HDHP Comparison Grid: Comparing the Old to the New

	BCBS Traditional PPO	BCBS HDHP with HSA
	Traditional Copay Health Plan	High Deductible Health Plan and Health Savings Account
This Plan provides benefits through a group of contracted providers (Network Providers) who are defined as either HH Health System, Marshall Medical Centers, Lawrence Medical Center, Med-South, Inc. or Blue Cross Blue Shield Preferred Providers. **HH Health System:** Athens-Limestone Hospital, Bradford Health Services, Decatur Morgan Hospital, HealthSouth Rehab Hospital of North Alabama, Helen Keller Hospital, Hospice Family Care, Hospice of the Valley, Hospice of Limestone County, Huntsville Hospital, Huntsville Hospital for Women and Children, Madison Hospital, Red Bay Hospital, Surgery Center of Decatur, The Surgery Center of Huntsville, Lincoln Medical Center, HGA Home Medical Equipment, LLC.		
GENERAL PROVISIONS Mental Health Services are included under each benefit category		
Calendar Year Deductible	$400 per individual per calendar year.	$1,350 individual; $2,700 family.
Calendar Year Out-of-Pocket Maximum	**Individual** $6,550 /**Family** $13,100 Medical (Ind. $4,050/Fam. $8,100) Pharmacy (Ind. $2,500/Fam. $5,000)	**Individual** $5,000 /**Family** $10,000
Benefit Feature	Embedded Deductible and Out-of-Pocket Maximum	Aggregate Deductible and Out-of-Pocket Maximum
Spending Accounts	Health Flexible Spending Account (FSA)	Health Savings Account (HSA)
HH Health System Annual Contributions	Not applicable	**Employee Only:** $ 500 **Employee + Child(ren):** $1,000 **Family:** $1,000 *HSA contributions will be funded at the beginning of each quarter, after you open your HSA account. The quarterly installment you receive will be based on your elected in-force coverage on the date funds are deposited.
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services	Covered at 100%; no copay or deductible See AlabamaBlue.com/preventiveservices for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy.	Covered at 100%; no copay or deductible See AlabamaBlue.com/preventiveservices for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy.
Additional Preventive Services	Covered at 100%; no copay or deductible. • Urinalysis – when necessary • Complete Blood Count – when necessary • EKG – when necessary • Comprehensive Metabolic Panel – when necessary • Lipid Panel – when necessary • CA125 – when necessary • Chest X-Ray – when necessary • Routine OB/GYN visit (Age 7 & older) – One per calendar year	Covered at 100%; no copay or deductible. • Urinalysis – when necessary • Complete Blood Count – when necessary • EKG – when necessary • Comprehensive Metabolic Panel – when necessary • Lipid Panel – when necessary • CA125 – when necessary • Chest X-Ray – when necessary. • Routine OB/GYN visit (Age 7 & older) – One per calendar year

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INPATIENT HOSPITAL FACILITY SERVICES		
Inpatient Facility Coverage (including maternity) Charges for Joint Camp Services made by Huntsville Hospital and Decatur Morgan Hospital are payable as part of the Inpatient Facility Services based on the number of days designated by Joint Camp. Pre- certification is not required for Joint Camp Services.	**HH Health System:** Covered at 100% of the allowance subject to a $150 facility copay per admission. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to a $500 facility copay per admission. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to a $2,500 facility copay per admission.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Routine Newborn – Inpatient Routine Nursery Care includes room, board and Hospital Miscellaneous Expenses for a Newborn Dependent child.	Covered at 100%; no copay or deductible.	Covered at 90%; subject to the calendar year deductible.
Robotic Surgery (Gallbladder, Hernia Repair and Tonsillectomy)	**HH Health System:** Covered at 100% of the allowance, subject to a $250 admission copay and the calendar year deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, subject to a $600 admission copay and the calendar year deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, subject to a $2,600 facility copay per admission and the calendar year deductible.	**HH Health System:** Covered at 85% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 75% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 65% of the allowance subject to the deductible.
Residential Treatment Facilities	**Blue Cross Blue Shield Preferred Providers:** Covered at 100% of the allowance subject to a $150 facility copay per admission.	**Blue Cross Blue Shield Preferred Providers:** Covered at 90% of the allowance subject to the deductible.
OUTPATIENT HOSPITAL BENEFITS		
Outpatient Surgery (including Ambulatory Surgical Centers)	**HH Health System:** Covered at 100% of the allowance, subject to a $150 facility copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, subject to a $200 facility copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, subject to a $500 facility copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Medical Emergency & Accident Injury	Covered at 100% of the allowance, subject to a $75 facility copay.	Covered at 90% of the allowance, subject to the deductible.

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Non-Medical Emergency or Non-Accidental Injury Treatment Rendered in the Emergency Room	**HH Health System:** Covered at 100% of the allowance, subject to a $75 facility copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, subject to a $200 facility copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, subject to a $500 facility copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Urgent Care Facility	**HH Health System:** Covered at 100% of the allowance, subject to a $75 facility copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, subject to a $75 facility copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, subject to a $75 facility copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Diagnostic X-ray Facility Services - Outpatient	**HH Health System:** Covered at 100% of the allowance, no deductible or copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, no deductible or copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, no deductible or copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Diagnostic Mammograms & Diagnostic Colonoscopies	**HH Health System:** Covered at 100% of the allowance, subject to a $150 facility copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, subject to a $200 facility copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, subject to a $500 facility copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
MRI, CAT Scan, PET Scan, Cardiac Cath, or Nuclear Medicine Facility Services – Outpatient	**HH Health System:** Covered at 100% of the allowance, subject to a $100 facility copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, subject to a $150 facility copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, subject to a $200 facility copay. **Office Setting: Covered at 70% of the allowance, subject to a $200 copay.**	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.

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Diagnostic Lab and Pathology Facility Services – Outpatient	**HH Health System:** Covered at 100% of the allowance, no deductible or copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, no deductible or copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, no deductible or copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Infusion Services – Outpatient (Includes Home infusion)	**HH Health System:** Covered at 100% of the allowance, no deductible or copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, no deductible or copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, no deductible or copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Chemotherapy/Radiation Therapy	**HH Health System:** Covered at 100% of the allowance, no deductible or copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, no deductible or copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, no deductible or copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Robotic Surgery (Gallbladder, Hernia Repair and Tonsillectomy)	**HH Health System:** Covered at 100% of the allowance, subject to a $250 facility copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, subject to a $300 facility copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, subject to a $600 facility copay.	**HH Health System:** Covered at 85% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 75% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 65% of the allowance subject to the deductible.
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	**Decatur Morgan West/Bradford Health**: Covered at 100% of the allowance subject to a $150 per admission copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 80% of the allowance subject to a $500 per admission deductible.	**Decatur Morgan West/Bradford Health**: Covered at 90% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 80% of the allowance subject to the deductible.
PHYSICIAN BENEFITS		
Office Visits and Outpatient Consultations (including Second Surgical Opinions)	Covered at 100% of the allowance, subject to a $40 copay. **Mental Health Disorders/Substance Abuse Outpatient Professional Services:** Covered at 100% of the allowance, subject to a $40 copay.	Covered at 80% of the allowance subject to the deductible. **Mental Health Disorders/Substance Abuse Outpatient Professional Services:** Covered at 80% of the allowance, subject to the deductible.

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Emergency Room Physician Fees	Covered at 100% of the allowance no deductible or copay.	Covered at 80% of the allowance subject to the deductible.
Surgery and Anesthesia	Covered at 100% of the allowance no deductible or copay.	Covered at 80% of the allowance subject to the deductible.
Inpatient Visits and Inpatient Consultations	Covered at 100%, subject to the deductible. **Mental Health Disorders/Substance Abuse Inpatient Professional Services:** Covered at 80% of the allowance no deductible or copay.	Covered at 80% of the allowance subject to the deductible. **Mental Health Disorders/Substance Abuse Outpatient Professional Services:** Covered at 80% of the allowance, subject to the deductible.
Diagnostic Lab and X-Ray Professional Services	Covered at 100% of the allowance no deductible or copay.	Covered at 80% of the allowance subject to the deductible.
Radiation and Chemotherapy	Covered at 70% of the allowance no deductible or copay.	Covered at 70% of the allowance subject to the deductible.
Diagnostic Mammograms & Diagnostic Colonoscopies	Covered at 100% of the allowance subject to the deductible. First mammograms and colonoscopies during any Benefit Period regardless of diagnosis or claim coding and subsequent mammograms ordered for routine purposes; covered at 100% of the allowance no deductible or copay for HH Health System Providers.	Covered at 80% of the allowance subject to the deductible. First mammograms and colonoscopies during any Benefit Period **only when the diagnosis or claim coding is submitted for routine purposes**; covered at 100% of the allowance no deductible or copay for HH Health System Providers.
Infusion Services (Includes Home infusion)	**Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance no deductible or copay.	**Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Diagnostic Infertility Testing Includes services for the diagnosis of infertility and injections only.	Covered at 80% of the allowance no deductible; $40 office visit copay when applicable.	Covered at 80% of the allowance subject to the deductible.
Maternity	Covered at 100% of the allowance subject to the deductible. Note: First ultrasound paid at 100% of the allowance, no deductible or copay.	Covered at 80% of the allowance subject to the deductible.
OTHER COVERED SERVICES		
Allergy Testing & Treatment	Covered at 100% of the allowance, no deductible; $40 office visit copay when applicable.	Covered at 80% of the allowance subject to the deductible.
Ambulance Services	Covered at 80% of the allowance subject to the deductible.	Covered at 80% of the allowance subject to the deductible.

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Durable Medical Equipment	**HGA Home Medical Equipment:** Covered at 80% of the allowance, no deductible or copay. **Med-South:** Covered at 75% of the allowance, no deductible or copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, no deductible or copay.	**HGA Home Medical Equipment:** Covered at 90% of the allowance subject to the deductible. **Med-South:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Diabetic Shoes Limited to a maximum benefit of $100 per member per calendar year; limited to a lifetime maximum of $500 per member.	Covered at 70% of the allowance, no deductible or copay.	Covered at 70% of the allowance subject to the deductible.
Wig or Hair Prosthesis Limited to one wig or hair prosthesis; up to a $500 lifetime maximum per member.	Covered at 100% of the allowance, no deductible or copay	Covered at 80% of the allowance subject to the deductible.
Chiropractor Services Limited to 24 visits per member per calendar year.	Covered at 80% of the allowance, no deductible or copay.	Covered at 80% of the allowance subject to the deductible.
Physical, Speech & Occupational Therapy (Outpatient Facility and Professional Services)	**HH Health System (including Drayer providers on the ALH campus):** Covered at 100% of the allowance, no deductible or copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, no deductible or copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, no deductible or copay.	**HH Health System (including Drayer providers on the ALH campus):** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Hearing Exam, Testing and Hearing Aids Limited to a maximum of $1,000 per member per benefit period.	Covered at 80% of the allowance subject to the deductible.	Covered at 80% of the allowance subject to the deductible.
Skilled Nursing Facility Limited to 60 days per admission.	Covered at 100% of the allowance after a $150 facility copay per admission.	Covered at 90% of the allowance subject to the deductible.
Private Duty Nursing Limited to 60 days per member per calendar year.	Covered at 100% of the allowance after a $150 facility copay per admission.	Covered at 90% of the allowance subject to the deductible.
Impacted Wisdom Teeth & Anesthesia	**Blue Cross Blue Shield Preferred Providers:** Covered at 100% of the allowance subject to the deductible; $40 office visit copay when applicable.	**Blue Cross Blue Shield Preferred Providers:** Covered at 80% of the allowance subject to the deductible.
Preferred Home Health Care Limited to 120 days per calendar year.	Covered at 100% of the allowance no deductible or copay.	Covered at 90% of the allowance subject to the deductible.

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Preferred Hospice Care Limited to 30 days per calendar year.	**HH Health System:** Covered at 100% of the allowance, no deductible or copay. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance, no deductible or copay. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance, no deductible or copay.	**HH Health System:** Covered at 90% of the allowance subject to the deductible. **Marshall/Lawrence Medical Centers:** Covered at 80% of the allowance subject to the deductible. **Blue Cross Blue Shield Preferred Providers:** Covered at 70% of the allowance subject to the deductible.
Dialysis	Covered at 80% of the allowance, subject to the deductible. **Note: $40 copay applies to office visit.**	Covered at 80% of the allowance subject to the deductible.
PRESCRIPTION DRUG BENEFITS		
Deductible Applies?	**No.** Prescription drugs are covered at 100% of the allowance, subject to the copays listed below.	**Yes.** No prescription drug benefits, except HSA preventive drugs, are paid by the plan until combined medical and pharmacy expenses paid by the individual equal the deductible amount**.** After the deductible is met, the plan will pay 100% of the allowance for prescription drugs, subject to the copays listed below.
Prepaid Drug Card HH Health System Network contains Huntsville Hospital; Heart Center, LLC, Med Mall, Decatur Morgan Hospital, Athens Community Pharmacy, Helen Keller Community Pharmacy and Redmont Pharmacy. • The Prime pharmacy network for this plan is the **ValueONE Network.** • Prescription drugs - up to a 30-day supply. • (Tier 4) specialty drugs are limited to a 30 day supply and are available through the HH Health System Network to include HH Mail Order Pharmacy and the Prime Therapeutics Specialty Pharmacy™; visit **AlabamaBlue.com/DrugList** for a list of these (Tier 4) specialty drugs. • View the **Net Results 1.0** drug lists at **AlabamaBlue.com/DrugList.** • Locate a **ValueONE Network** pharmacy at **AlabamaBlue.com/pharmacy.**	**HH Health System Network:** **Tier 1 drugs:** $10 copay **Tier 2 drugs:** $30 copay **Tier 3 drugs:** $45 copay **Tier 4 (Specialty) drugs:** 90% (Member owes 10%). **Prime ValueOne Network Participating Pharmacy:** **Tier 1 Drugs:** $15 copay **Tier 2 Drugs:** $45 copay **Tier 3 Drugs:** $60 copay **Tier 4 (Specialty) drugs:** 80% (Member owes 20%). **Non-Participating Pharmacy:** **Not covered** **There is a separate $2,500 individual; $5,000 family prescription drug out-of-pocket maximum.** Generic mandatory and may be classified at any Tier. If a member chooses to fill a name brand drug and there is a generic equivalent, then the member will be responsible for the difference in cost between the brand name drug and the generic, plus the Tier 3 copay *Any injectable medicine purchased at the pharmacy and administered in a provider's office is subject to 80% of the allowed amount after the deductible.*	**HH Health System Network:** **Tier 1 drugs:** $10 copay **Tier 2 drugs:** $30 copay **Tier 3 drugs:** $45 copay **Tier 4 (Specialty) drugs:** 90% (Member owes 10%). **Prime ValueOne Network Participating Pharmacy:** **Tier 1 Drugs:** $15 copay **Tier 2 Drugs:** $45 copay **Tier 3 Drugs:** $60 copay **Tier 4 (Specialty) drugs:** 80% (Member owes 20%). **Non-Participating Pharmacy:** **Not covered** Prescription drug out-of-pocket amounts are applied to the plan's combined calendar year out-of-pocket maximum. Generic mandatory and may be classified at any Tier. If a member chooses to fill a name brand drug and there is a generic equivalent, then the member will be responsible for the difference in cost between the brand name drug and the generic, plus the Tier 3 copay *Any injectable medicine purchased at the pharmacy and administered in a provider's office is subject to 80% of the allowed amount after the deductible.*

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Mail Order Pharmacy Benefits HH Health System Mail Order Pharmacies include Huntsville Hospital Mail Order Pharmacy and HH Health System Medical Mall. For maintenance medications, members are allowed 2 fills at Prime's ValueOne Network. After those 2 fills, members must use a HH Health System affiliate hospital pharmacy (HH Health System Medical Mall pharmacy on the HH campus only), Huntsville Hospital Mail Order pharmacy or PrimeMail. Prescription drugs – up to a 90-day supply. To enroll in PrimeMail® go online at **AlabamaBlue.com** or call 1-800-391- 1886). View the **Net Results 1.0** drug lists at **AlabamaBlue.com/DrugList.**	**HH Health System Mail Order Pharmacy:** **Copays 1 to 30-day supply:** **Tier 1 Drugs**: $10 copay **Tier 2 Drugs:** $30 copay **Tier 3 Drugs:** $45 copay **Copays 31 to 90-day supply:** **Tier 1 Drugs**: $20 copay **Tier 2 Drugs:** $60 copay **Tier 3 Drugs:** $90 copay There is a separate $2,500 individual; $5,000 family prescription drug out-of-pocket maximum. Generic mandatory and may be classified at any Tier. If a member chooses to fill a name brand drug and there is a generic equivalent, then the member will be responsible for the difference in cost between the brand name drug and the generic, plus the tier 3 copay.	**HH Health System Mail Order Pharmacy:** **Copays 1 to 30-day supply:** **Tier 1 Drugs**: $10 copay **Tier 2 Drugs:** $30 copay **Tier 3 Drugs:** $45 copay **Copays 31 to 90-day supply:** **Tier 1 Drugs**: $20 copay **Tier 2 Drugs:** $60 copay **Tier 3 Drugs:** $90 copay Prescription drug out-of-pocket amounts are applied to the plan's combined calendar year out-of-pocket maximum. Generic mandatory and may be classified at any Tier. If a member chooses to fill a name brand drug and there is a generic equivalent, then the member will be responsible for the difference in cost between the brand name drug and the generic, plus the tier 3 copay.
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury; For more information, please call 1-800-821-7231.	
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 maternity program; coordinates high-risk pregnancy early intervention	
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.	