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BlueCard® PPO
Plan Benefits

State Employees' Health Insurance Plan
BlueCard PPO
Group 13000

Effective January 1, 2015

Visit the State Employees' Insurance Board's (SEIB) website at www.alseib.org or call 1-866-836-9737

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

SUMMARY OF BENEFITS

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 see 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 $25 co-pay per day for days 2-5.	Covered at 80% of the allowance, subject to a $200 per admission deductible if precertification obtained within 72 hours. If precertification received late, covered at 80% of the allowance, subject to a $600 per admission deductible.
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 a $150 facility co-pay. Certain outpatient surgeries require precertification, call 1-800-551-2294.	Covered at 80% of the allowance subject to the calendar year deductible. Certain outpatient surgeries require precertification, call 1-800-551-2294.
Medical Emergency	Covered at 100% of the allowance subject to a $150 facility co-pay for true medical emergencies.	Covered at 100% of the allowance subject to a $150 facility co-pay for true medical emergencies.
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 within 72 hours of the accident. Thereafter, covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 100% of the allowance with no deductible or co-pay 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.
Urgent Care Facility	Covered at 100% of the allowance subject to a $50 co-pay.	Covered at 80% of the allowance subject to the calendar year deductible.
Diagnostic X-rays and Tests	Covered at 100% of the allowance subject to a $75 facility co-pay (one co-pay per test; limited to 2 co-pays per date of service.) for each of the following: Angiography/arteriography, cardiac cath/arteriography, colonoscopy, UGI endoscopy, CAT Scan, MRI, MUGA-Gated Cardia Scan, ERCP, PET/PECT and Thallium Scan.	Covered at 80% of the allowance subject to the calendar year deductible.
Diagnostic Lab and Pathology	Covered at 100% of the allowance subject to a $7.50 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 and Outpatient Consultations	Covered at 100% of the allowance subject to a $35 office visit co-pay.	Covered at 80% of the allowance subject to the calendar year deductible.
Nurse Practitioner / Nurse Midwives, Physician Assistant Office Visits, Office Surgery and Outpatient Consultations	Covered at 100% of the allowance subject to a $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 applicable office visit co-pay.	Covered at 100% of the allowance subject to the applicable office visit co-pay.
Out of Office Surgery and Anesthesia	Covered at 100% of the allowance.	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.
Diagnostic X-rays and Tests	Covered at 100% of the allowance.	Covered at 80% of the allowance subject to the calendar year deductible.
Lab and Pathology Exams	Covered at 100% of the allowance subject to a $7.50 co-pay per test.	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 with no deductible.	Covered at 80% of the allowance subject to a $100 per admission deductible.
Inpatient Provider Services	Covered at 80% of the allowance with no deductible or co-pay.	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 each calendar year.
SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance with no deductible or co-pay.	Covered at 80% of the allowance subject to a $100 per admission deductible
Inpatient Physician Services	Covered at 80% of the allowance with no deductible or co-pay.	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	$300 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). **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).	
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 and Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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 MEMBERS		
Prescription Drugs	**Participating Pharmacy:** Prescription drugs will be covered at 100%, subject to the following co-pays: ● Tier 1 - $10 co-pay per prescription for 30-day or 60-day supply; $15 co-pay per prescription for 90-day supply ● Tier 2 - 20% of the cost of the prescription with a minimum co-pay of $25 and a maximum co-pay of $40 per prescription; **limited to 30-day or 60-day supply.** ● Tier 3 - 20% of the cost of the prescription with a minimum co-pay of $55 and a maximum co-pay of $105 per prescription; **limited to 30-day supply.**	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a participating pharmacy where your drug card was not used.
PRESCRIPTION DRUGS – MEDICARE MEMBERS – BLUERX		
Tier 1 Drugs	**Preferred/Extended Supply Pharmacy:** • $10 co-pay for 30-day supply • $10 co-pay for 60-day supply • $10 co-pay for 90-day supply **Non-Preferred Pharmacy:** • $10 co-pay for 30-day supply • $10 co-pay for 60-day supply • $15 co-pay for 90-day supply	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a participating pharmacy where your drug card was not used.
Tier 2 Drugs	**Preferred/Extended Supply Pharmacy:** • $30 co-pay for 30-day supply • $30 co-pay for 60-day supply • $30 co-pay for 90-day supply **Non-Preferred Pharmacy:** • $30 co-pay for 30-day supply • $30 co-pay for 60-day supply • $55 co-pay for 90-day supply	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a participating pharmacy where your drug card was not used.
PRESCRIPTION DRUGS – MEDICARE MEMBERS – BLUERX (continued)		
Tier 3 & 4 Drugs	**Preferred/Extended Supply Pharmacy:** • $60 co-pay for 30-day supply • $60 co-pay for 60-day supply • $60 co-pay for 90-day supply **Non-Preferred Pharmacy:** • $60 co-pay for 30-day supply • $60 co-pay for 60-day supply • $115 co-pay for 90-day supply	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a participating pharmacy where your drug card was not used.
Zostavax, Flu & Pneumonia vaccines $0 co-pay when administered at a BlueRx Pharmacy. If administered at MD office or non-BlueRx Pharmacy, covered under Medicare Part B.		
SEIB DISCOUNTED VISION CARE PROGRAM (Note: This is an SEIB administered benefit. No claims are to be filed with Blue Cross and Blue Shield of Alabama.)		
Routine Eye Exam	Examinations are limited to one per year subject to a $40 member payment 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 1-800-824-0435
Visit our website at www.alseib.org