



**BlueCard** 

# 320 Plan



An Independent Association of Blue Cross and Blue Shield Plans.

P L A N      B E N E F I T S

## 320 Plan

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>INPATIENT HOSPITAL FACILITY SERVICES</b>		
<b>Deductibles and Copay</b>	No per admission deductible; \$150 daily copay for days 1 – 5	\$750 per admission deductible*
<b>Inpatient Facility Coverage (including maternity)</b>	100% coverage 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 available only in cases of accidental injury; reimbursement of \$10 per day for room and board and 75% for covered ancillaries	80% coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries*
<b>Preadmission Certification</b>	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	
<b>Individual Case Management and Care Management</b>	The Individual Case Management program assists employees and their families in coordinating care in the event of a lengthy illness; the Care Management program includes chronic conditions such as asthma, diabetes, coronary artery disease and congestive heart failure	
<b>OUTPATIENT HOSPITAL FACILITY SERVICES</b>		
<b>Surgery</b>	100% of the allowed amount, subject to \$150 facility copay	80% of the allowed amount, subject to calendar year deductible*
<b>Medical Emergency and Accidental Injury</b>	100% of the allowed amount, subject to \$150 facility copay	80% of the allowed amount, subject to calendar year deductible*
<b>Diagnostic Lab, X-ray, and Pathology</b>	100% of the allowed amount, subject to \$150 facility copay	80% of the allowed amount, subject to calendar year deductible*
<b>Chemotherapy and Radiation Therapy</b>	100% of the allowed amount with no deductible or copay required	80% of the allowed amount, subject to calendar year deductible*
<b>Hemodialysis and IV Therapy</b>	100% of the allowed amount with no deductible or copay required	80% of the allowed amount, subject to calendar year deductible*
<b>Note:</b> In Alabama, outpatient benefits for non-member hospitals available <b>only</b> in cases of accidental injury		
<b>PHYSICIAN SERVICES</b>		
<b>PPO SERVICES NOT SUBJECT TO \$350 CALENDAR YEAR DEDUCTIBLE</b>		
<b>Office Visits</b>	100% of the allowed amount, subject to \$30* office visit copay with no deductible	<b>In Alabama:</b> 50% of the PMD allowed amount, subject to calendar year deductible* <b>Outside Alabama:</b> 80% of allowed amount, subject to calendar year deductible*
<b>Emergency Room Physician Fees</b>	100% of the allowed amount, subject to \$30* ER visit copay with no deductible	<b>In Alabama:</b> 50% of the PMD allowed amount, subject to calendar year deductible* <b>Outside Alabama:</b> 80% of the allowed amount, subject to calendar year deductible*
<b>Outpatient Second Surgical Opinions and Outpatient Consultations</b>	100% of the allowed amount, subject to \$30* office visit copay with no deductible	<b>In Alabama:</b> 50% of the PMD allowed amount, subject to calendar year deductible* <b>Outside Alabama:</b> 80% of allowed amount, subject to calendar year deductible*
<b>Diagnostic X-rays and Lab Exams</b>	100% of the allowed amount with no deductible or copay	<b>In Alabama:</b> 50% of the PMD allowed amount, subject to calendar year deductible* <b>Outside Alabama:</b> 80% of the allowed amount, subject to calendar year deductible*
<b>PPO SERVICES SUBJECT TO \$350 CALENDAR YEAR DEDUCTIBLE</b>		
<b>Surgery and Anesthesia</b>	100% of the allowed amount, subject to calendar year deductible	<b>In Alabama:</b> 50% of the PMD allowed amount, subject to calendar year deductible* <b>Outside Alabama:</b> 80% of the allowed amount, subject to calendar year deductible*
<b>Inpatient Visits and Inpatient Consultations</b>	100% of the allowed amount, subject to calendar year deductible	<b>In Alabama:</b> 50% of the PMD allowed amount, subject to calendar year deductible* <b>Outside Alabama:</b> 80% of the allowed amount, subject to calendar year deductible*
<b>Maternity</b>	100% of the allowed amount, subject to calendar year deductible	<b>In Alabama:</b> 50% of the PMD allowed amount, subject to calendar year deductible* <b>Outside Alabama:</b> 80% of the allowed amount, subject to calendar year deductible*

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>PREVENTIVE CARE PHYSICIAN SERVICES</b>		
<b>Inpatient Newborn Exam</b>	100% of the allowed amount with no deductible or copay	Not covered
<b>Well Child Care Exams</b>	100% of the allowed amount, subject to \$30* office visit copay with no deductible; includes 9 visits during the first two years of the child's life and one visit each year thereafter through age 6	Not covered
<b>Preventive Office Visit</b> (when combined with a routine pap smear, routine mammogram, or routine prostate specific antigen)	100% of the allowed amount, subject to \$30* office visit copay with no deductible; limited to one office visit per year	Not covered
<b>Preventive Immunizations</b> (Age limitations apply to certain immunizations)	100% of the allowed amount with no deductible or copay	Not covered
<b>Preventive Pap Smears</b>	100% of the allowed amount with no deductible or copay; limited to one per year; subject to \$30* office visit copay if applicable	Not covered
<b>Preventive Mammograms</b>	100% of the allowed amount 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 \$30* office visit copay if applicable	Not covered
<b>Preventive Prostate Specific Antigen</b>	100% of the allowed amount with no deductible or copay; limited to one per year for males age 40 and over; subject to \$30* office visit copay if applicable	Not covered
<b>PRESCRIPTION DRUGS</b>		
<b>Prepaid Prescription Drug Program</b> <ul style="list-style-type: none"> <li>The appropriate copay applies for each 30-day supply of all covered prescription drugs, including maintenance drugs.</li> </ul> <b>Diabetic Supplies</b> (copays apply) Diabetic Supplies are covered only through the Prescription Drug Card Program. Copays have been combined for some products if purchased on the same day.	<b>Participating Pharmacy</b> Prescription drugs are 100% with no deductible subject to the following copays: <b>Generic:</b> \$15 copay* <b>Preferred Brand:</b> \$30 copay* <b>Non-Preferred Brand:</b> \$50 copay* <ul style="list-style-type: none"> <li>Insulin, insulin needles and syringes purchased on the same day require only one copay</li> <li>Blood glucose strips and lancets purchased on the same day require only one copay</li> <li>Glucose monitors always require a separate copay</li> </ul>	<b>Non-Participating Pharmacy</b> There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy in or outside of Alabama
<b>Note:</b> To view the most current Preferred Brand Drug List, visit our web site at <a href="http://www.bcbsal.com">www.bcbsal.com</a>		
<b>HOME HEALTH AND HOSPICE</b>		
<b>Preferred Home Health and Hospice Within the State of Alabama</b>	100% of the allowed amount, subject to calendar year deductible	Not covered
<b>Preferred Home Health and Hospice Outside the State of Alabama</b>	100% of the allowed amount, subject to calendar year deductible; <b>precertification required; call 1-800-821-7231</b>	80% of the allowed amount, subject to calendar year deductible; * <b>precertification required; call 1-800-821-7231</b>
<b>GENERAL PROVISIONS</b>		
<b>Calendar Year Deductible</b>	\$350 per person; \$1,050 aggregate maximum per family each calendar year	
<b>Annual Out-of-Pocket Maximum</b>	\$1,500 maximum per person; \$4,500 aggregate maximum per family plus calendar year deductibles; the following apply to the out-of-pocket maximum: PPO inpatient facility copay (except for mental and nervous services), PPO outpatient facility copay, all Other Covered Services except for inpatient and outpatient mental and nervous services and non-Preferred Physical and Occupational Therapy services in Alabama	
<b>Lifetime Maximum</b>	\$1,000,000 lifetime maximum for each covered member; the following services are applicable to the lifetime maximum: Other Covered Services, non-PPO Physician Services, non-PPO outpatient facility services, and physician services for the treatment of mental health and substance abuse services	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>OTHER COVERED SERVICES</b>		
<b>Chiropractor Services</b>	<b>Participating Chiropractors in Alabama and any Chiropractors outside Alabama:</b> 80% of the allowed amount, subject to calendar year deductible; limited to a maximum payment of \$600 per person each calendar year <b>Non-Participating Chiropractors in Alabama:</b> There are no benefits available for services provided by a non-Participating Chiropractor in Alabama	
<b>Occupational Therapy Services for the Hand</b>	<b>Preferred Occupational Therapist in Alabama and any Occupational Therapist outside Alabama:</b> 80% of the allowed amount, subject to calendar year deductible, limited to certain services related to the hand <b>Non-Preferred Occupational Therapist in Alabama:</b> 50% of the allowed amount, subject to calendar year deductible*	
<b>Physical Therapy</b>	<b>Preferred Physical Therapist in Alabama and any Physical Therapist outside Alabama:</b> 80% of the allowed amount, subject to calendar year deductible <b>Non-Preferred Physical Therapist in Alabama:</b> 50% of the allowed amount, subject to calendar year deductible*	
<b>Durable Medical Equipment (DME)</b>	<b>Preferred DME Supplier in Alabama, Non-Preferred DME Supplier in Alabama and DME Supplier outside of Alabama:</b> 80% of the allowed amount, subject to calendar year deductible	
<b>Ambulance Services</b>	80% of the allowed amount, subject to calendar year deductible	
<b>Allergy Testing &amp; Treatment</b>	80% of the allowed amount, subject to calendar year deductible; limited to a maximum payment of \$200 per person per calendar year	
<b>MENTAL HEALTH AND SUBSTANCE ABUSE WITH EXPANDED PSYCHIATRIC SERVICES (EPS)</b>		
<b>Inpatient Facility Services</b>	<b>EPS Facility:</b> 100% with no deductible or copay for up to 30 days each year when a member is admitted by an EPS participating provider for mental health disorders or treatment for chemical dependency; includes facility, physician and therapy expenses by EPS providers <b>PPO Facility:</b> 100% of the allowed amount subject to the inpatient in-network copay; covers up to 30 days of inpatient treatment during any 12 consecutive months* <b>Other Facility:</b> 80% of the allowed amount, subject to the out-of-network inpatient hospital deductible; covers up to 30 days of inpatient treatment during any 12 consecutive months* Note: In Alabama, inpatient benefits for non-member hospitals available only in cases of accidental injury; reimbursement is \$10 per day for room and board and 75% for covered ancillaries	
<b>Inpatient Physician Services</b>	<b>EPS Provider:</b> 100% with no deductible or copay for up to 30 days each year when a member visits an EPS participating provider for mental health disorders or treatment for chemical dependency <b>Other Provider:</b> 80% of the allowed amount, subject to calendar year deductible; covers up to 30 days of inpatient treatment during any 12 consecutive months*	
<b>Outpatient Physician Services</b>	<b>EPS Provider:</b> 100% with no deductible or copay for outpatient mental health and chemical dependency (alcohol and drug abuse) when a member visits a participating EPS provider for care or treatment; includes office visits, therapy or counseling, and tests by EPS providers <b>Other Provider:</b> 50% of the allowed amount, subject to calendar year deductible; limited to 20 visits per person per calendar year*	
<b>NOTE:</b> EPS providers available throughout Alabama and in Pensacola, Florida and Meridian, Mississippi		

**Please note:** Providers/Specialists may be listed in a PPO directory or on the provider finder web site ([www.bcbs.com](http://www.bcbs.com)), but not covered as PPO benefits by this group health plan (i.e., Ambulance, Allergists).

**\*These services do not apply to the out-of-pocket maximums.**

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