Local Government Health Insurance Plan Benefit Summary

Effective January 1, 2023

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Local Government Health Insurance Plan
JANUARY 1, 2023

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, **AlabamaBlue.com**. 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 the "Benefit Conditions" section of the Plan's hand book.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Precertification is required for inpatient admissions (except medical emergency, maternity and as required by Federal law); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 for precertification.		
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance, subject to a $200 per admission deductible and $50 copay per day for days 2-5	Covered at 80% of the allowance, subject to a $200 per admission deductible and $50 copay per day for days 2-5.
OUTPATIENT HOSPITAL BENEFITS		
Precertification is required for certain outpatient hospital benefits, including radiology services and a select group of provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.		
Surgery	Covered at 100% of the allowance, subject to the $100 facility copay. Certain outpatient surgeries require pre-certification, call 1-800-248-2342.	Covered at 80% of the allowance, subject to the calendar year deductible. Certain outpatient surgeries require pre-certification, call 1-800-248-2342.
Medical Emergency	Covered at 100% of the allowance, subject to the $200 facility copay for treatment of sudden and severe symptoms that require immediate medical attention and meet medical emergency guidelines. Claims with emergency room charges that do not meet medical emergency guidelines will be covered under Major Medical.	Covered at 100% of the allowance, subject to the $200 facility copay for treatment of sudden and severe symptoms that require immediate medical attention and meet medical emergency guidelines. Claims with emergency room charges that do not meet medical emergency guidelines will be covered under Major Medical.
Accidental Injury	Covered at 100% of the allowance with no deductible or copay	Covered at 100% of the allowance with no deductible or copay
Diagnostic X-rays & Tests	Covered at 100% of the allowance, subject to the $100 facility copay per visit or cost of service, whichever is less.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic Lab & Pathology Certain outpatient x-rays and tests require precertification, call 1-866-803-8002.	Covered at 100% of the allowance, subject to a $7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance, subject to the $25 facility copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Note: In Alabama, inpatient and outpatient benefits for non-member hospitals are available only in cases of accidental injury or medical emergency and covered as an out-of-network hospital.		
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Precertification is required for a select group of provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Primary Care Physician Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $40 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Specialist Physician Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $50 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Nurse Practitioners / Nurse Midwives, Physician Assistant Office Visits, Registered Dietician, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $20 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Physician fees for Outpatient Surgery and Anesthesia (other than in a physician's office)	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Second Surgical Opinion	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Telephone and Online Video Consultations Program A telephone and online video consultation service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. Telephone and online video consultations are available 24 hours a day, 7 days a week.	Covered at 100% of the allowance; no copay or deductible	Not covered.
Emergency Room	Covered at 100% of the allowance, subject to the office visit copay.	Covered at 100% of the allowance, subject to the office visit copay.
Inpatient Visits	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Lab & Pathology Exams	Covered at 100% of the allowance, subject to a $7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Tests	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
ROUTINE PREVENTIVE CARE		
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 immunizations and preventive services or call the BCBS Customer Service Department for a printed copy	Covered at 80% of the allowance subject to the calendar year deductible. • See **AlabamaBlue.com/preventiveservices** for a listing of the immunizations and preventive services or call Customer Service Department for a printed copy
Additional Routine Preventive Services	Covered at 100% of the allowance with no deductible or copay. In addition to the standard, the following will apply: • Urinalysis (once by age 5, then once between ages 12-17) • CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) • Glucose testing (once every calendar year age 18 and over) • Cholesterol testing (once every calendar year age 18 and over) • TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)	Covered at 80% of the allowance subject to the calendar year deductible. In addition to the standard, the following will apply: • Urinalysis (once by age 5, then once between ages 12-17) • CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) • Glucose testing (once every calendar year age 18 and over) • Cholesterol testing (once every calendar year age 18 and over) • TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)
MENTAL HEALTH SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.
Inpatient Provider Services	Covered at 80% of the allowance, no copay or deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.
LGHIP Outpatient Provider Services **(See Mental Health and Substance Abuse chapter in your plan book for more information on approved LGHIP providers.)**	**Approved LGHIP providers**: Covered at 100% of the allowance, subject to a $14 copay per visit; limited to 24 visits per person per calendar year. Other copays may apply based on services rendered. **Blue Choice Behavioral Network providers:** Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person per calendar year.
Residential Treatment Facilities for treatment of Eating Disorders	Covered at 80% of the allowance, subject to the calendar year deductible. Services must be approved by New Directions; precertification and ongoing medical necessity review required; limited to 60 days per member per calendar year	Covered at 80% of the allowance, subject to the calendar year deductible. Services must be approved by New Directions; precertification and ongoing medical necessity review required; limited to 60 days per member per calendar year

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.
Inpatient Provider Services	Covered at 80% of the allowance; no copay or deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.
LGHIP Outpatient Provider Services **(See Mental Health and Substance Abuse chapter in your plan book for more information on approved LGHIP providers.)**	**Approved LGHIP providers:** Covered at 100% of the allowance, no copay or deductible; limited to 40 visits per person per calendar year. **Blue Choice Behavioral Network providers:** Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible	$200 per person each calendar year; maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$9,100 individual annual out-of-pocket maximum; $18,200 family maximum. **In-Network Services:** Deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum, including prescription drugs. For members up to age 19, deductibles and coinsurance for in-network dental services under the group dental benefits apply to the out-of-pocket maximum. **Out-of-Network Services:** Do not apply to the out-of-pocket maximum. After you reach your Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowance for remainder of the calendar year.	
MAJOR MEDICAL SERVICES		
Precertification is required for certain major medical services and a select group of provider administered drugs; please see benefit booklet. Call 1-800-248-2342 for precertification. If no precertification is obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th visit.	Non-Participating: Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 18th visit.
Applied Behavioral Analysis (ABA) Therapy	For children 18 years or younger, covered at 100% of the allowance after $14 copay per visit and subject to the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter or for any member nearing the ABA annual maximum to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.	For children 18 years or younger, covered at 80% of the allowance subject to calendar year deductible and following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter or for any member nearing the ABA annual maximum to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Physical Therapy, Speech Therapy and Occupational Therapy related to the screening, diagnosis, and treatment of Autism Spectrum Disorder	For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
Rehabilitative and Habilitative Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
Ground Ambulance 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. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
Air Ambulance 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.
Allergy Testing & Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
Home Health Services	Covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency; Precertification is required; call 1-800-821-7231.	Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required; call 1-800-821-7231. In Alabama: No coverage for services rendered by a non-participating Home Health agency.
Home Infusion Services	Covered at 100% of the allowance, subject to the $25 office visit copay when services are rendered by a participating Home Infusion Service Provider; Precertification is required for provider-administered drugs; call 1-800-821-7231.	Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required for provider-administered drugs; call 1-800-821-7231. In Alabama: No coverage for services rendered by a non-participating Home Infusion Service Provider.
Diabetic Education	Covered at 100% of the allowance with no deductible; 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 1-800-248-2342.	Not covered.
Medical Nutrition Therapy For Adults and Children, 6 hours per member per calendar year	Covered at 100% of the allowance, subject to the applicable office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS		
Prescription drug benefits are covered through OptumRx®. For more information, call OptumRx Member Services at 1 844-785-1603 or visit the website at www.OptumRx.com.		
TIER 1 DRUGS (PRESCRIPTION DRUG CARD PROGRAM) • Generic non-maintenance drugs may be dispensed up to a 30-day supply. • Generic maintenance drugs may be dispensed up to a 60-day supply, for one $15 copay, after an initial 30-day supply fill. • The plan utilizes the OptumRx Premium Formulary; however, plan benefits will supersede the Premium Formulary drug list.	Covered at 100% of the allowance subject to a $15 copay per prescription	No benefits are available for prescriptions purchased at a non-participating pharmacy.
TIER 2 AND TIER 3 DRUGS (POINT OF SALE DRUG PROGRAM) • Brand drugs (Tier 2 and Tier 3) may be dispensed up to a 90-day supply. Member must pay the cost of the drug and file a claim for reimbursement. • The prescription receipt (not the register receipt) is required for reimbursement requests. See the Prescription Drugs Chapter in the Planbook for additional receipt requirements. • Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Optum Specialty Pharmacy. Call Optum Specialty Pharmacy at 1-855-427-4682 for more information.	Covered at 80% of the allowance after being submitted for reimbursement. Subject to the calendar year deductible of $200.	No benefits are available for prescriptions purchased at a non-participating pharmacy.
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231 and press 7.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions. For more information, please call 1-833-964-1448 and press 0.	
Baby Yourself®	A maternity program that will waive the hospital deductible and daily copays for inpatient admission at delivery. For the waived hospital deductible and daily copays to apply, the member must enroll in the Baby Yourself program within the first two trimesters of pregnancy. Members may enroll at **AlabamaBlue.com/BabyYourself**. For more information, please call 1-800-222-4379.	

Note: Teladoc Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

For precertification call 1-800-248-2342. Call Blue Cross and Blue Shield of Alabama at 1-800-321-4391. Visit the Local Government Health Insurance Board's website at www.lghip.org.
The LGHIP is a self-insured health benefits plan administered by the LGHIB. The LGHIP provides minimum essential coverage and meets the minimum value standard as defined by the Affordable Care Act.
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. Please visit our website at www.AlabamaBlue.com.

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