Jefferson County Commission

BlueCard® PPO

Effective October 1, 2017

Jefferson County Commission
BlueCard® PPO
Effective October 1, 2017

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
GENERAL PROVISIONS		
Deductible	$200 per person each 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
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 FACILITY SERVICES		
Inpatient Facility Coverage (including maternity)	$100 copay per day for days 1-3. Covered at 100% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	Covered at 50% of the allowance subject to the plan year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
Preadmission Certification	All hospital admissions require preadmission certification (except emergency hospital admissions and maternity); notification within 48 hours for emergencies. For preadmission certification, call 1-800-248-2342. If preadmission certification is not obtained, no benefits are available.	
Individual Case Management	Coordinates care in the event of a catastrophic or lengthy illness or injury. For more information, 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. For more information, call 1-800-841-5741.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com.**	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Precertification is required for some outpatient hospital benefits and physician-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)		
Surgery	Covered at 100% of the allowance, subject to a $100 facility copay.	Covered at 50% of the allowance, subject to the plan year deductible.
Emergency Room for Medical Emergency	Covered at 100% of the allowance, subject to a $150 facility copay. Copay waived if admitted within 24 hours.	Covered at 100% of the allowance, subject to a $150 facility copay. Copay waived if admitted within 24 hours.
Emergency Room for Medical Non-Emergency	Covered at 50% of the allowance, subject to the plan year deductible.	Covered at 50% of the allowance, subject to the plan year deductible.
Emergency Room for Accidental Injury **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 allowance, subject to a $150 facility copay. Copay waived if admitted within 24 hours.	Covered at 100% of the allowance, subject to a $150 facility copay for services rendered within 72 hours of the accident; 50% of the allowance, subject to the plan year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan.
Diagnostic Lab, X-ray, and Pathology	Covered at 100% of the allowance with no deductible or copay.	Covered at 50% of the allowance, subject to the plan year deductible.
Hemodialysis, IV Therapy Chemotherapy and Radiation Therapy	Covered at 100% of the allowance with no deductible or copay.	Covered at 50% of the allowance, subject to the plan year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PHYSICIAN SERVICES		
Precertification is required for some physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits and Outpatient Consultations	Covered at 100% of the allowance, subject to a $25 office visit copay. **Note:** Office visit copay waived at Cooper Green Mercy Health Services	Covered at 50% of the allowance, subject to the plan year deductible.
Emergency Room Physician Fees	Covered at 100% of the allowance, subject to a $25 visit copay.	Covered at 100% of the allowance, subject to a $25 visit copay.
Surgery and Anesthesia	Covered at 100% of the allowance with no deductible or copay.	Covered at 50% of the allowance, subject to the plan year deductible.
Inpatient Visits and Inpatient Consultations	Covered at 100% of the allowance with no deductible or copay.	Covered at 50% of the allowance, subject to the plan year deductible.
Maternity	Covered at 100% of the allowance with no deductible or copay.	Covered at 50% of the allowance, subject to the plan year deductible.
Infertility Services (Diagnostic & Testing)	Covered at 100% of the allowance with no deductible or copay.	Not covered.
Diagnostic X-rays and Lab Exams	Covered at 100% of the allowance with no deductible or copay.	Covered at 50% of the allowance, subject to the plan year deductible.
PREVENTIVE CARE SERVICES		
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 our Customer Service Department for a printed copy. Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/pharmacy** for more information.	Not covered.
Additional Routine Preventive Services	Covered at 100% of the allowance with no deductible or copay: • 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.
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.		
Organ Transplants	Covered at 100% of the allowance with no deductible or copay when rendered in a Centers of Excellence facility. Pre-approval is required.	Not covered.
Participating Chiropractor Services	Covered at 80% of the allowance, subject to the $200 plan year deductible.	Covered at 50% of the allowance, subject to the plan year deductible.
Rehabilitative Occupational, Physical and Speech Therapy	Covered at 80% of the allowance, subject to the $200 plan year deductible.	Covered at 50% of the allowance, subject to the plan year deductible.
	Limited to 20 visits per person per plan year for each service Children ages 0-9 with an autistic diagnosis are allowed unlimited visits.	
Habilitative Occupational, Physical and Speech Therapy	Covered at 80% of the allowance, subject to the $200 plan year deductible.	Covered at 50% of the allowance, subject to the plan year deductible.
	Limited to 20 visits per person per plan year for each service Children ages 0-9 with an autistic diagnosis are allowed unlimited visits.	
Allergy Testing and Treatment	Covered at 80% of the allowance, subject to the $200 plan year deductible.	Covered at 50% of the allowance, subject to the plan year deductible.
Durable Medical Equipment	Covered at 80% of the allowance, subject to the $200 plan year deductible.	Covered at 50% of the allowance, subject to the plan year deductible.
Temporomandibular Joint Services	Covered at 80% of the allowance, subject to the $200 plan year deductible.	Covered at 50% of the allowance, subject to the plan year deductible.

<table>
<tr><th>BENEFIT</th><th>IN-NETWORK (PPO)</th><th>OUT-OF-NETWORK (NON-PPO)</th></tr>
<tr><td>Skilled Nursing Facility</td><td colspan="2">Covered at 80% of the allowance, subject to the $200 in-network plan year deductible. Limited to 60 days per person per plan year.</td></tr>
<tr><td>Ambulance Services</td><td colspan="2">Covered at 80% of the allowance, subject to the $200 in-network plan year deductible.</td></tr>
<tr><td rowspan="2">Preferred Home Health and Hospice</td><td>Covered at 100% of the allowance with no deductible or copay. Precertification required for services rendered outside of Alabama. Call 1-800-821-7231.</td><td>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 the plan year deductible. Precertification required. Call 1-800-821-7231.</td></tr>
<tr><td colspan="2">Home health limited to 60 visits per member per plan year.
Hospice limited to a 180 day lifetime maximum per person.</td></tr>
<tr><td colspan="3">PRESCRIPTION DRUGS</td></tr>
<tr><td colspan="3">Precertification is required for some drugs; if no precertification is obtained, no benefits are available.</td></tr>
<tr><td>Prescription Drug Card
• The pharmacy network for the plan is the Prime Participating Pharmacy Network
• Non-maintenance – up to a 30 day supply at retail
• Blue Cross Maintenance Drug List – up to a 60 day supply for 2 copays or up to a 90 day supply for 3 copays
Diabetic Supplies
(copays apply)
• Diabetic Supplies are covered only through the Prescription Drug Card Program.
• Copays are combined for some products if purchased on the same day.</td><td>Participating Pharmacy:
Prescription drugs covered at 100% 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 strips and lancets purchased on the same day will require only one copay.
• Glucose monitors will always require a separate copay.</td><td>Non-Participating Pharmacy:
There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy.</td></tr>
<tr><td colspan="3">Note: View the Standard Prescription Drug list that applies to the plan at AlabamaBlue.com/web/pharmacy/drugguide.html.</td></tr>
<tr><td>Mail Order Program

• Provided through PrimeMail®. Enroll online at AlabamaBlue.com or call 1-877-579-7627.</td><td colspan="2">Prescription drugs covered at 100%. For a 90 day supply the following copays apply:

Tier 1 Drugs: $10 copay per prescription

Tier 2 Drugs: $80 copay per prescription

Tier 3 Drugs: $180 copay per prescription

Coverage provided only for maintenance medications listed on Blue Cross and Blue Shield of Alabama's Maintenance Drug List. The current list may be viewed on our website at AlabamaBlue.com.</td></tr>
</table>

Please note: Providers/Specialists may be listed in a PPO directory or on the provider finder website (**www.bcbs.com**), but not covered as PPO benefits by this group health plan (i.e., DME, Ambulance, Allergists). Please check your benefit matrix or benefit booklet to determine coverage.

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.

Blue Cross and Blue Shield of Alabama Customer Service:
1-877-255-7250
Mental health and substance abuse services provided through
Behavioral Health Systems
call
1-800-245-1150

Group #60100
Revised 10/6/2017 SF

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 bezplatnej 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。