

**City of Montgomery**  
BlueCard PPO  
Post-65 Retirees

Effective October 1, 2016

**Premium Rates:**

Contact the Benefits Division for premium rates for Post-65 Retirees

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BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>INPATIENT HOSPITAL FACILITY SERVICES</b>		
<b>Deductibles and Copay</b>	\$250 per admission deductible. \$50 copay per day for days 2 through 5.	\$500 per admission deductible.
<b>Inpatient Facility Coverage (including maternity)</b>	Covered at 100% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries. <b>Note:</b> In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury.	Covered at 65% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
<b>Preadmission Certification</b>	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.	
<b>Individual Case Management</b>	Coordinates care in the event of a catastrophic or lengthy illness or injury. For more information, call 1-800-821-7231.	
<b>Disease Management</b>	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
<b>Baby Yourself</b>	A prenatal wellness program. For more information, call 1-800-222-4379. You can also enroll online at <a href="http://www.behealthy.com">www.behealthy.com</a> . If a member enrolls in the Baby Yourself program up to 24 weeks gestation, both the inpatient per admission deductible and the inpatient per day copay are waived when the member is admitted to the hospital for the delivery of the baby.	
<b>OUTPATIENT HOSPITAL FACILITY SERVICES</b>		
<b>Surgery</b>	Covered at 100% of the allowance subject to a \$150 facility copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
<b>Medical Emergency</b>	Covered at 100% of the allowance subject to a \$125 facility copay.	Covered at 100% of the allowance subject to a \$125 facility copay and the calendar year deductible.
<b>Accidental Injury</b>	Covered at 100% of the allowance with no deductible or copay required.	Covered at 100% of the allowance with no deductible or copay within 72 hours of the accident. Thereafter, covered at 65% of the allowance, subject to the calendar year deductible.
<b>Diagnostic Lab, X-ray, and Pathology</b>	Covered at 100% of the allowance with no deductible or copay required.	Covered at 65% of the allowance, subject to the calendar year deductible.
<b>Hemodialysis, IV Therapy, Chemotherapy and Radiation Therapy</b>	Covered at 100% of the allowance with no deductible or copay required.	Covered at 65% of the allowance, subject to the calendar year deductible.
<b>Note:</b> In Alabama, outpatient benefits for non-member hospitals are available only in cases of accidental injury.		
<b>PHYSICIAN SERVICES</b>		
<b>Office Visits and Outpatient Consultations rendered by a Primary Care Physician (PCP)</b>	Covered at 100% of the allowance subject to a \$40 office visit copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
<b>Office Visits and Outpatient Consultations rendered by a Specialist</b>	Covered at 100% of the allowance subject to a \$50 office visit copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
<b>Emergency Room Physician Fees</b>	Covered at 100% of the allowance subject to a \$50 visit copay.	Covered at 100% of the allowance subject to a \$50 visit copay and the calendar year deductible.
<b>Surgery and Anesthesia</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
<b>Inpatient Visits, Second Surgical Opinions and Inpatient Consultations</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
<b>Maternity</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
<b>Diagnostic X-rays and Lab Exams</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 65% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>PREVENTIVE CARE SERVICES</b>		
<b>Routine Immunizations and Preventive Services</b>	Covered at 100% of the allowance with no deductible or copay. See <a href="http://AlabamaBlue.com/preventiveservices">AlabamaBlue.com/preventiveservices</a> for a listing of the specific immunizations and preventive services.	Not covered
<b>Additional Routine Preventive Services</b>	Covered at 100% of the allowance with no deductible or copay. <ul style="list-style-type: none"> <li>• Urinalysis (when necessary)</li> <li>• CBC (when necessary)</li> <li>• TB skin test (when necessary)</li> <li>• Bone density test (one per calendar year for female employees and dependents age 50 and older)</li> </ul>	Not covered
<b>GENERAL PROVISIONS</b>		
<b>Calendar Year Deductible</b>	\$300 per person each calendar year; \$900 aggregate maximum per family.	
<b>Annual Out-of-Pocket Maximum</b>	\$750 individual annual out-of-pocket maximum plus the \$300 calendar year deductible. Other Covered Services are the only expenses applicable to the annual out-of-pocket maximum.	
<b>Comprehensive Annual Maximum on Essential Health Benefits</b>	\$2,000,000 per person	
<b>OTHER COVERED SERVICES</b>		
<b>Participating Chiropractor Services</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. <b>Non-Participating in Alabama:</b> Covered at 50% of the allowance subject to the calendar year deductible when services are provided by a non-Participating Chiropractor.
<b>Physical Therapy</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	
<b>Occupational Therapy</b>	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to certain services related to the hand and lymphedema.	
<b>Durable Medical Equipment</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	
<b>Ambulance Services</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	
<b>Allergy Testing &amp; Treatment</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	
<b>Attention Deficit Disorders (When provided by a Doctor of Medicine)</b>	Covered at 50% of the allowance, subject to the calendar year deductible.	
<b>HOME HEALTH AND HOSPICE</b>		
<b>Preferred Home Health and Hospice</b>	Covered at 100% of the allowance with no deductible or copay. Precertification required for services rendered outside of Alabama. Call 1 800 821-7231	Covered at 65% of the allowance subject to the calendar year deductible. Precertification required. Call 1 800 821-7231. <b>Non-Preferred in Alabama:</b> No benefits are available if a non-Preferred provider is used.

**Please note:** Providers/Specialists may be listed in a PPO directory or on the provider finder website ([AlabamaBlue.com](http://AlabamaBlue.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.