BlueCard® PPO

Local Government
Health Insurance Plan
BlueCard PPO

Group 30000

Effective July 1, 2012

Visit The State Employees' Insurance Board's (SEIB) website at www.alseib.org or call 1-866-836-9137

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PLAN BENEFITS

Visit our web site at www.bcbsal.com

Local Government
July 1, 2012

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 $100 per admission deductible if pre-certification obtained within 48 hours. If pre-certification received late, covered at 100% of the allowance, subject to a $500 per admission deductible. No benefits if pre-certification is not obtained. $50 co-pay per day for days 2-5	Covered at 80% of the allowance, subject to a $100 per admission deductible if pre-certification obtained within 48 hours. If pre-certification received late, covered at 80% of the allowance, subject to a $500 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 require preadmission certification except maternity. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1-800-551-2294. 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 $100 facility co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Accidental Injury	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.
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 $30 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.	Not Covered.
Emergency Room	Covered at 100% of the allowance, subject to the office visit co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
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		
Inpatient Visits for Routine Newborn Care	Initial inpatient newborn well baby examination covered at 100% of the allowance with no deductible or co-pay.	Initial inpatient newborn well baby examination covered at 80% of the allowance, subject to the calendar year deductible.
Routine Physical Exams	Covered at 100% of the allowance, subject to the office visit co-pay. Nine Well Child visits are allowed from birth to age 2. One visit per calendar year allowed from age 2 to any age. One gynecological exam per year allowed for females age 6 to any age.	Covered at 80% of the allowance, subject to the calendar year deductible. Nine Well Child visits are allowed from birth to age 2. One visit per calendar year allowed from age 2 to any age. One gynecological exam per year allowed for females age 6 to any age.
Routine Immunizations (Age limitations apply to certain immunizations)	Covered at 100% of the allowance with no deductible or co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Routine Mammograms	Covered at 100% of the allowance with no deductible or co-pay. Limited to one baseline exam for females between the ages of 35-39 and one exam per year for females age 40 and over.	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to one baseline exam for females between the ages of 35-39 and one exam per year for females age 40 and over.
Routine Pap Smear	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.
Routine HPV Screening	Covered at 100% of the allowance, subject to a $3 co-pay per test. Limited to once every three years for females, beginning at age 30.	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to once every three years for females, beginning at age 30.
Routine Prostate Specific Antigen	Covered at 100% of the allowance with no deductible or co-pay. Limited to one screening each calendar year for males age 40 and over.	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to one screening each calendar year for males age 40 and over.
Routine Colorectal Cancer Screening	Covered at 100% of the allowance, subject to the applicable co-pay. Limited to the following for members age 50 and over: • Fecal occult blood test each year • Flexible sigmoidoscopy every three years • Double-contrast barium enema every five years • Colonoscopy every 10 years	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to the following for members age 50 and over: • Fecal occult blood test each year • Flexible sigmoidoscopy every three years • Double-contrast barium enema every five years • Colonoscopy every 10 years
Other Routine Screenings	Covered at 100% of the allowance, subject to a $3 co-pay per test. Includes the following: Lead screening once by age 2; urinalysis once by age 5, then once between ages 12-17; TB skin testing once before age 1, once between the ages of 1-4 and once between the ages 14-18; CBC ages 6-17, one every other year, then annually, age 18 and older; cholesterol testing (annually, age 18 and older); glucose testing (annually, age 18 and older).	Covered at 80% of the allowance, subject to the calendar year deductible. Includes the following: Lead screening once by age 2; urinalysis once by age 5, then once between ages 12-17; TB skin testing once before age 1, once between the ages of 1-4 and once between the ages 14-18; CBC ages 6-17, one every other year, then annually, age 18 and older; cholesterol testing (annually, age 18 and older); glucose testing (annually, age 18 and older).
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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar Year Deductible	$200 per person each calendar year; Maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$1,000 individual annual out-of-pocket maximum plus the $200 calendar year deductible. Other Covered Services and Point-of-Sale Prescription Drugs are the only expenses applicable to the annual out-of-pocket maximum. **Services covered under the PPO, provided by non-PPO providers do not apply to the Annual Out-of-Pocket Maximum.**	
MAJOR MEDICAL SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible.	**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.
Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and medical review.	
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; limited to 6 services in a home setting (including, but not limited to physical, occupational, and speech therapy); services in excess of this maximum must be certified through case management; 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		
Prescription Drug Card Program	**Participating Pharmacy:** Generic 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	**Participating Pharmacy:** Brand name 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.
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 SEIB's website at www.alseib.org.

Your group believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, this plan does not have to include certain consumer protections of the Affordable Care Act that apply to Non-grandfathered plans. Benefits are subject to the terms, limitations and conditions of the group contract. Check your benefit booklet for more detailed coverage information.