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BlueCard[®] PPO Plan Benefits

**Local Government
Health Insurance Plan
BlueCard[®] PPO
Group 30000**

Effective January 1, 2018

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, 2018

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 provider-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.
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance, subject to the \$25 facility co-pay.	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/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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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.
IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance.	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. <ul style="list-style-type: none"> See AlabamaBlue.com/preventiveservices and AlabamaBlue.com/StandardACAPreventiveDrugList for a listing of the specific drugs, 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. <ul style="list-style-type: none"> See AlabamaBlue.com/preventiveservices and AlabamaBlue.com/StandardACAPreventiveDrugList for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy
Additional Routine Preventive Services Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See AlabamaBlue.com/pharmacy for more information.	Covered at 100% of the allowance with no deductible or copay. In addition to the standard, the following will apply: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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.	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	\$7,350 individual annual out-of-pocket maximum; \$14,700 family maximum.	
	<p>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.</p> <p>Out-of-Network Services: Do not apply to the out-of-pocket maximum.</p>	

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 1-800-248-2342 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. <i>Preauthorization</i> is required after the 15 th 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.	
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. <i>Preauthorization</i> is required after the 15 th 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		
Prescription Drug Card Program for Tier 1 Drugs <ul style="list-style-type: none"> The pharmacy network for the plan is the Prime Participating Pharmacy Network 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 with one copay Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Pharmacy Select Network. Go to AlabamaBlue.com/web/pharmacy/drugguide.htm for a list of these specialty drugs. View the Standard Prescription Drug list that applies to the plan at AlabamaBlue.com/web/pharmacy/drugguide.html 	Participating Pharmacy: Tier 1 drugs covered at 100% of the allowance subject to a \$10 co-pay per prescription. Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See AlabamaBlue.com/pharmacy for more information.	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 <ul style="list-style-type: none"> The pharmacy network for the plan is the Prime Participating Pharmacy Network 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 under the major medical point-of-sale drug program. Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Pharmacy Select Network. Go to AlabamaBlue.com/web/pharmacy/drugguide.htm for a list of these specialty 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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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.

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Group 30000
Effective January 1, 2018

Notice 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. 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 Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés 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 ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ 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 नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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。