Public Education Employees' Health Insurance Plan (PEEHIP)

BlueCard PPO

Group 14000

Effective October 1, 2009

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BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL FACILITY SERVICES		
Deductibles and Copay	$100 per admission deductible. No copay required.	$100 per admission deductible.
Inpatient Facility Coverage (including 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, except maternity. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1 800 248-2342 (toll-free). 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.	
Baby Yourself	A prenatal wellness program. For more information, call 1 800 222-4379. You can also enroll online at **BeHealthy.com**.	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Surgery	Covered at 100% of the allowance subject to the $75 facility copay.	Covered at 80% of the allowance subject to the calendar year deductible.
Medical Emergency & Hemodialysis	Covered at 100% of the allowance subject to the $25 facility copay.	Covered at 80% of the allowance subject to the calendar year deductible.
Accidental Injury	Covered at 100% of the allowance with no deductible or copay required.	Covered at 100% of the allowance with no deductible or copay within 72 hours of the accident. Thereafter, covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic Lab & Pathology	Covered at 100% of the allowance subject to the $3 copay per test.	Covered at 80% of the allowance subject to the calendar year deductible.
Diagnostic X-ray	Covered at 100% of the allowance with no deductible or copay required.	Covered at 80% of the allowance subject to the calendar year deductible.
IV Therapy Chemotherapy and Radiation Therapy	Covered at 100% of the allowance subject to the $25 facility copay.	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.		
PHYSICIAN SERVICES		
Office Visits and Outpatient Consultations	Covered at 100% of the allowance subject to the $20 office visit copay.	Covered at 80% of the allowance subject to the calendar year deductible.
Emergency Room Physician Fees	Covered at 100% of the allowance subject to the $20 office visit copay.	Covered at 80% of the allowance subject to the calendar year deductible.
Surgery and Anesthesia	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.
Inpatient Visits, Second Surgical Opinions and Inpatient Consultations	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.
Diagnostic Lab & Pathology Exams	Covered at 100% of the allowance. There is a $3 copay per test.	Covered at 80% of the allowance subject to the calendar year deductible.
Diagnostic X-ray	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.
ENHANCED PREVENTIVE CARE SERVICES		
Inpatient Visits for Routine Newborn Care	Covered at 100% of the allowance with no deductible or copay.	Not covered.
Well Child Care Exams	Covered at 100% of the allowance subject to the $20 office visit copay. Includes 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 Physical Exams	Covered at 100% of the allowance subject to the $20 office visit copay. Limited to one exam every year for members age 19 or older.	Not covered.

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Routine Immunizations (Age limitations apply to certain immunizations)	Covered at 100% of the allowance with no deductible or copay.	Not covered.
Zostavax (Shingles) Vaccine	Covered at 50% of the allowance with no deductible or copay for members age 60 and over.	Not covered.
Human Papilloma Virus (HPV) Vaccine	Covered at 50% of the allowance with no deductible or copay for females age 9 through 26.	Not covered.
Routine Pap Smears	Covered at 100% of the allowance with no deductible or copay. Limited to one per year.	Not covered.
Routine Mammograms	Covered at 100% of the allowance with no deductible or copay. Limited to one exam for females between the ages of 35-39 and one per year for females age 40 and over. Subject to the $20 office visit copay if applicable.	Not covered.
Routine Prostate Specific Antigen	Covered at 100% of the allowance with no deductible or copay. Limited to one per year for males age 40 and over. Subject to the $20 office visit copay if applicable.	Not covered.
Other Routine Screening	Covered at 100% of the allowance. Includes lead screening once by age 2; urinalysis once by age 5, then once between ages 12-17; 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), hemocult stool check (annually beginning at age 50), sigmoidoscopy (every 3 years beginning at age 50).	Not covered.
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Covered at 100% of the allowance subject to the following copays: $15 per day for days 10-14 $20 per day for days 15-19 $25 per day for days 20-24 $30 per day for days 25-30 Covers up to 30 days per person each plan year (10/1-9/30). Inpatient Substance Abuse limited to one admission per plan year and a maximum of two admissions per lifetime. Mental Health and Substance Abuse days are aggregate. No rollover to Major Medical.	Covered at 100% of the allowance subject to a $100 per admission deductible. Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital. Precertification is required.
Inpatient Physician Services	Covered at 80% of the allowance subject to the calendar year deductible. Coverage is available only during a covered admission up to 30 days per plan year.	Covered at 80% of the allowance subject to the calendar year deductible.
Outpatient Physician Services	Covered at 80% of the allowance with no deductible. See Summary Plan Description for coverage limitations.*	Covered at 50% of the allowance subject to the calendar year deductible. Limited to 10 visits each plan year.*
GENERAL PROVISIONS		
Calendar Year Deductible	$100 per person each calendar year; 3 member family maximum.	
Annual Out-of-Pocket Maximum	$400 individual annual out-of-pocket maximum plus the $100 calendar year deductible; no family maximum. Other Covered Services are the only expenses applicable to the annual out-of-pocket maximum. Members responsible for expenses above the allowed amount.	
Lifetime Maximum	$1,000,000 lifetime maximum for each covered member. Only the following services are applicable to the lifetime maximum: Other Covered Services, non-PPO Physician Services, non-PPO outpatient facility services (excluding care rendered within 72 hours), and physician services for the treatment of mental health and substance abuse services.	
OTHER COVERED SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance, with no deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member responsible for any difference between the charge and the allowed amount.
Physical Therapy	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member responsible for any difference between the charge and the allowed amount.

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Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member responsible for any difference between the charge and the allowed amount.
Occupational Hand Therapy	Covered at 80% of the allowance, subject to the calendar year deductible, limited to certain services related to the hand and lymphedema.	
Speech Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to 30 sessions per person per calendar year.	
Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	
Allergy Testing & Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	
HOME HEALTH AND HOSPICE		
Preferred Home Health and Hospice	Covered at 100% of the allowance with no deductible or copay. Precertification required for services rendered outside of Alabama. Call 1 800 821-7231.	Covered at 80% of the allowance subject to the calendar year deductible. Precertification required. 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.	

PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH EXPRESS SCRIPTS, INC.		
Prescription Drug Plan • A copay will be charged for each 30-day supply • Approved maintenance drugs may be purchased up to a 90-day supply for refills with one copay when the drug is on the approved list of maintenance drugs and is prescribed as a maintenance drug. • **First fill for a new maintenance drug will be a 30-day supply** • Certain medications are subject to Step Therapy • Pharmacists must dispense generic drugs unless physician indicates in Longhand "Do not substitute." **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:** $5 copay per prescription **Preferred Brand Name Drugs:** $30 copay per prescription **Non-Preferred Brand Name Drugs:** $50 copay per prescription Diabetic Supplies are covered only through the Prescription Drug Card Program unless the member has Medicare as his/her primary coverage. Medicare Part B medications and supplies for Medicare eligible members must be filed with Medicare first and then filed with Blue Cross and Blue Shield of Alabama for secondary coverage.	**Non-Participating Pharmacy in Alabama:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy in Alabama. **Non-Participating Pharmacy Outside Alabama:** Same as participating pharmacy with applicable copayments. Member will be responsible for the difference between the allowance and drug charge.
Note: To view current Prescription Drug Lists, visit the web site at www.rsa-al.gov/PEEHIP/pharm-benefits.html.		

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

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 hospital / medical benefits or a claim, call 1 800 327-3994.
To certify emergency or maternity admission, call 1 800 354-7412.
To certify home health and hospice services, call 1 800 821-7231.
To take advantage of the Baby Yourself program, call 1 800 222-4379.
Visit our web site at www.bcbsal.org/peehip1/
For questions concerning prescription drugs, call Express Scripts, Inc. at 1-866-243-2125
Express Scripts, Inc. web site: www.express-scripts.com