City of Montgomery

BlueCard PPO

Pre-65 Retirees

Effective October 1, 2016

Premiums:
Individual Coverage - $185/month
Family Coverage - $375/month

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BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL FACILITY SERVICES		
Deductibles and Copay	$300 per admission deductible. $60 copay per day for days 2 through 5.	$500 per admission deductible.
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	Covered at 65% of the allowance 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.	
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.	
Baby Yourself	A prenatal wellness program. For more information, call 1-800-222-4379. You can also enroll online at **www.behealthy.com**. 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.	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Surgery	Covered at 100% of the allowance subject to a $175 facility copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
Medical Emergency	Covered at 100% of the allowance subject to a $150 facility copay.	Covered at 100% of the allowance subject to a $150 facility copay and the calendar year deductible.
Accidental Injury	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.
Diagnostic Lab, X-ray, and Pathology	Covered at 100% of the allowance with no deductible or copay required.	Covered at 65% of the allowance, subject to the calendar year deductible.
Hemodialysis, IV Therapy Chemotherapy and Radiation Therapy	Covered at 100% of the allowance with no deductible or copay required.	Covered at 65% 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 SERVICES		
Office Visits and Outpatient Consultations rendered by a Primary Care Physician (PCP)	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.
Office Visits and Outpatient Consultations rendered by a Specialist	Covered at 100% of the allowance subject to a $60 office visit copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
Emergency Room Physician Fees	Covered at 100% of the allowance subject to a $60 visit copay.	Covered at 100% of the allowance subject to a $60 visit copay and the calendar year deductible.
Surgery and Anesthesia	Covered at 100% of the allowance with no deductible or copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
Inpatient Visits, Second Surgical Opinions and Inpatient Consultations	Covered at 100% of the allowance with no deductible or copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance with no deductible or copay.	Covered at 65% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays and Lab Exams	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)
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.	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 test (when necessary) • Bone density test (one per calendar year for female employees and dependents age 50 and older)	Not covered
GENERAL PROVISIONS		
Calendar Year Deductible	$300 per person each calendar year; $900 aggregate maximum per family.	
Annual Out-of-Pocket Maximum	$1,500 individual; $3,000 aggregate maximum per family. All deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum. Out-of-network services do not apply to the out-of-pocket maximum. For members up to age 19, all deductibles and coinsurance for in-network dental services under the group dental benefits apply to the out-of-pocket maximum. After you reach Calendar Year Out-of-Pocket Maximum, applicable expenses covered at 100% for remainder of calendar year.	
OTHER COVERED SERVICES		
Participating Chiropractor Services	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. **Non-Participating in Alabama:** Covered at 50% of the allowance subject to the calendar year deductible when services are provided by a non-Participating Chiropractor.
Physical Therapy	Covered at 80% of the allowance, subject to the calendar year deductible.	
Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Limited to certain services related to the hand and lymphedema.	
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	
Allergy Testing & Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	
Attention Deficit Disorders (When provided by a Doctor of Medicine)	Covered at 50% of the allowance, subject to the calendar year deductible.	
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	Covered at 65% of the allowance 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.

Please note: Providers/Specialists may be listed in a PPO directory or on the provider finder website (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.

This is not a contract, benefit booklet or a Summary Plan Description.
Benefits are subject to the terms, limitations and conditions of the group contract.
Please visit our website, AlabamaBlue.com.