BLUE CROSS

PREFERRED CARE

350 Plan

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

P L A N B E N E F I T S

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MKT-10 (Rev. 11-2002)

Preferred Medical Care
350 Plan

BENEFIT	PREFERRED CARE (PMD)	NON-PREFERRED CARE (NON-PMD)
INPATIENT HOSPITAL FACILITY SERVICES		
Deductibles and Copay	$100 per admission deductible.* $25 copay per day* for days 2nd through 11th days.	
Inpatient Facility Coverage (including maternity)	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 are available only in cases of accidental injury. Reimbursement is $10 per day for room and board and 75% for covered ancillaries. *	
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 and congestive heart failure.	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Surgery	Covered at 100% of the allowance, subject to the $150 facility copay.*	
Medical Emergency	Covered at 100% of the allowance, subject to the 150 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.	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.
Hemodialysis	Covered at 100% of the allowance with no deductible or copay.	
Diagnostic Lab, X-ray, and Pathology	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
IV Therapy, Chemotherapy and Radiation Therapy	Covered at 100% of the allowance with no deductible or 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 (Note: Office visits only. Any services received during the visit may be covered at 80%. Please read below for more information.)	Covered at 100% of the allowance, subject to the $25 office visit copay. *	**In Alabama:** Covered at 50% of the PMD allowance, subject to the calendar year deductible.* **Outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible.
Emergency Room Physician Fees (Note: Office visits only. Any services received during the visit may be covered at 80%. Please read below for more information.)	Covered at 100% of the allowance, subject to the $25 ER visit copay. *	**In Alabama:** Covered at 50% of the PMD allowance, subject to the calendar year deductible.* **Outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible.
Surgery and Anesthesia	Covered at 80% of the allowance with no deductible or copay. The 20% coinsurance applies to the annual $1,000 out of pocket maximum. Once the out-of-pocket maximum is met each year, payment increases to 100% for the remainder of that year.	**In Alabama:** Covered at 50% of the PMD allowance, subject to the calendar year deductible.* **Outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible.
Inpatient Visits, Second Surgical Opinions and Inpatient Consultations	Covered at 80% of the allowance with no deductible or copay. The 20% coinsurance applies to the annual $1,000 out of pocket maximum. Once the out-of-pocket maximum is met each year, payment increases to 100% for the remainder of that year.	**In Alabama:** Covered at 50% of the PMD allowance, subject to the calendar year deductible.* **Outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 80% of the allowance with no deductible or copay. The 20% coinsurance applies to the annual $1,000 out of pocket maximum. Once the out-of-pocket maximum is met each year, payment increases to 100% for the remainder of that year.	**In Alabama:** Covered at 50% of the PMD allowance, subject to the calendar year deductible.* **Outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	PREFERRED CARE (PMD)	NON-PREFERRED CARE (NON-PMD)
Diagnostic X-rays and Lab Exams	Covered at 80% of the allowance with no deductible or copay. The 20% coinsurance applies to the annual $1,000 out of pocket maximum. Once the out-of-pocket maximum is met each year, payment increases to 100% for the remainder of that year.	**In Alabama:** Covered at 50% of the PMD allowance, subject to the calendar year deductible.* **Outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible.
PREVENTIVE CARE SERVICES		
Well Child Care Exams	Covered at 100% of the allowance, subject to the $25 office visit copay. * Includes 4 visits during the first year of the child's life and 1 visit each year thereafter through age 5. This does not include the initial inpatient routine newborn care.	Not covered.
Routine Immunizations (Age limitations apply to certain immunizations)	Covered at 80% of the allowance with no deductible or copay. The 20% coinsurance applies to the annual $1,000 out of pocket maximum. Once the out-of-pocket maximum is met each year, payment increases to 100% for the remainder of that year.	Not covered.
Routine Pap Smears	Covered at 80% of the allowance with no deductible or copay for lab charges only. Limited to one per year. The 20% coinsurance applies to the annual $1,000 out of pocket maximum. Once the out-of-pocket maximum is met each year, payment increases to 100% for the remainder of that year.	Not covered.
Routine Mammograms	Covered at 80% 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. The 20% coinsurance applies to the annual $1,000 out of pocket maximum. Once the out-of-pocket maximum is met each year, payment increases to 100% for the remainder of that year.	Not covered.
OTHER COVERED SERVICES		
Calendar Year Deductible	$200 per person each calendar year; 3 member family maximum.	
Annual Out-of-Pocket Maximum	$1,000 individual annual out-of-pocket maximum plus the $200 calendar year deductible.	
Lifetime Maximum	$1,000,000 lifetime maximum for each covered member.	
Participating Chiropractor Services	**Participating Chiropractors in Alabama, Participating and Non-Participating Chiropractors outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible. Limited to a maximum of $400 or 12 visits per person per calendar year. **Non-Participating Chiropractors in Alabama**: There are no benefits available for services provided by a non-Participating Chiropractor in Alabama. ***Effective 1/1/2003:*** ***$600 per person maximum each calendar year.***	
Occupational Therapy Services for the Hand	**Preferred Occupational Therapist in Alabama, Preferred and Non-Preferred outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible. **Non-Preferred Occupational Therapist in Alabama**: Covered at 50% of the allowance, subject to the calendar year deductible.*	
Physical Therapy	**Preferred Physical Therapist in Alabama, Preferred and Non-Preferred outside Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible. **Non-Preferred Physical Therapist in Alabama**: Covered at 50% of the allowance, subject to the calendar year deductible.*	
Durable Medical Equipment (DME)	**Preferred DME Supplier in Alabama, Non-Preferred DME Supplier in Alabama and DME Supplier Outside of Alabama:** Covered at 80% of the allowance, subject to the calendar year deductible.	
Ambulance Services (Not part of the Preferred Care Network)	Covered at 80% of the allowance, subject to the calendar year deductible.	
Allergy Testing & Treatment (Not part of the Preferred Care Network)	Covered at 80% of the allowance, subject to the calendar year deductible and limited to a $200 calendar year maximum.	

BENEFIT	PREFERRED CARE (PMD)	NON-PREFERRED CARE (NON-PMD)
PRESCRIPTION DRUGS		
Point-of-Sale Drug Program	**Participating Pharmacy:** **Generic and Brand Name**: Covered at 80% of the allowance, subject to the calendar year deducible. **Drugs for Mental/Nervous Treatment**: Covered at 50% of the allowance, subject to the calendar year deducible.	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy in or outside of Alabama.
HOME HEALTH AND HOSPICE		
Preferred Home Health and Hospice	**Preferred In Alabama:** Covered at 100% of the allowance with no deductible or copay. **Non-Preferred in Alabama:** No benefits are available if a non-Preferred provider is used. **Outside Alabama:** Precertification is required, call 1 800 821-7231.	
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Facility Services	Covered at 100% of the allowance, subject to the inpatient per admission deductible and copay. Covers up to 30 days per person each 12 consecutive months.	
Inpatient Physician Services (Not part of the Preferred Care Network)	Covered at 80% of the allowance, subject to the calendar year deductible. Physician services are only available as long as inpatient facility services are available.	
Outpatient Physician Services (Not part of the Preferred Care Network)	Covered at 50% of the allowance, subject to the calendar year deductible. Limited to 20 visits per person each calendar year.*	
EXPANDED PSYCHIATRIC SERVICES (EPS)		
Inpatient Facility and Physician Services	Covered at 100% with no deductible or copay for up to 30 days each year when a member visits an EPS participating facility for mental health disorders or treatment of chemical dependency.	
Outpatient Physician Services	Covered at 100% for outpatient mental health and chemical dependency (alcohol and drug abuse) when a member visits a participating EPS provider for care or treatment.	

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

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