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BlueCard® PPO
Plan Benefits

State Employees'
Health Insurance Plan

Group 13000

Effective January 1, 2021

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

BlueCross BlueShield of Alabama

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 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. Please see the benefit booklet for more information.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Precertification is required for inpatient admissions (except medical emergency and maternity); notification is required within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-551-2294 for precertification. **Note:** In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury or medical emergency and covered as an out-of-network hospital.		
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance, subject to a $200 per admission deductible and $25 copay per day for days 2-5 per admission.	Covered at 80% of the allowance, subject to a $200 per admission deductible.
OUTPATIENT HOSPITAL BENEFITS		
Precertification is required for certain outpatient hospital benefits, radiology services, and a select group of physician-administered drugs; visit AlabamaBlue.com and the benefit booklet for more information. Call 1-800-551-2294 for precertification. If precertification is not obtained, no benefits are available. **Note:** In Alabama, 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.		
Surgery	Covered at 100% of the allowance, subject to a $150 facility copay. 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 copay for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention). Claims with emergency room charges that do not meet medical emergency guidelines will be considered under Major Medical.	Covered at 100% of the allowance, subject to a $150 facility copay for treatment of a medical emergency (treatment of sudden and severe symptoms that require immediate medical attention). Claims with emergency room charges that do not meet medical emergency guidelines will be considered under Major Medical.
Accidental Injury	Covered at 100% of the allowance with no deductible or copay required within 72 hours of the accident. Thereafter, covered at 80% of the allowance, subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the Plan.	Covered at 100% of the allowance with no deductible or copay within 72 hours of the accident; Thereafter, covered at 80% of the allowance, subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the Plan.
Urgent Care Facility	Covered at 100% of the allowance, subject to a $50 copay.	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 copay. One copay per test; limited to 2 copays 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.
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Precertification is required for a select group of physician-administered drugs; for more information visit AlabamaBlue.com/DrugList. Call 1-800-551-2294 for precertification. If precertification is not obtained, no benefits are available.		
Physician Office Visits, Office Surgery and Outpatient Consultations	Covered at 100% of the allowance, subject to a $35 office visit copay.	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 copay.	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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. To enroll, go to Teladoc.com/Alabama or call 1-855-477-4549.	Covered at 100% of the allowance.	Not covered.
Emergency Room	Covered at 100% of the allowance, subject to the applicable office visit copay.	Covered at 100% of the allowance, subject to the applicable office visit copay.
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.
Lab and Pathology Exams	Covered at 100% of the allowance, subject to a $7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
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 BCBS Customer Service at 1-800-824-0435 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 BCBS Customer Service at 1-800-824-0435 for a printed copy.
Additional Routine Preventive Services	Covered at 100% of the allowance with no deductible or copay. In addition to the standard services, 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) • Blood 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 services, 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) • Blood 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 copay.	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 copay 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 copay.	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 copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar Year Deductible	$300 per person each calendar year; maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$8,550 individual annual out-of-pocket maximum; $17,100 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 Rx plan). **Out-of-Network Services:** Deductibles, copays and coinsurance for out-of-network services do not apply to the out-of-pocket maximum.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MAJOR MEDICAL SERVICES		
Precertification is required for certain major medical services; please see benefit booklet. Call 1-800-551-2294 for precertification. If precertification is not 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.
Habilitative and Rehabilitative Physical, Speech, and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits for each service per calendar year. *Precertification* is required after the 15th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	Covered at 80% of the allowance, subject to the calendar year deductible and limited to 15 visits for each service per calendar year. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. *Precertification* is required after the 15th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
Applied Behavioral Analysis (AB) Therapy	Covered for children 18 years or younger at 100% of the allowance, subject to a $14 copay per visit and the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 *Precertification* is required prior to rendering ABA therapy to determine the medical necessity. *Precertification* is also required every six months thereafter to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.	Covered for children 18 years or younger at 80% of the allowance, subject to the calendar year deductible and the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 *Precertification* is required prior to rendering ABA therapy to determine the medical necessity. *Precertification* is also required every six months thereafter to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.
Applied Behavioral Analysis (ABA) Therapy	Covered for children 18 years or younger at 100% of the allowance, subject to a $14 copay per visit and the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 *Precertification* is required prior to rendering ABA therapy to determine the medical necessity. *Precertification* is also required every six months thereafter to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.	Covered for children 18 years or younger at 80% of the allowance, subject to the calendar year deductible and the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 *Precertification* is required prior to rendering ABA therapy to determine the medical necessity. *Precertification* is also required every six months thereafter to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Physical, Speech, and Occupational Therapy related to the screening, diagnosis, and treatment of Autism Spectrum Disorder for children 18 years of age or under	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. For coverage related to the screening, diagnosis, and treatment of Autism Spectrum Disorder, precertification shall be based on the most recent treatment plan. BCBS may only request an updated treatment plan once every six months from the treating licensed physician or licensed psychologist to review medical necessity, unless BCBS and the treating licensed physician or licensed psychologist agree that a more frequent review is necessary for a particular patient. Coverage is limited to children 18 years of age or under.	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 15th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied. For coverage related to the screening, diagnosis, and treatment of Autism Spectrum Disorder, precertification shall be based on the most recent treatment plan. BCBS may only request an updated treatment plan once every six months from the treating licensed physician or licensed psychologist to review medical necessity, unless BCBS and the treating licensed physician or licensed psychologist agree that a more frequent review is necessary for a particular patient. Coverage is limited to children 18 years of age or under.
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	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.
Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	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.
Allergy Testing and Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	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.
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.	Not covered.
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 for certification.	Not covered.
Medical Nutrition Therapy For Adults and Children, 6 hours per member per calendar year	Covered at 100% of the allowance, subject to a $35 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury; for more information, please call 1-800-551-2294 and press 3.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease and other specialized conditions; for more information, please call 1-800-551-2294 and press 5.	
Baby Yourself®	A maternity program; the hospital deductible and daily copay's may be waived on the maternity inpatient admission at delivery if the member enrolls in the Baby Yourself Program within the first two trimesters of pregnancy. For more information, please call 1-800-551-2294 and press 4. You can also enroll online at **AlabamaBlue.com/BabyYourself.**	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS – ACTIVE AND NON-MEDICARE MEMBERS Prescription drug benefits are administered by OptumRx. For more information, call OptumRx Member Services at 1-844-785-1604 or visit the website at www.OptumRx.com.		
Prescription Drugs	**Participating Pharmacy:** Prescription drugs will be covered at 100%, subject to the following copays: • Tier 1 - $10 copay per prescription for 30-day or 60-day supply; $15 copay per prescription for 90-day supply. • Tier 2 - 20% of the cost of the prescription with a minimum copay of $40 and a maximum copay of $80 per prescription; limited to 30, 60 or 90-day supply. • Tier 3 - 20% of the cost of the prescription with a minimum copay of $60 and a maximum copay of $120 per prescription; limited to 30-day supply. • Tier 4 - 50% of the cost of the prescription with a maximum copay of $150 per prescription; limited to 30-day supply. • Tier 5 - Specialty Drugs- $150 copay per prescription; limited to 30-day supply. Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs.	**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.

This is not a contract, benefit booklet or Summary Plan Description.
Benefits are subject to the terms, limitations and conditions of the group contract (including your benefit booklet).
Check your benefit booklet for more detailed coverage information.

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
Group 13000
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Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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)
Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.
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）。
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).
Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).
German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche leistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).
French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855-216-3144 (ATS: 711).
French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).
Gujarati: ધ્યાન આપો: જો તમે ગજરાતી બોલતા હો, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).
Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).
Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं।
1-855-216-3144 (TTY: 711) पर कॉल करें।
Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).
Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).
Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).
Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).
Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.
Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).
Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。