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BlueCard® PPO Plan Benefits

Public Education Employees' Health Insurance Plan (PEEHIP)

BlueCard PPO®

Group 14000

Effective January 1, 2018

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BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Public Education Employees' Health Insurance Plan (PEEHIP)
Effective January 1, 2018

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL FACILITY SERVICES		
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 (toll free) for precertification.		
Deductibles and Copay	$200 per admission copayment and a $25 per day copay for days 2-5.	$200 per admission copayment and a $25 per day copay for days 2-5.
Inpatient Facility Coverage* (including maternity) **Note:** Maternity benefits are not available to dependent children of any age.	Covered at 100% of the allowed amount for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	Covered at 80% of the allowed amount for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
	Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury and medical emergency. ***Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®**	
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. Disease Management is provided by ActiveHealth for subscribers and covered spouses. For more information, call 1-855-294-6580. Disease Management is provided by Blue Cross and Blue Shield of Alabama for children and adult child dependents. For more information, call 1-888-841-5741.	
Baby Yourself®	A maternity program highly recommended for all pregnancies. For more information, call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com**. **Note:** The $200 maternity admission copayment will be waived for all members who enroll in the Baby Yourself® program within the first trimester of pregnancy, The $25 per day copay will still apply for days 2-5, if applicable.	
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.		
Surgery*	Covered at 100% of the allowed amount subject to a $150 facility copay.	Covered at 80% of the allowed amount subject to the calendar year deductible. In Alabama, out-of-network facilities are not covered.
	***Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®**	
Medical Emergency In-Area / Out-of-Area Emergency Room Facility Charge	Covered at 100% of the allowed amount subject to a $150 facility copay if a true medical emergency. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 100% of the allowed amount subject to a $150 facility copay if a true medical emergency. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible.
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 allowed amount subject to a $150 facility copay.	Covered at 100% of the allowed amount subject to a $150 facility copay for services within 72 hours of the accident; 80% of the allowed amount, subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan.
Diagnostic Lab & Pathology	Covered at 100% of the allowed amount subject to a $5 copay per test.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Diagnostic X-ray	Covered at 100% of the allowed amount with no deductible or copay required.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Hemodialysis	Covered at 100% of the allowed amount subject to a $25 facility copay.	Covered at 80% of the allowed amount subject to the calendar year deductible.
IV Therapy, Chemotherapy and Radiation Therapy	Covered at 100% of the allowed amount subject to a $25 facility copay.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Note: In Alabama, outpatient benefits for non-member hospitals are available only in cases of accidental injury.		
PHYSICIAN SERVICES		
Precertification is required for some physician benefits and physician administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits and In-Person Consultations Rendered by a Primary Physician (Includes Urgent Care, Internal Medicine, Family Practice, General Practice, Physician Assistant, Clinic, Gynecology, Obstetrics, Certified Nurse Practitioner, Midwives, and Pediatrician)	Covered at 100% of the allowed amount subject to a $30 office visit copay.	Covered at 80% of the allowed amount subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Office Visits and In-Person Consultations Rendered by a Specialist	Covered at 100% of the allowed amount subject to a $35 office visit copay.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Telephone and online video consultations program A service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc®. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4549.	Covered at 100% of the allowed amount with no deductible or copay.	Group 14000 members have access to Teladoc® nationwide. Teleconsultation providers other than Teladoc® are not covered.
Emergency Room Physician Fees	Covered at 100% of the allowed amount subject to a $35 visit copay.	Covered at 100% of the allowed amount subject to a $35 visit copay.
Surgery and Anesthesia	Covered at 100% of the allowed amount with no deductible or copay.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Inpatient Visits, Second Surgical Opinions and Inpatient Consultations*	Covered at 100% of the allowed amount with no deductible or copay.	Covered at 80% of the allowed amount subject to the calendar year deductible.
	***Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®**	
Maternity	Covered at 100% of the allowed amount with no deductible or copay.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Diagnostic Lab & Pathology Exams	Covered at 100% of the allowed amount. There is a $5 copay per test.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Diagnostic X-ray	Covered at 100% of the allowed amount with no deductible or copay.	Covered at 80% of the allowed amount subject to the calendar year deductible.
PREVENTIVE CARE SERVICES		
Routine Immunizations and Preventive Services	Covered at 100% of the allowed amount with no deductible or copay. **See AlabamaBlue.com/preventiveservices** and **AlabamaBlue.com/StandardACAPreventiveDrugList** for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy.	Not covered.
Additional Routine Preventive Services	Covered at 100% of the allowed amount with no deductible or copay: • Urinalysis (once by age 5 and once between ages 12 through 17) • CBC (once each calendar year) • Cholesterol Screening (once per calendar year for members age 18 and older) • Glucose Screening (once per calendar year for member age 18 and older)	Not covered.
Note: Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		
MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE		
Inpatient Facility Services	Covered at 100% of the allowed amount subject to the following copays: No charge for days 1-9; $15 per day for days 10-14; $20 per day for days 15-19; $25 per day for days 20-24; $30 per day for days 25-30. Covers up to 30 days per person each plan year (10/1-9/30). Inpatient Substance Abuse limited to one admission per plan year and a maximum of two admissions per lifetime. Mental Health and Substance Abuse days are aggregate. No rollover to Major Medical.	Covered at 100% of the allowed amount subject to a $200 per admission copayment and a $25 per day copay for days 2-5. Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital. Precertification is required.
Inpatient Physician Services	Covered at 80% of the allowed amount subject to the calendar year deductible. Coverage is available only during a covered admission up to 30 days per plan year.	Covered at 80% of the allowed amount, subject to the calendar year deductible. Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital. Precertification is required.
Outpatient Physician Services at PEEHIP Certified Community Mental Health Centers	Covered at 100% of the allowed amount subject to a $10 copay per visit. Limited to 20 visits per member each plan year. Maximum visits are combined for mental and substance abuse.	Not applicable. All PEEHIP Certified Community Mental Health Centers are in-network.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Outpatient Physician Services for Blue Choice Network Providers	Covered at 100% of the allowed amount, subject to a $50 copay per visit. Limited to 12 visits per member each plan year for in-network; deductible does not apply and no balance billing when using a Blue Choice Behavioral Network provider. Maximum visits are combined for mental and substance abuse. For a list of in-network Blue Choice Behavioral Health Network providers, see **AlabamaBlue.com**.	Covered at 50% of the allowed amount, subject to the overall deductible; limited to a maximum of 10 visits per member per plan year for out-of-network.* Maximum visits are combined for mental and substance abuse.
GENERAL PROVISIONS		
Calendar Year Deductible for Major Medical Services	$300 per person each calendar year; $900 family maximum.	
Annual Out-of-Pocket Maximum	$400 individual annual major medical out-of-pocket maximum plus the $300 calendar year deductible; no family maximum. In-network Other Covered Services are the only expenses applicable to the calendar year major medical out-of-pocket maximum. $7,350 individual; $14,700 family contract calendar year overall out-of-pocket maximum All deductibles, copays and coinsurance for in-network services apply to the calendar year overall out-of-pocket maximum, including prescription drugs. After you reach your individual Calendar Year Out-of-Pocket Maximum (even if you are covered under family coverage), applicable expenses for you will be covered at 100% of the allowed amount for the remainder of the calendar year.	
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.		
Participating Chiropractor Services	Covered at 80% of the allowed amount with no deductible. **Note:** In Alabama, more than 18 visits in a calendar year rendered by a Participating Chiropractor require precertification.	Covered at 80% of the allowed amount subject to the calendar year deductible. Member responsible for any difference between the charge and the allowed amount. Limited to 12 visits in a calendar year.
Physical Therapy	Covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 80% of the allowed amount subject to the calendar year deductible. Member responsible for any difference between the charge and the allowed amount.
Durable Medical Equipment	Covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 80% of the allowed amount subject to the calendar year deductible. Member responsible for any difference between the charge and the allowed amount.
Applied Behavioral Analysis (ABA) Therapy for Autism Spectrum Disorders	Covered for children 0-18 years at 100% of the allowed amount, subject to a $15 copay per visit and the following annual maximum benefits: **Note**: Members may be balance billed from out-of-network providers for the difference between the provider's charge and the allowed amount. Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 *Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied.	Covered for children 0-18 years at 100% of the allowed amount, subject to a $15 copay per visit and the following annual maximum benefits: **Note**: Members may be balance billed from out-of-network providers for the difference between the provider's charge and the allowed amount. Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 *Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied.
Occupational Hand Therapy	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to certain services related to the hand and lymphedema.	
Speech Therapy	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 30 sessions per person per calendar year.	
Ambulance Services	Covered at 80% of the allowed amount subject to the calendar year deductible.	
Allergy Testing & Treatment	Covered at 80% of the allowed amount subject to the calendar year deductible.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Infertility Services	Covered at 100% of the allowed amount. Copays do apply.	Covered at 80% of the allowed amount subject to the calendar year deductible.
	Limited to a lifetime maximum of 8 artificial insemination attempts (whether successful or not). Benefits are not provided for IVF (in-vitro fertilization), ART or GIFT (gamete intrafallopian transfer).	
Preferred Home Health and Hospice	Covered at 100% of the allowed amount with no deductible or copay. Precertification required for services rendered outside of Alabama. Call 1-800-821-7231.	Covered at 80% of the allowed amount subject to the calendar year deductible. Precertification required. Call 1-800-821-7231. Non-Preferred in Alabama: No benefits are available if a non-Preferred provider is used.
	Covered PPO and non-PPO expenses for Preferred Home Health Care and covered non-PPO expenses for Preferred Hospice Care apply toward the annual out-of-pocket maximum.	
PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH MEDIMPACT		
Prescription Drug Plan • A copay will be charged for each 30-day supply • Approved maintenance drugs may be purchased up to a 90-day supply for one copayment of $12 for generic drugs. Approved maintenance preferred and non-preferred brand drugs may be purchased up to a 90-day supply with 3 copayments. The drug must be on the approved PEEHIP maintenance list of drugs and must be prescribed as a maintenance drug. • First fill for a new maintenance drug will be a 30-day supply • Refills on Retail and Specialty medications (30-day supply) are allowed only after 75% of the previous prescription has been used (for example, 23 days into a 30-day supply). For maintenance medications (90-day supply), refills are allowed only after 75% of the previous prescription has been used (for example, 67 days into a 90-day supply). • Certain medications are subject to Step Therapy, Prior Authorizations and Quantity Level Limits. • Pharmacists must dispense generic drugs unless physician indicates by mark or signature in the appropriate place on the prescription, or indicates in an electronic prescription, "medically necessary", "dispense as written", or "do not substitute." • DAW (Dispense as Written) Cost Differential: Member pays the difference between the cost of a multi-source brand drug and its generic equivalent, regardless of whether the physician indicates the brand must be taken.* • Drug benefits for medically necessary fertility drugs are covered at 50% copay for any fertility drug up to a lifetime maximum of $2,500 cost to the PEEHIP plan. • **Diabetic Supplies** (copays apply)	**Participating Pharmacy:** Each prescription purchased from a Participating Pharmacy will be covered at 100% subject to the following copays: **Generic Drugs:** $6 copay per prescription (30-day supply) **Preferred Brand Name Drugs:** $40 copay per prescription (30-day supply) **Non-Preferred Brand Name Drugs:** $60 copay per prescription (30-day supply) **Specialty Drugs:** 20% coinsurance per prescription, with a minimum copay of $100 and maximum copay of $150 Diabetic Supplies are covered only through the Prescription Drug Plan unless the member has Medicare as his/her primary coverage. These supplies are covered under Medicare Part B. **Effective January 1, 2017**: Medicare-eligible members and Medicare-eligible dependents covered on a retiree contract and enrolled in Medicare Part A and Part B will be enrolled in the new UnitedHealthcare® Group Medicare Advantage (PPO) plan for PEEHIP retirees.	**In-State and Out-of-State Non-Participating Pharmacies:** Same as participating pharmacy with applicable copayments. Member will be responsible for the difference between the allowed amount and drug charge. Members must pay the full amount of the prescription and then file the claim to be reimbursed at the participating pharmacy rate less the applicable copay.
Note: To view current Prescription Drug Lists, visit the website at www.rsa-al.gov/index.php/members/peehip/pharmacy/		
These services do not apply to the out-of-pocket maximums.		

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.

PEEHIP members who use non-participating hospitals, providers or outpatient facilities will incur additional out-of-pocket costs.

To maximize your benefits, always use network providers.

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

If you have any questions concerning your PEEHIP hospital / medical benefits or a claim, call 1-800-327-3994.

To certify emergency or maternity admission, call 1-800-354-7412.
To certify home health and hospice services, call 1-800-821-7231.
To take advantage of the Baby Yourself® program, call 1-800-222-4379.
Visit our website at **AlabamaBlue.com/peehip**
For questions concerning prescription drugs, call MedImpact at 1-877-606-0727.
https://mp.medimpact.com/ala **G**roup 14000 Revised 5-21-2018 afr

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。