Jefferson County Commission

BlueCard® PPO

Effective October 01, 2018

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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.		
SUMMARY OF COST SHARING PROVISIONS		
Plan Year Deductible	$200 per person per plan year; no family maximum Applies to Chiropractor Services, Allergy Testing and Treatment, Durable Medical Equipment (DME), Physical Therapy, Speech Therapy, Occupational Therapy, Skilled Nursing Facility, Temporomandibular Joint Services (TMJ) and Ambulance Services.	$1,000 per person each plan year; 2 member family maximum
Plan Year Out-of-Pocket Maximum	$2,000 individual; 2 member family maximum All deductibles, copays and coinsurance for in-network services (except Skilled Nursing services) apply to the out-of-pocket maximum. Coinsurance for out-of-network Home Health, Hospice and Other Covered Services (excluding occupational therapy, physical therapy, speech therapy and DME in Alabama) applies to the out-of-pocket maximum. After you reach Plan Year Out-of-Pocket Maximum, applicable expenses covered at 100% for remainder of calendar year.	
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS		
Precertification is required for inpatient admissions (except medical emergency services and maternity); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll-free) for precertification.		
Inpatient Hospital Facilities	Covered at 100% of the allowed amount, after $100.00 hospital copay per day for days 1-3 Covered for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	Covered at 50% of the allowed amount, subject to plan year deductible Covered for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
OUTPATIENT HOSPITAL BENEFITS		
Precertification is required for some outpatient hospital benefits and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available. **NOTE: Facility copay waived for services rendered at Cooper Green Health Services Facility (Tax ID 636001579)**		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, after $100.00 hospital copay	Covered at 50% of the allowed amount, subject to plan year deductible
Emergency Room (Medical Emergency) Copay waived if admitted within 24 hours.	Covered at 100% of the allowed amount, subject to $150.00 hospital copay	Covered at 100% of the allowed amount, subject to $150.00 hospital copay
Emergency Room Non-Emergency	Covered at 50% of the allowed amount, subject to out-of-network plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Accident) **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 allowed amount, subject to $150.00 hospital copay Copay waived if admitted within 24 hours.	Covered at 100% of the allowed amount, subject to $150.00 hospital copay for services rendered within 72 hours; covered at 50%, subject to the plan year deductible when services are rendered after 72 hours after the accident and not a medical emergency as defined by the plan
Emergency Room (Physician)	Covered at 100% of the allowed amount, subject to $25.00 physician copay	Covered at 100% of the allowed amount, subject to $25.00 physician copay
Chemotherapy, Hemodialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
PHYSICIAN BENEFITS		
Precertification is required for some physician benefits and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits and In-Person Consultations	Covered at 100% of the allowed amount, subject to $25.00 physician copay **Note:** Office visit copay waived at Cooper Green Mercy Health Services	Covered at 50% of the allowed amount, subject to plan year deductible
Surgery & Anesthesia	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Maternity Care	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Infertility Services (Diagnostic & Testing)	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Diagnostic Lab & X-ray	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services 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 100% of the allowed amount, no copy or deductible	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Additional Preventive Services	Covered at 100% of the allowed amount, no copay or deductible • Urinalysis (when necessary) • CBC (when necessary) • TB skin testing (when necessary) • Bone density scan (when necessary) • Chest x-ray (annually) • EKG (annually) • Cholesterol screening and/or Lipid panel (annually)	Not Covered
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		
PRESCRIPTION DRUG BENEFITS **Precertification is required for some drugs; if precertification is not obtained, no benefits are available.**		
Retail Prescription Drug Card Benefits • The pharmacy network for the plan is **Prime Participating Network** • Some copays combined for diabetic supplies • Prescription drugs (other than maintenance drugs) - up to a 30-Day supply • Maintenance-up to a 60 day supply for 2 copays or up to a 90 day supply for 3 copays • The only in-network pharmacy for some specialty drugs is the **Pharmacy Select Network**; visit **AlabamaBlue.com/DrugList** for a list of these drugs • View the **Standard Prescription Drug List (Up to 4 Tier)** drug lists that apply to the plan at **AlabamaBlue.com/DrugList** • Locate a **Prime Participating Network** pharmacy at **AlabamaBlue.com/pharmacy**	Covered at 100% of the allowed amount, subject to the following copays: **Tier 1 Drugs:** $5 copay per prescription **Tier 2 Drugs:** $40 copay per prescription **Tier 3 Drugs:** $90 copay per prescription Insulin, insulin needles and syringes purchased on the same day will require only one copay Blood glucose stripes and lancets purchased on the same day will require only one copay Glucose monitors will always require a separate copay	Not Covered
Mail Order Pharmacy Benefits • Up to a 90-day supply with one copay • Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com** or call 1-800-391-1886) • Only maintenance drugs can be purchased through this mail order pharmacy service • View the Standard Prescription Drug List (Up to 4 Tier) drug lists that apply to the plan at **AlabamaBlue.com/DrugList** • Specialty Drugs are not available through mail order	Covered at 100% of the allowed amount, subject to the following copays: **Tier 1 Drugs:** $10 copay per prescription **Tier 2 Drugs:** $80 copay per prescription **Tier 3 Drugs:** $180 copay per prescription	Not Covered
BENEFITS FOR OTHER COVERED SERVICES **Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.**		
Allergy Testing & Treatment	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Ambulance Service	Covered at 80% of the allowed amount, subject to the in-network plan year deductible	Covered at 80% of the allowed amount, subject to the in-network plan year deductible
Participating Chiropractic Services	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to 20 visits per person per plan year for each service Children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to 20 visits per person per plan year for each service Children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Bariatric Surgery	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
TMJ (Temporomandibular Joint Disorder) - Phase I only	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Organ Transplants	Covered at 100% of the allowed amount, no copay or deductible when rendered in a Centers of Excellence facility. Pre-approval is required.	Not Covered
Home Health and Hospice Home Health limited to a maximum of 60 visits per member per plan year Hospice limited to a 180 day lifetime maximum per person	Covered at 100% of the allowed amount, no copay or deductible Precertification required for services rendered outside of Alabama. Call 1-800-821-7231	**Non-Preferred in Alabama:** No benefits are available if a non-Preferred provider is used. **Outside Alabama:** Covered at 50% of the allowance, subject to plan year deductible. Precertification is required. Call 1-800-821-7231.

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Skilled Nursing Facility Limited to 60 days per person per plan year	Covered at 80% of the allowed amount, subject to the in-network plan year deductible	Covered at 80% of the allowed amount, subject to the in-network plan year deductible
MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE		
Mental Health Disorders and Substance Abuse	Mental Health Disorders and Substance Abuse benefits are not administered by Blue Cross and Blue Shield of Alabama	
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com.**	

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website **(AlabamaBlue.com)** or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*
- *Prime Therapeutics LLC® is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.*
- *Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-800-222-4379 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status*

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. Please visit our website, AlabamaBlue.com.

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 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, 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。