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BlueCard[®] PPO Plan Benefits

Jefferson County Commission
BlueCard[®] PPO

Effective October 01, 2024



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

Jefferson County Commission
BlueCard® PPO
Effective October 01, 2024

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<p><i>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.</i></p>		
SUMMARY OF COST SHARING PROVISIONS		
Plan year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Plan Year Deductible (Plan Year runs October 1 – September 30)	\$200 per person per plan year; no family maximum Applies to Chiropractor Services, Allergy Testing and Treatment, Durable Medical Equipment (DME), Physical Therapy, Speech Therapy, Occupational Therapy, Skilled Nursing Facility, Temporomandibular Joint Services (TMJ) and Ambulance Services.	\$1,000 per person each plan year; 2 member family maximum
Plan Year Out-of-Pocket Maximum (Plan Year runs October 1 – September 30)	\$2,000 individual; 2 member family maximum All deductibles, copays and coinsurance for in-network services (except Skilled Nursing services) apply to the out-of-pocket maximum. Payments made by drug manufacturer assistance programs may not apply towards the deductible or out-of-pocket maximum. Coinsurance for out-of-network Home Health, Hospice and Other Covered Services (excluding occupational therapy, physical therapy, speech therapy and DME in Alabama) applies to the out-of-pocket maximum. After you reach Plan Year Out-of-Pocket Maximum, applicable expenses covered at 100% for remainder of plan year.	
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS		
<p>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.</p>		
Inpatient Hospital Facilities	Covered at 100% of the allowed amount, after \$100.00 hospital copay per day for days 1-3 Covered for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	Covered at 50% of the allowed amount, subject to the plan year deductible Note: In Alabama, available only for medical emergency services and accidental injury Covered for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to the plan year deductible
OUTPATIENT HOSPITAL BENEFITS		
<p>Precertification is required for some outpatient hospital benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available. NOTE: Facility copay waived for services rendered at Cooper Green Health Services Facility (Tax ID 636001579)</p>		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, after \$100.00 hospital copay	Covered at 50% of the allowed amount, subject to the plan year deductible In Alabama, not covered
Emergency Room (Medical Emergency) Copay waived if admitted within 24 hours.	Covered at 100% of the allowed amount, subject to \$200.00 hospital copay	Covered at 100% of the allowed amount, subject to \$200.00 hospital copay
Emergency Room Non-Emergency	Covered at 50% of the allowed amount, subject to out-of-network plan year deductible	Covered at 50% of the allowed amount, subject to the plan year deductible
Emergency Room (Accident)	Covered at 100% of the allowed amount, subject to \$200.00 hospital copay Copay waived if admitted within 24 hours.	Covered at 100% of the allowed amount, subject to \$200.00 hospital copay

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Physician)	Covered at 100% of the allowed amount, subject to \$25.00 physician copay	Covered at 100% of the allowed amount, subject to \$25.00 physician copay
Outpatient Diagnostic Lab & X-ray	Covered at 100% of the allowed amount, subject to \$100.00 hospital copay	Covered at 50% of the allowed amount, subject to the plan year deductible In Alabama , not covered
Chemotherapy, Hemodialysis, IV Therapy, Pathology & Radiation Therapy	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to the plan year deductible In Alabama , not covered

PHYSICIAN BENEFITS

Precertification is required for some physician benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. 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.

Office Visits and Consultations	Covered at 100% of the allowed amount, subject to \$25.00 physician copay Note: Office visit copay waived at Cooper Green Mercy Health Services	Covered at 50% of the allowed amount, subject to the plan year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount, subject to \$25.00 physician copay	Covered at 50% of the allowed amount, subject to the plan year deductible
Surgery & Anesthesia	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to the plan year deductible
Bariatric Surgery Pre-approval required	Covered at 80% of the allowed amount, subject to the plan year deductible	Covered at 50% of the allowed amount, subject to the plan year deductible
Maternity Care	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to the plan year deductible
Infertility Services (Diagnostic & Testing)	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Diagnostic Lab & X-ray	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to the plan 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.

PREVENTIVE CARE BENEFITS

Routine Immunizations and Preventive Services <ul style="list-style-type: none"> See AlabamaBlue.com/PreventiveServices and AlabamaBlue.com/StandardACAPreventiveDrugList for a listing of the 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/VaccineNetworkDrugList for more information. 	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Additional Preventive Services	Covered at 100% of the allowed amount, no copay or deductible <ul style="list-style-type: none"> • Urinalysis (when necessary) • CBC (when necessary) • TB skin testing (when necessary) • Bone density scan (when necessary) • Chest x-ray (annually) • EKG (annually) • Cholesterol screening and/or Lipid panel (annually) 	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

Recertification is required for some drugs; if recertification is not obtained, no benefits are available.

Retail Prescription Drug Card Benefits <ul style="list-style-type: none"> • The pharmacy network for the plan is Prime Participating Network • Some copays combined for diabetic supplies • Infertility drugs are not covered • Prescription drugs (other than maintenance drugs) - up to a 30-day supply • View the Standard Prescription Drug List drug lists that apply to the plan at AlabamaBlue.com/StandardDrugList • Maintenance drugs - up to a 60-day supply for 2 copays or up to a 90-day supply for 3 copays • The only in-network pharmacy for some Tier 4 (specialty) drugs is the Pharmacy Select Network • Tier 4 (specialty) drugs can be dispensed for up to a 30-day supply • View the Specialty Drug List at AlabamaBlue.com/SelfAdministeredSpecialtyDrugList • Locate a Prime Participating Network pharmacy at AlabamaBlue.com/PrimeParticipatingPharmacyLocator • Certain drugs are part of the FlexAccess Program. See list at AlabamaBlue.com/FlexAccessDrugList • View the Specialty Drug List at AlabamaBlue.com/SelfAdministeredSpecialtyDrugList 	Covered at 100% of the allowed amount, subject to the following copays: <p>Tier 1 Drugs: \$5 copay per prescription</p> <p>Tier 2 Drugs: \$40 copay per prescription</p> <p>Tier 3 Drugs: \$90 copay per prescription</p> <p>Tier 4 (specialty) Drugs: \$150 copay per prescription</p> <p>Insulin, insulin needles and syringes purchased on the same day will require only one copay</p> <p>Blood glucose stripes and lancets purchased on the same day will require only one copay</p> <p>Glucose monitors will always require a separate copay</p> <p>For drugs on the FlexAccess Drug List, cost share may vary based on available drug manufacturer assistance. If assistance is available, the amount member pays out-of-pocket will be set by the drug manufacturer assistance program.</p>	Not Covered
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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<p>Mail Order Pharmacy Benefits</p> <ul style="list-style-type: none"> Up to a 90-day supply with one copay Mail Order Drugs are available through Home Delivery Network (Enroll online at AlabamaBlue.com/HomeDeliveryNetwork or call 1-855-793-5326) Only maintenance drugs can be purchased through this mail order pharmacy service View the Standard Drug List that applies to the plan at AlabamaBlue.com/StandardDrugList View the maintenance drug list that applies to the plan at AlabamaBlue.com/MaintenanceDrugList Tier 4 (specialty) Drugs are not available through mail order 	<p>Covered at 100% of the allowed amount, subject to the following copays:</p> <p>Tier 1 Drugs: \$10 copay per prescription</p> <p>Tier 2 Drugs: \$80 copay per prescription</p> <p>Tier 3 Drugs: \$180 copay per prescription</p> <p>Tier 4 (specialty) Drugs: Not covered</p>	<p>Not Covered</p>
BENEFITS FOR OTHER COVERED SERVICES		
<p>Precertification is required for some other covered services; please see your benefit booklet. 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.</p>		
<p>Allergy Testing & Treatment</p>	<p>Covered at 80% of the allowed amount, subject to the plan year deductible</p>	<p>Covered at 50% of the allowed amount, subject to the plan year deductible</p>
<p>Ambulance Service</p>	<p>Covered at 80% of the allowed amount, subject to the plan year deductible</p>	<p>Covered at 80% of the allowed amount, subject to the in-network plan year deductible</p>
<p>Participating Chiropractic Services</p>	<p>Covered at 80% of the allowed amount, subject to the plan year deductible</p>	<p>Covered at 50% of the allowed amount, subject to the plan year deductible</p>
<p>Durable Medical Equipment (DME)</p>	<p>Covered at 80% of the allowed amount, subject to the plan year deductible</p>	<p>Covered at 50% of the allowed amount, subject to the plan year deductible</p>
<p>Rehabilitative Occupational, Physical and Speech Therapy</p> <p>Occupational, physical and speech therapy limited to 20 visits per person per plan year for each service</p> <p>Children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy</p>	<p>Covered at 80% of the allowed amount, subject to the plan year deductible</p>	<p>Covered at 50% of the allowed amount, subject to the plan year deductible</p>
<p>Habilitative Occupational, Physical and Speech Therapy</p> <p>Occupational, physical and speech therapy limited to 20 visits per person per plan year for each service</p> <p>Children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy</p>	<p>Covered at 80% of the allowed amount, subject to the plan year deductible</p>	<p>Covered at 50% of the allowed amount, subject to the plan year deductible</p>

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
TMJ (Temporomandibular Joint Disorder) - Phase I only	Covered at 80% of the allowed amount, subject to the plan year deductible	Covered at 50% of the allowed amount, subject to the plan year deductible
Organ Transplants	Covered at 100% of the allowed amount, no copay or deductible Services must be rendered in a Blue Distinction Center facility. Pre-approval is required	Not Covered
Home Health and Hospice Home Health limited to a maximum of 60 visits per member per plan year Hospice limited to a 180 day lifetime maximum per person	Covered at 100% of the allowed amount, no copay or deductible Precertification required for services rendered outside of Alabama. Call 1-800-821-7231	Non-Preferred in Alabama: No benefits are available if a non-Preferred provider is used. Outside Alabama: Covered at 50% of the allowance, subject to the plan year deductible Precertification is required. Call 1-800-821-7231.
Home Infusion Services	Covered at 100% of the allowed amount, no copay or deductible	Non-Preferred in Alabama: No benefits are available if a non-Preferred provider is used. Outside Alabama: Covered at 50% of the allowance, subject to the plan year deductible
Skilled Nursing Facility Limited to 60 days per person per plan year	Covered at 80% of the allowed amount, subject to the plan year deductible	Covered at 80% of the allowed amount, subject to the in-network plan year deductible
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per plan year	Covered at 100% of the allowed amount, subject to \$25.00 physician copay	Covered at 50% of the allowed amount, subject to the plan year deductible
MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE		
Mental Health Disorders and Substance Abuse	Mental Health Disorders and Substance Abuse benefits are not administered by Blue Cross and Blue Shield of Alabama	
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.	
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). 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.
- Prime Therapeutics LLC® is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.
- Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-800-222-4379 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

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: 한국어 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 નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ 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 नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໄບອາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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。