University of North Alabama
BlueCard PPO
Effective March 1, 2014

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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.		
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health and Substance Abuse)		
Preadmission Certification required for all inpatient admissions (except maternity); notification within 48 hours for emergencies. 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% after $300 per admission deductible; $50 per day hospital copay days 2-6 for each admission	Covered at 80% after $600 per admission deductible **Note**: In Alabama, available only for accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% subject to calendar year deductible **Mental Health and Substance Abuse Services covered at 100% not subject to calendar year deductible**	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible **Mental Health and Substance Abuse Services covered at 80% not subject to calendar year deductible**
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health and Substance Abuse)		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% after $200 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% after $200 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered **Mental Health and Substance Abuse Services covered at 100% after $200 hospital copay; in Alabama, not covered**
Emergency Room (Accident)	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
Emergency Room Physician	Covered at 100% after $35 physician copay	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible **Mental Health and Substance Abuse Services covered at 100% after $35 physician copay**
Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
PHYSICIAN BENEFITS (Includes Mental Health and Substance Abuse)		
Office Visits & Consultations	Covered at 100% after $35 physician copay	Covered at 80% subject to calendar year deductible
Surgery & Anesthesia	Covered at 100% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Maternity Care	Covered at 100% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible
Note: In Alabama, Out-of-Network physician services covered at 50% subject to calendar year deductible		
PREVENTIVE CARE BENEFITS		
Routine Newborn Exam (in hospital)	Covered at 100%; no copay or deductible	Not covered
Routine Well Child Care Exams Nine visits during first 24 months of life and one visit per calendar year thereafter through age six	Covered at 100% after $35 physician copay	Not covered
Routine Developmental Screening Three exams between 9 months and 30 months of life	Covered at 100%; no copay or deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Routine Immunizations • Age limitations apply to certain immunizations • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **www.bcbsal.com/pharmacy** for more information	Covered at 100%; 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% after $35 physician copay	Not covered
Routine Pap Smear One per calendar year	Covered at 100%; 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%; no copay or deductible	Not covered
Routine Chlamydia Screening One per calendar year for females ages 15-24	Covered at 100%; no copay or deductible	Not covered
Routine/Screening Mammogram One routine mammogram per calendar year for females ages 35 and over	Covered at 100%; 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%; 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%; no copay or deductible	Not covered
Routine Colorectal Cancer Screening Ages 50 and over • 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%; 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		
PRESCRIPTION DRUG BENEFITS (Includes Mental Health and Substance Abuse)		
Point-of-Sale Drug Program • Member must file claim with authorization number for reimbursement • Some drugs may require prior authorization • Certain Specialty Drugs can only be dispensed by a Specialty Participating Pharmacy. • Specialty Drugs, or biotech drugs, are generally high cost self-administered drugs • View the Prescription Drug guide at **www.bcbsal.com**.	**Generic Drugs:** Covered at 100%; no deductible **Brand Drugs:** Covered at 80% subject to the calendar year deductible	Not covered
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health and Substance Abuse)		
Calendar Year Deductible	$350 individual; $1,050 aggregate maximum per family	
Calendar Year Out-of-Pocket Maximum **Applies to:** • Other Covered Services • Home Health and Hospice • Point-of-Sale Prescription Drugs	$400 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% for the remainder of the calendar year.	
Lifetime Maximum	There is no lifetime maximum.	
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health and Substance Abuse)		
Allergy Testing & Treatment	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Ambulance Service	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Participating Chiropractic Services Limited to 18 visits 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
Durable Medical Equipment (DME)	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
Occupational, Physical & Speech Therapy • Occupational, physical and speech therapy limited to a combined maximum of 30 visits per year • Children ages 0-9 with an autistic diagnosis are allowed unlimited visits for occupational therapy and speech therapy	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
VISION BENEFITS		
Adult Routine Vision Limited to $250 maximum per person every two calendar years. Benefit limits start new each even year	Covered at 100%; no copay or deductible	
Pediatric Routine Vision • Members up to age 19 • Eye exam limited to one per calendar year • Limited to one pair of prescription glasses or contact lenses per calendar year	Covered at 100%; no copay or deductible	
HOME HEALTH AND HOSPICE BENEFITS **(Includes Mental Health and Substance Abuse)**		
Home Health and Hospice • Precertification required for visits by home health professionals outside Alabama • For precertification call 1-800-821-7231	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
EXPANDED PSYCHIATRIC SERVICES (EPS)		
Expanded Psychiatric Services (EPS) • EPS network 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 finder on our web site **www.bcbsal.com**	When care is received or coordinated by an EPS provider, the following mental health and substance abuse benefits are available: Covered at 100%; 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 and substance abuse benefits available will mirror all other categories of this matrix.	
HEALTH MANAGEMENT BENEFITS **(Includes Mental Health and Substance Abuse)**		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
Baby Yourself	A prenatal wellness program; For more information, please call 1-800-222-4379. You can also enroll online at **www.behealthy.com**	
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 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	

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**) 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 its Pharmacy Benefit Manager(s).*
- *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.*

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. This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract. Please visit our website, www.bcbsal.com