Jefferson County Commission

BlueCard PPO

Effective October 1, 2013

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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 out-of-pocket maximum plus the plan year deductible. 2 member family maximum. All covered out-of-network services will apply.*	
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 1-800-896-2724.	
Baby Yourself	A prenatal wellness program. For more information, call 1-800-222-4379. You can also enroll online at **www.behealthy.com**.	
OUTPATIENT HOSPITAL FACILITY SERVICES		
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	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. Thereafter, covered at 50% of the allowance, subject to the plan year deductible.
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.
PHYSICIAN SERVICES		
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.

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Maternity	Covered at 100% of the allowance with no deductible or copay. Initial office visit to confirm pregnancy subject to the $25 office visit 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. Limited to $2,000 per person per plan year; $15,000 per lifetime.	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 **www.bcbsal.com/preventiveservices** for a listing of the specific immunizations and preventive services. Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **www.bcbsal.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		
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.
Physical 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.	
Occupational 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. Children ages 0-9 with an autistic diagnosis are allowed unlimited visits.	
Speech Therapy	Covered at 80% of the allowance, subject to the $200 in-network plan year deductible.	Covered at 50% of the allowance, subject to the plan year deductible.
	Limited to 20 visits per person per plan year. 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.
Skilled Nursing Facility	Covered at 80% of the allowance, subject to the $200 in-network plan year deductible. Limited to 60 days per person per plan year.	
Ambulance Services	Covered at 80% of the allowance, subject to the $200 in-network plan year deductible.	

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HOME HEALTH AND HOSPICE		
Preferred Home Health and Hospice	Covered at 100% of the allowance with no deductible or copay. 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 the plan year deductible. Precertification required. Call 1-800-821-7231.
	Home health limited to 60 visits per member per plan year. Hospice limited to a 180 day lifetime maximum per person.	
PRESCRIPTION DRUGS		
Prescription Drug Card ***Preferred Rx Products*** • 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.	**Participating Pharmacy:** Prescription drugs covered at 100% subject to the following copays: **Generic Drugs:** $5 copay per prescription. **Preferred Brand Name Drugs:** $40 copay per prescription. **Other Brand Name 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.	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy.
Note: To view the most current Preferred Brand Drug List or Maintenance Drug List, visit our website at **www.bcbsal.com**.		
Mail Order Program • Provided through PrimeMail®. Enroll online at **www.bcbsal.com** or call 1-800-391-1886.	Prescription drugs covered at 100%. For a 90 day supply the following copays apply: **Generic Drugs:** $10 copay per prescription **Preferred Brand Drugs:** $80 copay per prescription **Non-Preferred Brand 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 **www.bcbsal.com**.	

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.

* These services do not apply to the out-of-pocket maximum: copays, deductibles and in-network or out-of-network non-covered charges.

Group 60100
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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