BlueCard® PPO
Plan Benefits

Local Government Health Insurance Plan
BlueCard® PPO
Group 30000

Effective January 1, 2019

Visit the Local Government Health Insurance Board’s website at www.lghip.org or call 1.866.836.9137
Local Government Health Insurance Plan  
**JANUARY 1, 2019**

This table is a summary of benefits and is subject to all other terms and conditions of the Plan.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard® Preferred Provider Organization (PPO) Program. To find out if your provider is a PPO member, call 1-800-810-BLUE (2583) or access the Blue Cross website, AlabamaBlue.com. Please be aware that not all providers participating in the BlueCard® PPO Program will be recognized by Blue Cross as approved providers for the type of service being furnished as explained more fully in the “Benefit Conditions” section of the Plan’s handbook.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK (PPO)</th>
<th>OUT-OF-NETWORK (NON-PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INPATIENT HOSPITAL BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precertification is required for inpatient admissions (except medical emergency and maternity); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 for precertification.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Coverage (including maternity)</td>
<td>Covered at 100% of the allowance, subject to a $200 per admission deductible and $50 co-pay per day for days 2-5</td>
<td>Covered at 80% of the allowance, subject to a $200 per admission deductible and $50 co-pay per day for days 2-5.</td>
</tr>
<tr>
<td><strong>OUTPATIENT HOSPITAL BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precertification is required for certain outpatient hospital benefits, including radiology services and a select group of provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>Covered at 100% of the allowance, subject to the $100 facility co-pay. Certain outpatient surgeries require pre-certification, call 1-800-248-2342.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible. Certain outpatient surgeries require pre-certification, call 1-800-248-2342.</td>
</tr>
<tr>
<td>Medical Emergency</td>
<td>Covered at 100% of the allowance, subject to the $200 facility co-pay.</td>
<td>Covered at 100% of the allowance, subject to the $200 facility co-pay.</td>
</tr>
<tr>
<td>Accidental Injury</td>
<td>Covered at 100% of the allowance with no deductible or co-pay required if services are provided within 72 hours of the accident.</td>
<td>Covered at 100% of the allowance with no deductible or co-pay required if services are provided within 72 hours of the accident. Thereafter, and when not a medical emergency as defined by the plan, covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Diagnostic X-rays &amp; Tests</td>
<td>Covered at 100% of the allowance, subject to the $100 facility co-pay per visit or cost of service, whichever is less.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Diagnostic Lab &amp; Pathology</td>
<td>Covered at 100% of the allowance, subject to a $3 co-pay per test.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Dialysis, IV Therapy, Chemotherapy &amp; Radiation Therapy</td>
<td>Covered at 100% of the allowance, subject to the $25 facility co-pay.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
</tbody>
</table>

**PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS**

Precertification is required for a select group of provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList.
Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.

<p>| Physician Office Visits, Office Surgery &amp; Outpatient In-Person Consultations | Covered at 100% of the allowance, subject to the $40 office visit co-pay. | Covered at 80% of the allowance, subject to the calendar year deductible. |
| Nurse Practitioners / Nurse Midwives, Physician Assistant Office Visits, Office Surgery &amp; Outpatient Consultations | Covered at 100% of the allowance, subject to the $20 office visit co-pay. | Covered at 80% of the allowance, subject to the calendar year deductible. |
| Telephone and Online Video Consultations Program | Covered at 100% of the allowance; no copay or deductible | Not covered. |
| Emergency Room | Covered at 100% of the allowance, subject to the office visit co-pay. | Covered at 100% of the allowance, subject to the office visit co-pay. |
| Inpatient Visits | Covered at 100% of the allowance; no copay or deductible | Covered at 80% of the allowance, subject to the calendar year deductible. |</p>
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK (PPO)</th>
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<tr>
<td>Maternity</td>
<td>Covered at 100% of the allowance; no copay or deductible</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Lab &amp; Pathology Exams</td>
<td>Covered at 100% of the allowance, subject to a $3 co-pay per test</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Diagnostic X-rays &amp; Tests</td>
<td>Covered at 100% of the allowance; no copay or deductible</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>IV Therapy, Chemotherapy &amp; Radiation Therapy</td>
<td>Covered at 100% of the allowance; no copay or deductible</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
</tbody>
</table>

### ROUTINE PREVENTIVE CARE

**Routine Immunizations and Preventive Services**

- Covered at 100% of the allowance with no deductible or copay.
  - See [AlabamaBlue.com/preventiveservices](http://AlabamaBlue.com/preventiveservices) and AlabamaBlue.com/StandardACA PreventiveDrugList for a listing of the specific drugs, immunizations and preventive services or call the BCBS Customer Service Department for a printed copy

- Covered at 80% of the allowance subject to the calendar year deductible.
  - See [AlabamaBlue.com/preventiveservices](http://AlabamaBlue.com/preventiveservices) and AlabamaBlue.com/StandardACAPreventiveDrugList for a listing of the specific drugs, immunizations and preventive services or call Customer Service Department for a printed copy

**Additional Routine Preventive Services**

- Covered at 100% of the allowance with no deductible or copay. In addition to the standard, the following will apply:
  - Urinalysis (once by age 5, then once between ages 12-17)
  - CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over)
  - Glucose testing (once every calendar year age 18 and over)
  - Cholesterol testing (once every calendar year age 18 and over)
  - TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)

**Note:** Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.

### MENTAL HEALTH SERVICES

**Inpatient Facility Services**

- Covered at 80% of the participating allowance, subject to a $200 inpatient per admission deductible.
- Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.

**Inpatient Physician Services**

- Covered at 80% of the allowance, no copay or deductible.
- Covered at 80% of the allowance, subject to the calendar year deductible.

**LGHIB Approved Outpatient Provider Services**

- Covered at 100% of the allowance, subject to a $14 co-pay per visit; limited to 20 visits per person per calendar year.
- Covered at 80% of the allowance, subject to the calendar year deductible; limited to 20 visits per person per calendar year.

### SUBSTANCE ABUSE SERVICES

**Inpatient Facility Services**

- Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.
- Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.

**Inpatient Physician Services**

- Covered at 80% of the allowance; no copay or deductible.
- Covered at 80% of the allowance, subject to the calendar year deductible.

**LGHIB Approved Outpatient Provider Services**

- Covered at 100% of the allowance, subject to a $14 co-pay per visit; limited to 20 visits per person per calendar year. (Other co-pays may apply based on services rendered.)
- Covered at 80% of the allowance, subject to the calendar year deductible; limited to 20 visits per person each calendar year.

### MAJOR MEDICAL GENERAL PROVISIONS

**Calendar Year Deductible**

- $200 per person each calendar year; maximum of three deductibles per family.

**Annual Out-of-Pocket Maximum**

- $7,900 individual annual out-of-pocket maximum; $15,800 family maximum.

**In-Network Services:** Deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum, including prescription drugs.

For members up to age 19, deductibles and coinsurance for in-network dental services under the group dental benefits apply to the out-of-pocket maximum.

**Out-of-Network Services:** Do not apply to the out-of-pocket maximum.

After you reach your Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowance for remainder of the calendar year.
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK (PPO)</th>
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<tr>
<td><strong>MAJOR MEDICAL SERVICES</strong></td>
<td><strong>Precertification is required for certain major medical services; please see benefit booklet. Call 1-800-248-2342 for precertification. If no precertification is obtained, no benefits are available.</strong></td>
<td></td>
</tr>
<tr>
<td>Participating Chiropractor Services</td>
<td>Covered at 80% of the allowance with no deductible. Precertification is required after the 18th visit.</td>
<td>Non-Participating: Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 18th visit.</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA) Therapy</td>
<td>For children 18 years or younger, covered at 100% of the allowance after $14 copay per visit and subject to the following annual maximum benefits:</td>
<td>For children 18 years or younger, covered at 80% of the allowance subject to calendar year deductible and following annual maximum benefits:</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>Annual Maximum</td>
</tr>
<tr>
<td></td>
<td>0 to 9</td>
<td>$40,000</td>
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<tr>
<td></td>
<td>10 to 13</td>
<td>$30,000</td>
</tr>
<tr>
<td></td>
<td>14 to 18</td>
<td>$20,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.</td>
</tr>
<tr>
<td>Physical Therapy, Speech Therapy and Occupational Therapy related to the screening, diagnosis, and treatment of Autism Spectrum Disorder</td>
<td>For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.</td>
<td>For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.</td>
</tr>
<tr>
<td></td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.</td>
</tr>
<tr>
<td>Rehaabilitative and Habilitative Physical Therapy, Speech Therapy and Occupational Therapy</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Allergy Testing &amp; Treatment</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible.</td>
</tr>
<tr>
<td>Participating Home Health Services</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency; Precertification is required; call 1-800-248-2342. NOTE: No coverage for services rendered by a non-participating Home Health agency.</td>
<td>Covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency; Precertification is required; call 1-800-248-2342. NOTE: No coverage for services rendered by a non-participating Home Health agency.</td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>Covered at 100% of the allowance with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1-800-248-2342.</td>
<td>Covered at 100% of the allowance with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1-800-248-2342.</td>
</tr>
</tbody>
</table>
### Prescription Drug Card Program for Tier 1 Drugs
- The pharmacy network for the plan is the Prime Participating Pharmacy Network.
- Generic non-maintenance drugs may be dispensed up to a 30-day supply.
- Generic maintenance drugs may be dispensed up to a 60-day supply with one copay.
- Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Pharmacy Select Network. Go to AlabamaBlue.com/SelfAdministratedSpecialtyDrugList for a list of these specialty drugs.
- Plan exclusions will supersede the Standard Drug List.
- View the Standard Prescription Drug List that applies to the plan at AlabamaBlue.com/StandardDrugList.

#### Participating Pharmacy:
- Tier 1 drugs covered at 100% of the allowance subject to a $10 co-pay per prescription.
- Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See AlabamaBlue.com/VaccineNetworkDrugList for more information.

#### Non-Participating Pharmacy:
- No benefits are available for prescriptions purchased at a non-Participating Pharmacy.

### Point-of-Sale Drug Program for Tier 2 and Tier 3 Drugs
- The pharmacy network for the plan is the Prime Participating Pharmacy Network.
- Brand drugs (Tier 2 and Tier 3) may be dispensed up to a 90 day supply. Member must pay the cost of the drug and file a claim for reimbursement under the major medical point-of-sale drug program.
- Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Pharmacy Select Network. Go to AlabamaBlue.com/SelfAdministratedSpecialtyDrugList for a list of these specialty drugs.

#### Participating Pharmacy:
- Tiers 2 & 3 drugs are covered at 80% of the allowance, subject to the calendar year deductible. **Claims Authorization Number is required.**

#### Non-Participating Pharmacy:
- No benefits are available for prescriptions purchased at a non-Participating Pharmacy.

### LGHIB DISCOUNTED VISION CARE PROGRAM
(Note: This is a LGHIB administered benefit. No claims should be filed to Blue Cross and Blue Shield of Alabama.)

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK (PPO)</th>
<th>OUT-OF-NETWORK (NON-PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Eye Exam</td>
<td>Routine examinations are limited to one per year for a $40 fee when a participating provider is used. Please see benefit booklet for additional program provisions. LGHIP’s vision network is on our website at <a href="http://www.lghip.org">www.lghip.org</a>.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

#### Note:
- Teladoc® is an independent company providing phone and online physician consultation services to Blue Cross and Blue Shield of Alabama members.
- Prime Therapeutics LLC® is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.

For precertification call 1-800-248-2342. Call Blue Cross and Blue Shield of Alabama at 1-800-321-4391. Visit the Local Government Health Insurance Board’s website at www.lghip.org.

The LGHIP is a self-insured health benefits plan administered by the LGHIB. The LGHIP provides minimum essential coverage and meets the minimum value standard as defined by the Affordable Care Act.

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. Please visit our website at www.AlabamaBlue.com.

MKT-180 (REV 12-2018)
Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.


Foreign Language Assistance


Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711)。


Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।


Turkish: DIKKAT: Eğer Türkçe konuşuyorsanız, dil yardım hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.


Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。