



BlueCard[®] PPO

Local Government Health Insurance Plan BlueCard PPO

Group 30000

Effective January 1, 2010

Visit our web site 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

P L A N B E N E F I T S

Visit our web site at www.bcbsal.com

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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		
Deductibles & Co-pays	\$100 per admission deductible if pre-certification obtained within 48 hours; if pre-certification received late, \$500 deductible per admission; No benefits if pre-certification is not obtained. \$50 co-pay per day for days 2-5	\$100 per admission deductible if pre-certification obtained within 48 hours; if pre-certification received late, \$500 deductible per admission; No benefits if pre-certification is not obtained. \$50 co-pay per day for days 2-5
Inpatient Facility Coverage (including maternity)	100% coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries. Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury and covered as an out-of-network hospital.	80% coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
Preadmission Certification	All hospital admissions require preadmission certification except maternity. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1 800 248-2342. 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 1 800 248-2342.	Covered at 80% of the allowance, subject to the calendar year deductible. Certain outpatient surgeries require pre-certification, call 1 800 248-2342.
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.
Hemodialysis, IV Therapy, Blood Transfusions, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance, subject to the \$25 facility co-pay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Note: In Alabama, outpatient benefits for non-member hospitals are available only in cases of accidental injury.		
PHYSICIAN / NURSE PRACTITIONER 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 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 (once every 5 years beginning at age 18), hemocult stool check (annually, ages 50 and over).	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 (once every 5 years beginning at age 18), hemocult stool check (annually, ages 50 and over).
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 (see benefit booklet for listing)	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 per calendar year.
SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance, subject to a \$200 inpatient per admission deductible; limited to a maximum of 30 days per person each calendar year; limited to a maximum payment of \$9,600 per person each calendar year; limited to a lifetime maximum of \$12,000 per person.	Covered at 80% of the allowance, subject to a \$200 inpatient per admission deductible; limited to a maximum of 30 days per person each calendar year; limited to a maximum payment of \$9,600 per person each calendar year; limited to a lifetime maximum of \$12,000 per person.
Inpatient Physician Services	Covered at 80% of the allowance; limited to a maximum of 30 days per person each calendar year; limited to a maximum payment of \$9,600 per person each calendar year; limited to a lifetime maximum of \$12,000 per person.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to a maximum of 30 days per person each calendar year; limited to a maximum payment of \$9,600 per person each calendar year; limited to a lifetime maximum of \$12,000 per person.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
SUBSTANCE ABUSE SERVICES (Continued)		
SEIB Approved Outpatient Provider Services (see benefit booklet for listing)	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.
Note: The calendar year lifetime maximums are aggregate for In-Network and Out-of-Network; Inpatient and Outpatient Services.		
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.	
Lifetime Maximum	\$1,000,000 lifetime maximum for each covered member. Only the following services are applicable to the lifetime maximum: Other Covered Services, non-PPO Physician Services, non-PPO outpatient facility services (excluding care rendered within 72 hours), physician services for the treatment of mental health and substance abuse services, and Point-of-Sale Prescription Drug. Services covered under the PPO, provided by PPO providers do not apply toward the Major Medical Benefit Period and Lifetime maximums.	
OTHER COVERED SERVICES		
TMJ Services	Covered at 80% of the allowance with no deductible; non-surgical management of TMJ limited to a maximum payment of \$450 per person each calendar year; surgical management is limited to \$3,000 per person each calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; non-surgical management of TMJ limited to a maximum payment of \$450 per person each calendar year; surgical management is limited to \$1,000 per person each calendar year.
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.
Speech Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to 30 sessions per person per calendar year.	
Physical Therapy	Covered at 80% of the allowance, subject to the calendar year deductible.	
Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible; Limited to Hand Therapy Procedures and services related to Lymphedema.	
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.	
Hearing Aid Benefits	Covered at 100% for routine hearing services; limited to a maximum of \$100 per person each calendar year.	
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) per person each 30 consecutive days; services in excess of this maximum must be certified through case management; call 1 800 248-2342. 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 1 800 248-2342.	
Private Duty Nursing	Covered at 80% of the allowance, subject to the calendar year deductible. Pre-certification required. Call 1 800 248-2342.	
PRESCRIPTION DRUGS		
Point-of-Sale Drug Program*	Participating Pharmacy: Generic drugs and 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 Lenses & Frames	Routine examinations are limited to one per year for a \$40 fee when a participating provider is used. Frames and lenses are discounted 25% off retail prices.	Not covered.

* Point-of-sale drug benefits apply unless your group has selected a prescription drug rider.

For Precertification call 1 800 248-2342
Call Blue Cross and Blue Shield of Alabama at 1 800 321-4391
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