100% of the allowed amount, after $35.00 physician copay	Not Covered
Routine Developmental Screening Limited to three exams between 9 months and 30 months of life	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Immunizations • Age limits apply to certain immunizations • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/VaccineNetwork DrugList** for more information.	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Office Visit When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam	Covered at 100% of the allowed amount, after $35.00 physician copay	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Routine Pap Smear Limited to one per member per calendar year	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Human Papillomavirus (HPV) Testing One routine test every three calendar years for females ages 30 and over	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Chlamydia Screening Limited to one per calendar year for females ages 15-24	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine/Screening Mammogram One exam for females ages 35-39 and one per calendar year for females ages 40 and over	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Hepatitis C Screening Once in a lifetime for members born between 01/01/1945 and 12/31/1965	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Prostate Cancer Screening Males age 40 and over • Prostate Specific Antigen (PSA) each calendar year • Digital Rectal Exam each calendar year	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Colorectal Cancer Screening Ages 45 and over: • FIT-DNA (Cologuard) for ages 45-99, once every 3 calendar years • Hemocult stool check/ Fecal occult blood test each calendar year • Flexible sigmoidoscopy every three calendar years • Double-contrast barium enema every five calendar years • Colonoscopy every 10 calendar years	Covered at 100% of the allowed amount, no copay or deductible for physician charges (outpatient hospital services may require a copay)	Not Covered
Note: In case of Illness or family history of cancer services generally are not considered preventive and may be covered by other plan provisions. Blue Cross and Blue Shield of Alabama will process these claims are required by Section 1557 of the Affordable Care Act.		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 Point-of-Sale Prescription Drug Benefits The retail pharmacy network for the plan is **Prime Participating Retail Network** • Locate a **Prime Participating** Retail Network pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocator** Member must file claim with authorization number for reimbursement • View the **Standard** drug list that applies to the plan at **AlabamaBlue.com/ StandardDrugList** The only in-network pharmacy for some specialty drugs is the **Pharmacy Select Network** • Specialty drugs can be dispensed for up to a 30-day supply • View the Specialty Drug List at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList** 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**.	**Tier 1 Drugs:** Covered at 100% of the allowed amount; no copay or deductible **Tier 2 Drugs:** Covered at 80% of the allowed amount subject to the calendar year deductible **Tier 3 Drugs:** Covered at 80% of the allowed amount subject to the calendar year deductible Covered Insulin Products: $99 maximum cost share per 30-day supply	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.	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
VISION BENEFITS		
Adult Routine Vision • Limited to $250 maximum per member every two calendar years • Benefit limits start new each even year	Covered at 100% of the allowed amount, no copay or deductible	
Pediatric Routine Vision • Members up to age 19 • Eye exam limited to one per member per calendar year • Limited to one pair of prescription glasses or contact lenses per member per calendar year	Covered at 100% of the allowed amount, no copay or deductible	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 80% 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 18 visits per member per 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 **In Alabama,** covered at 50% 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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per 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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per 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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders 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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Home Health and Hospice	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Home Infusion	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per calendar year	Covered at 100% of the allowed amount, after $35.00 copay	Covered at 80% of the allowed amount, subject to calendar year deductible
EXPANDED PSYCHIATRIC SERVICES (EPS)		
Expanded Psychiatric Services (EPS) • EPS network is available throughout Alabama and in Meridian, Mississippi and Northwest Florida. • To find an EPS provider call Customer Service at 1-800-292-8868 or search the online provider on our website at **AlabamaBlue.com**	When care is received or coordinated by an EPS provider, the following mental health disorders and substance abuse benefits are available: Covered at 100% of the allowed amount; no copay or deductible **Inpatient:** Includes hospital, physician and therapy expenses **Outpatient:** Includes office visits, therapy, counseling and testing When care is not received or coordinated by an EPS provider, the mental health disorders and substance abuse benefit levels are not separately stated. Please refer to the appropriate subsections above and below that relate to the services or supplies you receive, such as Inpatient Hospital Benefits, Outpatient Hospitals Benefits, etc.	
HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other special conditions.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.**	
Contraceptive Management	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.	
Air Medical Transport	Air medical transportation 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.	

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 website **(AlabamaBlue.com)** or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *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 , or in accordance with applicable Federal law.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, 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.*
- *Please refer to your benefit book or contact Blue Cross directly about coverage for your hospital charges and other related medical services. Approval for air medical transportation does not mean that hospitalization and other medical expenses will be covered. All coverage determinations for medical benefits are subject to the terms, conditions, limitations and exclusions of the health plan. Air medical transportation services are provided through a contract with AirMed International, LLC, an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical transportation services terminate if coverage by your health plan ends.*
- *Prime Therapeutics LLC® is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.*

Your group believes this plan is a "grandfathered health 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. Please visit our website at AlabamaBlue.com

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: □ 1-855-216-3144 (TTY: 711)□

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。