



BlueCard[®] PPO

State of Alabama Employees' Insurance Board BlueCard PPO

Group 13000

Effective January 1, 2012

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

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

Visit our web site at www.bcbsal.com

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 if precertification obtained within 48 hours. If precertification received late, covered at 100% of the allowance, subject to a \$500 per admission deductible. No benefits if precertification is not obtained. \$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 48 hours. If precertification received late, covered at 80% of the allowance, subject to a \$500 per admission deductible. No benefits if precertification is not obtained.
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 a \$100 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 \$50 facility co-pay for true medical emergencies.	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 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, 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 \$10 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.	Not covered
Emergency Room Physician Fees	Covered at 100% of the allowance subject to the applicable office visit co-pay.	Covered at 80% of the allowance subject to the calendar year deductible.
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 \$10 co-pay per test (including routine pap smears).	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 \$10 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 \$10 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 per year for males age 40 and over.	Covered at 80% of the allowance subject to the calendar year deductible. Limited to one screening per 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 Screening	Covered at 100% of the allowance subject to a \$10 co-pay per test. Includes 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 ages 1-4 and once between ages 14-18; CBC ages 6-17, one every other year, then annually, age 18 and older; cholesterol and glucose testing annually, age 18 and older.	Covered at 80% of the allowance subject to the calendar year deductible. Includes 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 ages 1-4 and once between ages 14-18; CBC ages 6-17, one every other year, then annually, age 18 and older; cholesterol and glucose testing annually, age 18 and older.
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.
Outpatient Provider Services	Covered at 80% of the allowance with no deductible; limited to 20 visits per person each 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.
Outpatient Physician Services	Covered at 80% of the allowance; limited to 20 visits per person each calendar year.	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	\$100 per person each calendar year; Maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	\$400 individual annual out-of-pocket maximum plus the \$100 calendar year deductible. Other Covered Services 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.
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 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 and 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 DRUG BENEFITS		
Prescription Drugs Note: \$2,500 individual prescription drug annual out-of-pocket maximum	<p>Participating Pharmacy: Prescription drugs will be covered at 100%, subject to the following co-pays:</p> <p><u>Active employees and Non-Medicare retirees</u></p> <ul style="list-style-type: none"> • Tier 1 - \$10 co-pay per prescription • 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 • 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. <p><u>Medicare retiree contracts</u></p> <ul style="list-style-type: none"> • Tier 1 - \$5 co-pay per prescription • Tier 2 - maximum co-pay of \$25 per prescription • Tier 3 - maximum co-pay of \$55 per prescription; limited to 30 day supply. 	<p>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.</p>
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

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
DENTAL BENEFITS (Note: Member is responsible for any difference between billed charges and the fee schedule when using a non-participating provider.)		
Deductible	\$25 per person each calendar year; maximum of three deductibles per family, subject to \$1,500 maximum per person per calendar year.	\$25 per person each calendar year; maximum of three deductibles per family, subject to \$1,500 maximum per person per calendar year.
Diagnostic & Preventive Services	Covered at 100% of the Preferred Dental Fee Schedule with no deductible.	Covered at 100% of the Preferred Dental Fee Schedule with no deductible.
Basic and Major Services (Fillings, Oral Surgery, etc.)	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible.	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible.
Orthodontic Services	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible and a separate lifetime maximum of \$1,000 per person.	Covered at 50% of the Preferred Dental Fee Schedule subject to a \$25 annual deductible and a separate lifetime maximum of \$1,000 per person.

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

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.

Group 13000 LW
 Revised 11/08/11 RM