State of Alabama
State Employees' Children's
Health Insurance Plan
BlueCard PPO
Group 61013

P L A N   B E N E F I T S

Visit our web site at **www.alseib.org**

SUMMARY OF BENEFITS

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 at www.bcbs.com/healthtravel/finder.html.

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		
Deductibles and Co-pays	$5 co-pay per admission if pre-certification is obtained within 48 hours.	$5 co-pay per admission if pre-certification is obtained within 48 hours.
Inpatient Facility Coverage (including maternity)	100% coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	80% coverage 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. Reimbursement is $10 per day for room and board and 75% for covered ancillaries.	
Preadmission Certification	All hospital admissions require preadmission certification except maternity. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1 800 551-2294 (toll-free). If preadmission certification is not obtained, no benefits are available.	
OUTPATIENT HOSPITAL BENEFITS		
Surgery	Covered at 100% of the allowance after a $5 facility co-pay.	Covered at 80% of the allowance; subject to the calendar year deductible.
Medical Emergency	Covered at 100% of the allowance after a $5 facility co-pay.	Covered at 80% of the allowance; subject to the calendar year deductible.
Accidental Injury	Covered at 100% of the allowance with no deductible or co-pay required within 72 hours of the accident. Thereafter, covered at 80% of the allowance, after the calendar year deductible.	Covered at 100% of the allowance with no deductible or co-pay within 72 hours of the accident. Thereafter, covered at 80% of the allowance; subject to the calendar year deductible.
Diagnostic X-rays and Tests	Covered at 100% of the allowance after a $3 per visit facility co-payment.	Covered at 80% of the allowance; subject to the calendar year deductible.
Diagnostic Lab and Pathology	Covered at 100% of the allowance.	Covered at 80% of the allowance; subject to the calendar year deductible.
Hemodialysis, IV Therapy, Blood Transfusions, Chemotherapy, and Radiation Therapy	Covered at 100% of the allowance.	Covered at 80% of the allowance; subject to the calendar year deductible.
Note: In Alabama, outpatient benefits for non-member hospitals are available **only** in cases of accidental injury.		
PHYSICIAN / NURSE PRACTITIONER BENEFITS		
Physician Office Visits and Consultations	Covered at 100% of the allowance after a $3 office visit co-pay.	Covered at 80% of the allowance; subject to the calendar year deductible.
Nurse Practitioner / Nurse Midwives Office Visits and Consultations	Covered at 100% of the allowance after a $3 office visit co-pay.	Not Covered.
Emergency Room Physician Fees for Emergency Services	Covered at 100% of the allowance.	Covered at 80% of the allowance; subject to the calendar year deductible.
Emergency Room Physician Fees for Non-Emergency Services	Covered at 100% of the allowance after a $10 co-pay.	Covered at 80% of the allowance; subject to the calendar year deductible.
Out of Office Surgery and Anesthesia	Covered at 100% of the allowance.	Covered at 80% of the allowance; subject to the calendar year deductible.
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.
Diagnostic X-rays and Tests	Covered at 100% of the allowance.	Covered at 80% of the allowance; subject to the calendar year deductible.
Lab and Pathology Exams	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)
ROUTINE PREVENTIVE CARE		
Inpatient Visits for Routine Newborn Care	Initial inpatient newborn well baby examination covered at 100% of the allowance with no deductible or co-pay.	Initial inpatient newborn well baby examination covered at 80% of the allowance; subject to the calendar year deductible.
Routine Physical Exams	Covered at 100% of the allowance. Eight (8) visits from birth through 12 months; three (3) visits from 13 months through 35 months; one (1) annual visit from age 3 to age 19. One gynecological exam, including a pap smear, per year allowed for females age 6 to age 19.	Covered at 80% of the allowance; subject to the calendar year deductible. Eight (8) visits from birth through 12 months; three (3) visits from 13 months through 35 months; one (1) annual visit from age 3 to age 19. One gynecological exam, including a pap smear, per year allowed for females age 6 to age 19.
Routine Immunizations (Age limitations apply to certain immunizations)	Covered at 100% of the allowance with no deductible or co-pay.	Covered at 80% of the allowance; subject to the calendar year deductible.
Other Routine Screening	Covered at 100% of the allowance: lead screening once by age 2; urinalysis once by age 5, then once between ages 12-17; TB skin testing once before age 1, once between ages 1-4 and once between ages 14-18; CBC ages 6-17, one every other year, then annually, age 18 and older; cholesterol testing beginning at age 18.	Covered at 80% of the allowance; subject to the calendar year deductible: lead screening once by age 2; urinalysis once by age 5, then once between ages 12-17; TB skin testing once before age 1, once between ages 1-4 and once between ages 14-18; CBC ages 6-17, one every other year, then annually, age 18 and older; cholesterol testing beginning at age 18.
Allergy Testing	Covered at 100% of the allowance after a $5 office visit co-pay.	Covered at 80% of the allowance; subject to the calendar year deductible.
Allergy Treatment	Covered at 100% of the allowance after a $3 office visit co-pay.	Covered at 80% of the allowance; subject to the calendar year deductible.
MENTAL HEALTH SERVICES		
Inpatient Facility Services	Covered at 100% of the participating allowance after a $5 co-payment per admission.	Covered at 80% of the allowance; subject to the calendar year deductible.
Inpatient Physician Services	Covered at 100% of the allowance with no deductible or co-pay.	Covered at 80% of the allowance; subject to the calendar year deductible.
Outpatient Physician Services	Covered at 100% of the allowance with no deductible; limited to 20 visits per person each calendar year.	Covered at 80% of the allowance; subject to the calendar year deductible; benefits are limited to 20 visits per person each calendar year.
SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 100% of the allowance after a $5 co-payment; limited to a maximum of 30 days per person each calendar year; limited to a maximum payment of $9,600 per person each calendar year; limited to a lifetime maximum of $12,000 per person.	Covered at 80% of the allowance; subject to the calendar year deductible; limited to a maximum of 30 days per person each calendar year; limited to a maximum payment of $9,600 per person each calendar year; limited to a lifetime maximum of $12,000 per person.
Inpatient Physician Services	Covered at 100% of the allowance with no deductible or co-pay; limited to a maximum of 30 days per person each calendar year; limited to a maximum payment of $9,600 per person each calendar year; limited to a lifetime maximum of $12,000 per person.	Covered at 80% of the allowance; subject to the calendar year deductible; limited to a maximum of 30 days per person each calendar year; limited to a maximum payment of $9,600 per person each calendar year; limited to a lifetime maximum of $12,000 per person.
Outpatient Physician Services	Covered at 100% of the allowance; limited to 20 visits per person each calendar year; limited to a maximum payment of $9,600 per person each calendar year; limited to a lifetime maximum of $12,000 per person.	Covered at 80% of the allowance after the calendar year deductible, limited to 20 visits per person each calendar year; limited to a maximum payment of $9,600 per person each calendar year; limited to a lifetime maximum of $12,000 per person.
GENERAL PROVISIONS		
Calendar Year Deductible	$100 per person each calendar year; Maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$400 individual annual out-of-pocket maximum plus the $100 calendar year deductible. Other Covered Services are the only expenses applicable to the annual out-of-pocket maximum; **Services covered under the PPO, provided by non-PPO providers do not apply to the Annual Out-of-Pocket Maximum.**	
Lifetime Maximum	$1,000,000 lifetime maximum for each covered member; Services covered under the PPO, provided by PPO providers do not apply toward the Major Medical Benefit Period and Lifetime Maximum.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
OTHER COVERED SERVICES		
TMJ Services	Covered at 80% of the allowance, no deductible; non-surgical management of TMJ is limited to a maximum payment of $450 per person each calendar year; surgical management is limited to $3,000 per person each calendar year.	Covered at 80% of the allowance; subject to the calendar year deductible; non-surgical management of TMJ is limited to a maximum payment of $450 per person each calendar year; surgical management is limited to $1,000 per person each calendar year.
Participating Chiropractor Services	Covered at 100% of the allowance with no deductible; Limited to 12 visits per calendar year.	Non-Participating: Not Covered.
Outpatient Rehabilitation Services (Includes: Physical Therapy, Occupational Therapy, Speech Therapy, and Cardiac/Pulmonary Therapy.)	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
Durable Medical Equipment	Covered at 100% of the allowance.	Covered at 80% of the allowance, subject to the calendar year deductible.
Ambulance Services	Covered at 100% of the allowance, after a $5 co-payment per occurrence.	Covered at 80% of the allowance, subject to the calendar year deductible.
Skilled Nursing Facility	Limited to 100 days in a lifetime when approved through case management. NOTE: No coverage is available if prior approval is not obtained through case management; call 1 800 551-2294.	
Hearing Aid Benefit	Limited to a maximum of $750 each ear, once every two calendar years.	
Home Health and Hospice Services	Covered at 100% of the allowance when services are certified through case management; call 1 800 551-2294.	Non-Participating: Not Covered.
Diabetic Education	Covered at 100% of the allowance; 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 1 800 551-2294.	
PRESCRIPTION DRUG BENEFITS		
Prescription Drugs	**Participating Pharmacy:** Prescription drugs will be covered at 100% after the following co-pays: $1 co-pay per prescription for Tier 1 Drugs $3 co-pay per prescription for Tier 2 Drugs $5 co-pay per prescription for Tier 3 Drugs	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy or from a Participating Pharmacy where your drug card was not used.
SEIB DISCOUNTED VISION CARE PROGRAM (Note: This is an SEIB administered benefit. No claims are to be filed with Blue Cross Blue Shield of Alabama.)		
Routine Eye Exam **Lenses and Frames**	Examinations are limited to one per year subject to a $40 member payment when a participating provider is used. Frames and lenses are discounted 25% off retail prices.	Not covered.
DENTAL BENEFITS (Note: Member is responsible for any difference between billed charges and the fee schedule when using a non-participating provider.)		
Maximum Benefit	$1,500 maximum per person per calendar year, excluding preventive services.	$1,500 maximum per person per calendar year, excluding preventive services.
Diagnostic & Preventive Services	Covered at 100% of the Preferred Dental Fee Schedule.	Covered at 100% of the Preferred Dental Fee Schedule.
Basic and Major Services (Fillings, Oral Surgery, etc.)	Covered at 100% of the Preferred Dental Fee Schedule after a $3 co-pay per service.	Covered at 100% of the Preferred Dental Fee Schedule after a $3 co-pay per service.
Supplemental Services (Includes Prosthodontics and Prosthetics)	Covered at 100% of the Preferred Dental Fee Schedule after a $3 co-pay per service.	Covered at 100% of the Preferred Dental Fee Schedule after a $3 co-pay per service..
Periodontic Services	Covered at 100% of the Preferred Dental Fee Schedule after a $3 co-pay per service.	Covered at 100% of the Preferred Dental Fee Schedule after a $3 co-pay per service.

For precertification, call 1 800 551-2294
Call Blue Cross Blue Shield of Alabama at 1 800 824-0435
Visit our website at www.alseib.org