We cover what matters.

Visit our website at
AlabamaBlue.com

BlueCard® PPO
Plan Benefits

AAAS
automotive aftermarket association southeast

AAAS
employee benefit fund

Value AHP Plan
BlueCard® PPO
Group #58920

Effective January 1, 2024

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescription Drugs: PreferredONE Network

PreferredONE Network Facts:

- 55,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the **PreferredONE Retail Network**. This includes many national pharmacies you may already be using.
- 45,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the **PreferredONE Extended Supply Network (ESN)**. This includes many national pharmacies you may already be using.
- Generally, **PreferredONE Retail Network** pharmacies can fill up to a 30-day supply of retail drugs while **PreferredONE 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 PreferredONE Network, be sure to check your specific pharmacy.
- If you do not use a PreferredONE 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 PreferredONE Network pharmacy.

Find a PreferredONE Network Pharmacy

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

Effective January 1, 2024
BlueCard® PPO

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.		
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 The in-network and out-of-network calendar year deductibles are separate and do not apply to each other	$1,500 individual; $3,000 family	$2,000 individual; $4,000 family
Calendar Year Out-of-Pocket Maximum 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 including prescription drugs	$7,500 individual; $15,000 family The dollar amount of any specialty drug financial assistance provided by providers or manufacturers will not apply to the in-network 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 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, 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 100% of the allowed amount, after $350 daily hospital copay days 1-6 for each admission	Covered at 50% of the allowed amount, subject to $1,200 per admission deductible **Note:** In Alabama, available only for medical emergency services and accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to the calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 50% of the allowed amount, no copay or deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits. Precertification is also required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, after $350 hospital copay	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount, after $350 hospital copay	Covered at 100% of the allowed amount after $350 hospital copay
Emergency Room (Accident)	Covered at 100% of the allowed amount, after $350 hospital copay	Covered at 100% of the allowed amount after $350 hospital copay
Emergency Room (Physician)	Covered at 100% of the allowed amount, after $60 physician copay	Covered at 100% of the allowed amount after $60 physician copay

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic Lab, Pathology & X-ray	Covered at 100% of the allowed amount, after $350 hospital copay	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Chemotherapy, Dialysis, IV Therapy & Radiation Therapy	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowed amount, after $60 per day hospital copay	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits. Precertification is also required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Office Visits and Consultations-Primary Care Physician	Covered at 100% of the allowed amount, after $40 primary care physician copay	Covered at 50% of the allowed amount, subject to calendar year deductible
Office Visits and Consultations-Specialist	Covered at 100% of the allowed amount, after $60 specialist physician copay	Covered at 50% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program A service, through Teladoc™ to diagnose, treat and prescribe medication (when necessary) for certain medical issues. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4519	Covered at 100% of the allowed amount, after $10 payment per consultation	Not Covered
Surgery & Anesthesia	Covered at 100% 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 100% of the allowed amount, after $60 physician copay	Covered at 50% of the allowed amount, subject to calendar year deductible
Diagnostic X-ray	Covered at 100% of the allowed amount after $10 copay per procedure	Covered at 50% of the allowed amount subject to calendar year deductible
CAT Scan, MRI, PET/SPECT, ERCP, angiography/arteriography, cardiac cath/arteriography, UGI endoscopy, muga-gated cardiac scan & colonoscopy	Covered at 100% of the allowed amount after $350 copay per procedure	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 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Maternity Care	Covered at 100% 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 Limited to ages 0-18, for autism spectrum disorders	Covered at 100% of the allowed amount, after $40 primary care physician copay	Covered at 50% of the allowed amount, subject to 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.		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • 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 • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/Vaccine NetworkDrugList** for more information	Covered at 100% of the allowed amount, no copay or deductible; in addition to the standard, the following are covered: • Lipid panel (one per year) • Urinalysis (one per year) • Complete CBC (one per year)	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.		
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 • Locate a **PreferredONE** Retail Network pharmacy at **AlabamaBlue.com/ PreferredONERetailPharmacyLocator (Walgreens Anchor)** • Maintenance and Non-Maintenance drugs up to a 30-day supply • Specialty drugs may be purchased up to a 30-day supply • The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Pharmacy Select Network**; visit **AlabamaBlue.com/ SelfAdminsteredSpecialtyDrugList** for a list of these specialty drugs • View the **SourceRx 1.0 (Up to 4 Tier)** drug lists that apply to the plan at **AlabamaBlue.com/Source Rx1DrugList4T** • Locate a **PreferredONE Network (Walgreens Anchor)** pharmacy at **AlabamaBlue.com/PreferredOneRetail PharmacyLocator** • Some copays combined for diabetic supplies	Covered at 100% of the allowed amount, subject to the following copays or coinsurance: **Tier 1 drugs:** $15 copay per prescription **Tier 2 drugs:** $60 copay per prescription **Tier 3 drugs:** $100 copay per prescription **Tier 4 (specialty) drugs:** 50% of the allowed amount **Covered Insulin Products** $99 maximum cost share per 30-day supply	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Extended Supply Prescription Prepaid Benefits • The extended supply pharmacy network for the plan is the **PreferredONE ESN Network** • Locate a **PreferredONE ESN Network** Pharmacy at **AlabamaBlue.com/PreferredOneESN PharmacyLocator** • Maintenance and non-maintenance can be purchased through this extended supply pharmacy service – up to a 90-day supply with a copay for each 30-day supply • View the **SourceRx 1.0** drug lists and maintenance drug lists that apply to the plan at **AlabamaBlue.com/SourceRx1DrugList4T** • Tier 4 (specialty) drugs are not available through this extended supply pharmacy service	Covered at 100% of the allowed amount, subject to the following copays **Tier 1 drugs:** $15 copay per prescription **Tier 2 drugs:** $60 copay per prescription **Tier 3 drugs:** $100 copay per prescription **Tier 4 (specialty) drugs:** Not covered **Covered Insulin Products** $99 maximum cost share per 30-day supply	Not covered
Select Generic Specialty and Biosimilar drugs Generic specialty and biosimilar drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some generic specialty and biosimilar drugs is the Pharmacy Select Network. • View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at AlabamaBlue.com/SelectGeneric SpecialtyandBiosimilarDrugList. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	100% of the allowed amount, no copay or deductible	Not covered
Mail Order Pharmacy Benefits • Up to a 90-day supply with one copay • Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/HomeDelivery Network** or call 1-855-793-5326) • Maintenance drugs can be purchased through this mail order pharmacy • View the SourceRx 1.0 (Up to 4 Tier) drug lists that apply to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** • Tier 4 (specialty) drugs are not available through mail order • Note: if you have less than a 90-day supply, you will pay the same copay as a 90-day supply when using this mail order program	Covered at 100% of the allowed amount, subject to the following copays **Tier 1 drugs:** $37.50 copay per prescription **Tier 2 drugs:** $150 copay per prescription **Tier 3 drugs:** $250 copay per prescription **Tier 4 (specialty) drugs:** Not covered **Covered Insulin Products** $99 maximum cost share per 30-day supply	Not Covered
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 80% 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
Ambulance Service	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to in-network calendar year deductible
Participating Chiropractic Services Limited to a 15 visit maximum per member per calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational, Speech and Physical Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Habilitative Occupational, Speech and Physical Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 80% 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 80% 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 100% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Home Infusion Services	Covered at 100% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Medical Nutrition Therapy For Adults and Children, 6 hours per member per calendar year	Covered at 100% of the allowed amount, after $40 physician copay	Covered at 50% of the allowed amount, subject to calendar year deductible
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 and 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.**	
Air Medical Transport	Air medical transportation service to a network hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624.	
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.	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK

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, 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.*
- *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.*
- *Please refer to your benefit book or contact Blue Cross directly about coverage for your hospital charges and other related medical services. Approval for air medical transportation does not mean that hospitalization and other medical expenses will be covered. All coverage determinations for medical benefits are subject to the terms, conditions, limitations and exclusions of the health plan. Air medical transportation services are provided through a contract with AirMed International, LLC, an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical transportation services terminate if coverage by your health plan ends.*

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。