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BlueCard® PPO
Plan Benefits

Local Government Health Insurance Plan
BlueCard® PPO
Group 30000

Effective January 1, 2017

Visit the Local Government Health Insurance Board's website at www.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, 2017

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 "Benefit Conditions."

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
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.		
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 and $50 co-pay per day for days 2-5.
OUTPATIENT HOSPITAL BENEFITS		
Precertification is required for certain outpatient hospital benefits, including radiology services, and a select group of physician-administered drugs; visit AlabamaBlue.com and the benefit booklet. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.		
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 $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 **(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 or medical emergency and covered as an out-of-network hospital.		
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Precertification is required for a select group of physician-administered drugs; visit AlabamaBlue.com/DrugList. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.		
Physician Office Visits, Office Surgery & 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 & 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 A telephone and online video consultation service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. Telephone and online video consultations are available 24 hours a day, 7 days a week.	Covered at 100% of the allowance.	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.	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 or call our Customer Service Department for a printed copy.	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 or call our 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)	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.
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.	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	$6,250 individual annual out-of-pocket maximum; $12,500 family maximum. **In-Network Services:** Deductibles, copays and coinsurance for in-network 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.	
MAJOR MEDICAL SERVICES		
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.		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th 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.
Rehabilitative Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits for each therapy each calendar year. *Preauthorization* is required after the 15th visit to determine the medical necessity for continued therapy. **Call 1-800-248-2342 for precertification.** If preauthorization is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Habilitative Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits for each therapy each calendar year. *Preauthorization* is required after the 15th visit to determine the medical necessity for continued therapy. **Call 1-800-248-2342 for precertification.** 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 **1-800-248-2342**. **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**.	
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 $10 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:** 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.
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** $10 co-pay for 30-day supply $20 co-pay for 60-day supply $20 co-pay for 90-day supply **Non-Preferred Pharmacies** $10 co-pay for 30-day supply $20 co-pay for 60-day supply $30 co-pay for 90-day supply	**Non-Participating Pharmacy:** In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Please call BCBS customer service if you have any additional questions at 1-800- 321-4391.
Point-of-Sale Drug Program for Tier 2, Tier 3, and Tier 4 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:** In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Please call BCBS customer service if you have any additional questions at 1-800- 321-4391.
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.)		
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. LGHIP's vision network is on our website at **www.lghip.org**	Not covered.

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

The LGHIP is a self-insured health benefits plan administered by the Local Government Health Insurance Board. 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.

Statement 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.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)
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）。