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BlueCard® PPO
Plan Benefits

Local Government Health Insurance Plan
BlueCard® PPO
Group 30000

Effective January 1, 2020

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 Health Insurance Plan
JANUARY 1, 2020

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 the "Benefit Conditions" section of the Plan's hand book.

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 copay per day for days 2-5	Covered at 80% of the allowance, subject to a $200 per admission deductible and $50 copay 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 provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. 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 copay. 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 copay.	Covered at 100% of the allowance, subject to the $200 facility copay.
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 copay 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.	Covered at 100% of the allowance with no deductible or copay 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 copay 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 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance, subject to the $25 facility copay.	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 provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. 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 copay.	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 copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Second Surgical Opinion	Covered at 100% of the allowance; no copay or deductible	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; no copay or deductible	Not covered.
Emergency Room	Covered at 100% of the allowance, subject to the office visit copay.	Covered at 100% of the allowance, subject to the office visit copay.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Inpatient Visits	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance; no copay or deductible	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 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Tests	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
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 immunizations and preventive services or call the BCBS 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 immunizations and preventive services or call 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)
Note: Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		
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, no copay or deductible.	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 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 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; no copay or deductible.	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 copay per visit; limited to 20 visits per person per calendar year. (Other copays 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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar Year Deductible	$200 per person each calendar year; maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$8,150 individual annual out-of-pocket maximum; $16,300 family maximum. **In-Network Services:** Deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum, including prescription drugs. 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. After you reach your Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowance for remainder of the calendar year.	
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.
Applied Behavioral Analysis (ABA) Therapy	For children 18 years or younger, covered at 100% of the allowance after $14 copay per visit and subject to 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 medical necessity. Precertification is also required every six months thereafter to determine 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.	For children 18 years or younger, covered at 80% of the allowance subject to calendar year deductible and 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 medical necessity. Precertification is also required every six months thereafter to determine 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.
Physical Therapy, Speech Therapy and Occupational Therapy related to the screening, diagnosis, and treatment of Autism Spectrum Disorder	For children 18 years or younger, 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. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	For children 18 years or younger, 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. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
Rehabilitative and Habilitative Physical Therapy, Speech Therapy and Occupational Therapy	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. Call 1-800-248-2342 for precertification. 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. 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. Call 1-800-248-2342 for precertification. If precertification 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)
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		
Prescription drug benefits are covered through OptumRx®. For more information, call OptumRx Member Services at 1 844-785-1603 or visit the website at www.OptumRx.com.		
TIER 1 DRUGS (PRESCRIPTION DRUG CARD PROGRAM) • Generic non-maintenance drugs may be dispensed up to a 30-day supply. • Generic maintenance drugs may be dispensed up to a 60-day supply, for one $10 copay, after an initial 30-day supply fill. • The plan utilizes the OptumRx Premium Formulary; however, plan benefits will supersede the Premium Formulary drug list.	Covered at 100% of the allowance subject to a $10 copay per prescription	No benefits are available for prescriptions purchased at a non-participating pharmacy.
TIER 2 AND TIER 3 DRUGS (POINT OF SALE DRUG PROGRAM) • Brand drugs (Tier 2 and Tier 3) may be dispensed up to a 90-day supply. Member must pay the cost of the drug and file a claim for reimbursement. • The prescription claim ID number is required for reimbursement requests. • Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Optum Specialty Pharmacy. Call Optum Specialty Pharmacy at 1-855-427-4682 for more information.	Covered at 80% of the allowance after being submitted for reimbursement. Subject to the calendar year deductible of $200.	No benefits are available for prescriptions purchased at a non-participating pharmacy.
HEALTH MANAGEMENT BENEFITS		
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.**	

Note: Teladoc® is an independent company providing phone and online physician consultation services to Blue Cross and Blue Shield of Alabama members.

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

The LGHIP is a self-insured health benefits plan administered by the LGHIB. 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.

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Group 30000
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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 باللغات، 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 નિ:શુલ્ક 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, ໂດຍບໍ່ເສັງຄ່າ, 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。