*We cover what matters.*

# BlueCard® PPO Plan Benefits

## Alabama West Florida Conference Of The United

BlueCard® PPO - HSA Qualified HDHP

Effective January 01, 2024

Visit our website at
**AlabamaBlue.com**

BlueCross BlueShield of Alabama

# Prescription Drugs: ValueONE Network

**ValueONE Network Facts:**

- 51,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Retail Network. This includes many national pharmacies you may already be using.
- 50,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Extended Supply Network (ESN). This includes many national pharmacies you may already be using.
- Generally, ValueONE Retail Network pharmacies can fill up to a 30-day supply of retail drugs while ValueONE ESN Network pharmacies can fill up to a 90-day supply of certain medications (prescription must be written for up to a 90-day supply). Refer to your benefit booklet for the specific day supply permitted by your benefit plan. Since the type of pharmacy differs within the ValueONE Network, be sure to check your specific pharmacy.
- If you do not use a ValueONE Network pharmacy, you may be responsible for the full cost of your prescription medication. Benefits may not be provided for out-of-network pharmacies.
- To maximize your pharmacy benefits, you will need to transfer all your prescriptions to a ValueONE Network pharmacy.

**Find a ValueONE Network Pharmacy**

You can locate all of the participating pharmacies in your area at **AlabamaBlue.com/ValueONERetailPharmacyLocator**. Click on “Find a Pharmacy by Name or Location” located under Find a Pharmacy. When searching for a participating pharmacy, make sure either “ValueONE Retail Network” or “ValueONE ESN Network” is listed under “Network Participation” located to the right of the pharmacy address.

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| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.** | | |
| **HEALTH SAVINGS ACCOUNT (HSA)** | | |
| A Health Savings Account (HSA) is an account established with pre-taxed money in order to save for future medical expenses. In order to establish an HSA you must first be enrolled in an HSA-Qualified High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain government requirements for use in conjunction with a HSA. This plan is designed to meet those government requirements. Enrolling in an HDHP allows you the opportunity to make contributions to an HSA on a pre-tax basis. | | |
| **Maximum Contribution:** The maximum contribution amount is indexed each year by the U.S. Treasury. The 2024 maximum contribution is **$4,150** for single coverage and **$8,300** for family coverage. If you have any questions about the benefits of an HSA, please consult your tax accountant. | | |
| **SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.** | | |
| **Calendar Year Deductible**<br>The in-network and out-of-network calendar year deductibles are separate and do not apply to each other.<br>For family coverage, no benefits, except preventive care, are paid by the plan to any family member until the total medical expenses paid by the family equal the family deductible amount. | $4,000 self-only coverage; $8,000 family coverage | $8,000 self-only coverage; $16,000 family coverage |
| **Calendar Year Out-of-Pocket Maximum**<br>All deductibles, copays and coinsurance for in-network services and out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum | $6,000 self-only coverage; $12,000 family coverage<br>After you reach your self-only 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 remainder of calendar year | There is no out-of-pocket maximum for out-of-network services. |
| **INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Precertification is required for inpatient admissions (except medical emergency services and 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 (toll-free) for precertification.** | | |
| **Inpatient Hospital** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible<br>**Note:** In Alabama, available only for medical emergency services and accidental injury |
| **Inpatient Physician Visits and Consultations** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Precertification is required for some outpatient hospital benefits; please see benefit booklet. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.** | | |
| **Outpatient Surgery (Including Ambulatory Surgical Centers)** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **Emergency Room (Medical Emergency)** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible<br><br>**Mental Health Disorders and Substance Abuse Services** covered at 60% of the allowed amount, subject to in-network calendar year deductible |
| **Emergency Room (Accident)**<br><br>**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 60% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible for services rendered within 72 hours; covered at 50% 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 |
| **Emergency Room (Physician)** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible<br><br>**Mental Health Disorders and Substance Abuse Services** covered at 60% of the allowed amount, subject to in-network calendar year deductible |
| **Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Precertification is required for some physician benefits; please see benefit booklet. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.** | | |
| **Office Visits and Consultations** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Second Surgical Opinions** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Surgery & Anesthesia** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Maternity Care** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Applied Behavioral Analysis (ABA) Therapy**<br>Limited to ages 0-18 for autism spectrum disorders | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **PREVENTIVE CARE BENEFITS** | | |
| **Routine Immunizations and Preventive Services**<br>• See **AlabamaBlue.com/ PreventiveServices** and **AlabamaBlue.com/ SourceRxACAPreventiveDrugList** for listing of specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy<br>• Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/ VaccineNetworkDrugList** for more information | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Note:** In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act. | | |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Precertification is required for some drugs; if precertification is not obtained, no benefits are available.** | | |
| **Retail Prescription Prepaid Benefits**<br><br>The retail pharmacy network for the plan is **ValueONE Retail Network**<br><br>• Locate a **ValueONE Retail Network** pharmacy at **AlabamaBlue.com/ ValueONEPharmacyLocator**<br><br>Maintenance drugs – up to a 30-day supply<br><br>• View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList**<br><br>Prescription drugs (other than maintenance drugs) - up to a 30-day supply<br><br>• View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T**<br><br>The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Pharmacy Select Network**<br><br>• Tier 4 (specialty) drugs can be dispensed for up to a 30-day supply<br><br>• View the Specialty Drug List at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList**<br><br>Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network. A list of the eligible vaccines these pharmacies may provide can be found at: **AlabamaBlue.com/ VaccineNetworkDrugList**. | Covered at 100% of the allowed amount, subject to calendar year deductible and subject to the following copays:<br><br>**Tier 1 Drugs:**<br>$15 copay per prescription<br><br>**Tier 2 Drugs:**<br>$50 copay per prescription<br><br>**Tier 3 Drugs:**<br>$75 copay per prescription<br><br>**Tier 4 (specialty) Drugs:**<br>$395 copay per prescription<br><br>Covered Insulin Products: $99.00 maximum cost share per 30-day supply. When a Covered Insulin Product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a Covered Insulin Product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met. | Not Covered |
| **Extended Supply Prescription Prepaid Benefits**<br><br>The extended supply pharmacy network for the plan is the **ValueONE ESN Network**<br><br>• Locate a **ValueONE** Pharmacy at **AlabamaBlue.com/ ValueONEESNPharmacyLocator**<br><br>Maintenance drugs - up to 90-day supply may be purchased but copay applies for each 30-day supply<br><br>• View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList**<br><br>Prescription drugs (other than maintenance drugs) - up to a 30-day supply<br><br>• View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T**<br><br>• **Tier 4 (specialty)** drugs are not available through extended supply pharmacy service | Covered at 100% of the allowed amount, subject to the deductible and following copays:<br><br>**Tier 1 Drugs:**<br>$15 copay per prescription<br><br>**Tier 2 Drugs:**<br>$50 copay per prescription<br><br>**Tier 3 Drugs:**<br>$75 copay per prescription<br><br>**Tier 4 (specialty) Drugs:**<br>Not covered<br><br>Covered Insulin Products: $99.00 maximum cost share per 30-day supply. When a Covered Insulin Product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a Covered Insulin Product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met. | Not Covered |

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|---|---|---|
| **BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.** | | |
| **Allergy Testing & Treatment** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Ambulance Service** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| **Participating Chiropractic Services** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **Durable Medical Equipment (DME)** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Rehabilitative Occupational, Physical and Speech Therapy**<br><br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Habilitative Occupational, Physical and Speech Therapy**<br><br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |
| **Home Health and Hospice** | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **Home Infusion** | Covered at 100% of the allowed amount, after $395.00 copay and subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **Medical Nutrition Therapy Services**<br><br>For adults and children, limited to 6 hours per member per calendar year | Covered at 60% of the allowed amount, subject to calendar year deductible | Covered at 50% of the allowed amount, subject to calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)** | | |
| **Individual Case Management** | Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231. | |
| **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. | |
| **Baby Yourself ®** | A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.** | |
| **Contraceptive Management** | Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance. | |

***Useful Information to Maximize Benefits***

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website **(AlabamaBlue.com)** or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area , or in accordance with applicable Federal law.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*
- *Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.*

**This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract (including your benefit booklet). Check your benefit booklet for more detailed coverage information. Please visit our website, AlabamaBlue.com.**

## Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, 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。