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BlueCard® PPO
Plan Benefits

Local Government Health Insurance Plan
BlueCard PPO
Group 30000

Effective January 1, 2015

Visit the Local Government Health Insurance Board's website at LGHIP.org or call 1.866.836.9137

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

LOCAL GOVERNMENT JANUARY 1, 2015

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 at www.bcbs.com/healthtravel/finder.html. 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 "Benefit Conditions."

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance, subject to a $200 per admission deductible and $50 co-pay per day for days 2-5	Covered at 80% of the allowance, subject to a $200 per admission deductible if pre-certification obtained within 72 hours. If pre-certification received late, covered at 80% of the allowance, subject to a $600 per admission deductible. No benefits if pre-certification is not obtained. $50 co-pay per day for days 2-5
Preadmission Certification	All hospital admissions, including emergency admissions, require preadmission certification within 72 hours, except maternity. For preadmission certification, call 1-800-551-2294. Generally, If preadmission certification is not obtained, no benefits are available.	
OUTPATIENT HOSPITAL BENEFITS		
Surgery	Covered at 100% of the allowance, subject to the $100 facility co-pay. Certain outpatient surgeries require pre-certification, call 1-800-551-2294.	Covered at 80% of the allowance, subject to the calendar year deductible. Certain outpatient surgeries require pre-certification, call 1-800-551-2294.
Medical Emergency	Covered at 100% of the allowance, subject to the $200 facility co-pay.	Covered at 100% of the allowance, subject to the $200 facility co-pay.
Accidental Injury **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **Emergency Room (Medical Emergency)** above.	Covered at 100% of the allowance with no deductible or co-pay required if services are provided within 72 hours of the accident.	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.
Diagnostic X-rays & Tests	Covered at 100% of the allowance, subject to the $100 facility co-pay per visit or cost of service, whichever is less.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic Lab & Pathology	Covered at 100% of the allowance, subject to a $3 co-pay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Note: In Alabama, inpatient and outpatient benefits for non-member hospitals are available only in cases of accidental injury and covered as an out-of-network hospital.		
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Physician Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $35 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 & 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.
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.	Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
Lab & Pathology Exams	Covered at 100% of the allowance, subject to a $3 co-pay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Tests	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
ROUTINE PREVENTIVE CARE		
Routine Immunizations and Preventive Services	Covered at 100% of the allowance with no deductible or copay. See **AlabamaBlue.com/preventiveservices** for a listing of the specific immunizations and preventive services.	Covered at 80% of the allowance subject to the calendar year deductible. See **AlabamaBlue.com/preventiveservices** for a listing of the specific immunizations and preventive services.
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)	Covered at 80% of the allowance subject to the calendar year deductible. 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)
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.	Covered at 80% of the allowance, subject to the calendar year deductible.
SEIB 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.	Covered at 80% of the allowance, subject to the calendar year deductible.
SEIB 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	$6,250 individual annual out-of-pocket maximum; $12,500 aggregate family maximum. **In-Network Services:** Deductibles, copays and coinsurance for in-network services and out-of-network mental health disorders/substance abuse emergency services apply to the out-of-pocket maximum, including prescription drugs (excludes Medicare Blue Rx plan). 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 (with the exception of deductibles, copays and coinsurance for mental health disorders/substance abuse emergency services).	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MAJOR MEDICAL SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th visit. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.	**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. If more than one provider is being utilized (even if the provider is under the same tax identification number) precertification is required again after the 25th visit.
Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits each calendar year. *Preauthorization* is required after the 15th visit to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	
Allergy Testing & Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Participating Home Health Services	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 1-800-551-2294. **NOTE:** No coverage for services rendered by a non-participating Home Health agency.	
Diabetic Education	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 1-800-551-2294.	
PRESCRIPTION DRUGS – ACTIVE AND NON-MEDICARE RETIREES		
Prescription Drug Card Program for Tier 1 Drugs	**Participating Pharmacy:** Tier 1 drugs covered at 100% of the allowance subject to a $5 co-pay per prescription; 60-day supply on maintenance drugs for one co-pay.	**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	**Participating Pharmacy:** Tier 2 and Tier 3 drugs covered at 80% of the allowance, subject to the calendar year deductible. Claims Authorization Number required.	**Non-Participating Pharmacy:** No benefits are available for prescriptions purchased at a non-Participating Pharmacy.
PRESCRIPTION DRUGS – MEDICARE RETIREES AND MEDICARE DEPENDENTS OF RETIREES–LGHIP's EMPLOYER GROUP WAIVER PLAN (EGWP)		
Prescription Drug Card Program for Tier 1 Drugs	**Preferred/Extended Supply Network Pharmacies** $5 co-pay for 30-day supply $10 co-pay for 60-day supply $10 co-pay for 90-day supply **Non-Preferred Pharmacies** $5 co-pay for 30-day supply $10 co-pay for 60-day supply $15 co-pay for 90-day supply	**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	**Retail & Extended Supply Network Pharmacies** 20% coinsurance after the $100 drug deductible is met. Deductible applies only to Medicare covered Part D Drugs.	**Non-Participating Pharmacy:** No benefits are available for prescriptions purchased at a non-Participating Pharmacy.
VISION CARE (Note: This is an SEIB administered benefit. No claims should be filed to Blue Cross and Blue Shield of Alabama.)		
Routine Eye Exam	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. SEIB's vision network is on our website at **www.alseib.org**	Not covered.

For precertification call 1-800-551-2294. Call Blue Cross and Blue Shield of Alabama at 1-800-321-4391. Visit Local Government's website at LGHIP.org.

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