579 Plan

579 Plan
BlueCard PPO

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		
Preadmission Certification is required for inpatient admissions (except maternity); notification within 48 hours for emergencies. Call 1-800-248-2342 (toll free) for precertification.		
Inpatient Hospital **Note:** See special provisions for mental health and substance abuse benefits. In-Network inpatient hospital deductibles and copays do not apply to the Calendar Year Out-of-Pocket Maximum	Covered at 100% after $250 per admission deductible	Covered at 80% after $500 per admission deductible **Note**: In Alabama, available only for accidental injury.
Inpatient Physician Visits and Consultations	Covered at 100%; no copay or deductible	Covered at 50% subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% after $150 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% after $150 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered **Effective 10/1/2010:** **Covered at 100% after $150 hospital copay for services within 72 hours of medical emergency or until medically stabilized; thereafter 80% subject to calendar year deductible; 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 **Effective 10/1/2010:** **Covered at 100% no copay or deductible for services within 72 hours of accident or until medically stabilized; thereafter 80% subject to calendar year deductible**
Emergency Room Physician	Covered at 100% after $30 physician copay	Covered at 50% subject to calendar year deductible **Effective 10/1/2010:** **Covered at 100% after $30 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		
Office Visits & Consultations	Covered at 100% after $30 physician copay	Covered at 50% subject to calendar year deductible
Surgery & Anesthesia (excluding services related to Bariatrics)	Covered at 100%; no copay or deductible	Covered at 50% subject to calendar year deductible
Bariatric Surgery (Surgeon, Assistant Surgeon & Anesthesia) **Note:** Bariatric Services in Alabama must be performed by Bariatric Surgery Network Provider	Covered at 80%; no copay or deductible	Not covered
Maternity Care	Covered at 100%; no copay or deductible	Covered at 50% 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 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 year thereafter through age six	Covered at 100%; no copay or deductible Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $30 copayment for physician office visits.	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Routine Developmental Screening Three exams during the first 30 months of life	Covered at 100%; no copay or deductible	Not covered
Routine Immunizations Age limitations apply to certain immunizations	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%; no copay or deductible Claims for physician office visit charges will be processed as physician benefits and subject to any applicable physician benefit copayments, such as $30 copayment for physician office visits.	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 exam for females ages 35-39 and one per calendar year for females ages 40 and over	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		
Prescription Drug Card • Some drugs require prior authorization • Prescription drugs other than **Specialty Drugs** - 90 day supply may be purchased but copay applies for each 30 day supply; some copays combined for diabetic supplies • Specialty Drugs - up to a 30 day supply • Certain Specialty Drugs can only be dispensed by a Specialty Participating Pharmacy. • Specialty Drugs, or biotech drugs, are generally high cost self-administered drugs • Fertility Drugs are Specialty Drugs taken specifically for the purpose of conceiving • View the Prescription Drug lists at **www.bcbsal.com.**	100% after the following copays: **Generic Drugs-*mandatory when available:***$10 copay per prescription **Preferred Brand Drugs:** $35 copay per prescription **Non-Preferred Brand Drugs:** $50 copay per prescription	Not covered
SUMMARY OF COST SHARING PROVISIONS		
Calendar Year Deductible	$200 individual; $600 aggregate amount per family	
Calendar Year Out-of-Pocket Maximum **Applies to:** • Other Covered Services (except Out-of-Network occupational therapy, physical therapy and DME in Alabama) • Inpatient physician services for Mental Health and Substance Abuse treatment • In-network Physician services that pay less than 100% • Home Health and Hospice	$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% for the remainder of the calendar year.	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum **Applies to:** • Home Health Care and Non-Preferred Hospice Care • Other Covered Services • Out-of-Network hospital services (excluding outpatient accident care rendered within 72 hours) • Out-of-Network physician services • Physician services for the treatment of mental health and substance abuse	$1,000,000 per individual After you reach the Lifetime Maximum, In-Network hospital services, In-Network physician services and In-Network hospice services may be covered (subject to plan benefits). **Note: Effective October 1, 2010 there is no Lifetime Maximum.**	
BENEFITS FOR OTHER COVERED SERVICES		
Allergy Testing & Treatment $200 calendar year maximum per person	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Ambulance Service	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Participating Chiropractic Services $600 calendar year maximum per person	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
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 and Physical Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per 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
Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per year	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
HOME HEALTH AND HOSPICE		
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
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Inpatient Hospital Up to 30 days of inpatient treatment during any 12 consecutive months; no coverage after 30 days	Covered at 100% after $250 per admission deductible	Covered at 80% after $500 per admission deductible **Note**: In Alabama, not covered
Inpatient Physician Up to 30 days of inpatient treatment during any 12 consecutive months; no coverage after 30 days	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Outpatient Hospital & Physician Up to 20 visits per person per calendar year	Covered at 50% subject to calendar year deductible	Covered at 50% subject to calendar year deductible
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 at **www.bcbsal.com**	**Care must be coordinated by EPS provider** Covered at 100%; no copay or deductible **Inpatient:** Up to 30 days each year; includes hospital, physician and therapy expenses **Outpatient:** Includes office visits, therapy, counseling and testing	
HEALTH MANAGEMENT BENEFITS		
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.	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK

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.*
- *Physician assistants and physician assistants who assist with surgery acting under the supervision of PMD/PPO physicians are eligible providers.*

This is not a contract, benefit booklet or Summary Plan Description.
Benefits are subject to the terms, limitations and conditions of the group contract.
Check your benefit booklet for more detailed coverage information.

Blue Cross and Blue Shield of Alabama

Insert for 579 Plan

MKT-579 (7-2008)

Effective as of October 1, 2010

Attention: This insert amends the Group Health Care Summary Plan Description for the 579 Plan (7-2008). The changes made by this amendment are effective for services or supplies rendered on or after October 1, 2010.

- In the **Overview of the Plan** section of your benefit booklet, the **Claims and Appeals** subsection is amended to add the following before the last sentence of such subsection to read as follows:

  Thereafter, you may have the right to an external review by the Office of Personnel Management (OPM).

- The first box in the **Inpatient Hospital Benefits** subsection of the **Health Benefits** section of your benefit booklet is amended to add the words "emergency hospital admissions" after the word "except" and before the word "maternity".

- The **Outpatient Hospital Benefits** matrix in the **Health Benefits** section of your benefit booklet is amended to change the **Out-of-Network** cost-sharing amounts for **Emergency Room – medical emergency** as follows:

  100% of the allowed amount, subject to the calendar year deductible after payment of a $150 facility copayment

- The **Outpatient Hospital Benefits** matrix in the **Health Benefits** section of your benefit booklet is amended to change the **Out-of-Network** cost-sharing amounts for **Emergency Room – accident** as follows:

  100% of the allowed amount, subject to the calendar year deductible, when services are rendered within 72 hours of the accident; thereafter 80% of the allowed amount, subject to the calendar year deductible

- The **Physician Benefits** matrix in the **Health Benefits** section of your benefit booklet is amended to change the **Out-of-Network** cost-sharing amounts for **Emergency Room – physician** as follows:

  100% of the allowed amount, subject to the calendar year deductible after payment of a $30 physician copayment

- The **Physician Preventive Benefits** matrix in the **Health Benefits** section of your benefit booklet is deleted in its entirety and replaced with the following subsection to read as follows:

  Physician Preventive Benefits

  Attention: In some cases, routine immunizations and routine preventive services may be billed separately from your office or other facility visit. In that case, the applicable office visit or outpatient facility copayments under your physician benefits or outpatient hospital benefits may apply. In any case, applicable office visit or facility copayments may still apply when the primary purpose for your visit is not routine preventive services and/or routine immunizations.

SERVICE OR SUPPLY	IN-NETWORK	OUT-OF-NETWORK
Routine immunizations See www.bcbsal.com/immunizations for a listing of the specific immunizations	100% of the allowed amount, no deductible or coinsurance	Not covered
Routine preventive services See www.bcbsal.com/preventiveservices For a listing of the specific preventive services	100% of the allowed amount, no deductible or coinsurance	Not covered

- In the **Claims and Appeals** section of your benefit booklet, the second subparagraph in the **Urgent Pre-Service Claims** paragraph in the **Pre-Service Claims** subsection is deleted in its entirety and replaced with the following second subparagraph to read as follows:

  If your claim is urgent, we will notify you of our decision within 24 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 24 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing information to us.

- In the **Claims and Appeals** section of your benefit booklet, the last paragraph in the **Concurrent Care Determinations** subsection is deleted in its entirety and replaced with the following last paragraph to read as follows:

  If your request for additional care is urgent, we will give you our decision within 24 hours of when your request is submitted. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

- The first paragraph in the **Appeals** subsection of the **Claims and Appeals** section of your benefit booklet is deleted in its entirety and replaced with the following to read as follows:

  The rules in this section of this booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

  - Any determination we make with respect to a post-service claims that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
  - Our denial of a pre-service claim;
  - An adverse concurrent care determination (for example, we deny your request to extend previously approved care); or,
  - Your group's denial of your or your dependents' initial eligibility for coverage under the plan or your group's retroactive rescission of your or your dependents' coverage for fraud or intentional misrepresentation of a material fact.

  In all cases other than determinations by us to limit or reduce previously approved care and determinations by your group regarding initial eligibility or retroactive rescission, you have 180 days following our adverse benefit determination within which to submit an appeal.

  How to Appeal Your Group's Adverse Eligibility and Rescission Determinations: If you wish to file an appeal of your group's adverse determination relating to initial eligibility for coverage or retroactive rescission of coverage, you should check with your group regarding your group's appeal procedures.

- The **If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies** paragraph in the **Appeals** subsection of the **Claims and Appeals** section of your benefit booklet is deleted in its entirety and replaced with the following to read as follows:

  If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you have filed an appeal and are dissatisfied with our response, you may do one or more of the following:

  - You may ask our customer service department for further help;
  - You may file a voluntary appeal (discussed below); or
  - You may file a request for external review (discussed in the External Review section below).

- The following new **External Review** section is added to your benefit booklet to read as follows:

  External Reviews
  For most types of claims, you have the right to file a request with the Office of Personnel Management (OPM) for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. You can request an external review with OPM in writing by sending your request electronically to DisputedClaim@opm.gov; by faxing it to 1-202-606-0036, or by sending it by mail to: OPM, P.O. Box 791, Washington, D.C. 20044. If you request an external review, the examiner will review our decision and provide you with a written determination.

- The **Misrepresentation** subsection of the **General Information** section of your benefit booklet is deleted in its entirety and replaced with the following:

  Misrepresentation
  If you commit fraud or make an intentional material misrepresentation in apply for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.

- The **Allowed Amount** definition in the **Definitions** section of your benefit booklet is amended by adding the following at the end of such definition:

  For emergency services for medical emergencies provided within the emergency room department of an out-of-network hospital, the allowed amount will be determined in accordance with the requirements of the Patient Protection and Affordable Care Act.

- The **Medical Emergency** definition in the **Definitions** section of your benefit booklet is deleted in its entirety and replaced with the following definition:

  Medical Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or, (ii) serious dysfunction of any bodily organ or part.

Except as expressly modified herein, all other terms, conditions and provisions of your benefit booklet remain in full force and effect including (without limitation) those benefit changes previously sent to you in an insert dated July 1, 2010.

E. Gene Linton Jr.
Vice President, Group Sales