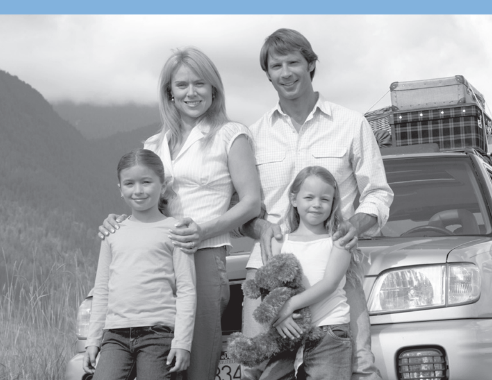
We cover what matters.

BlueCard® PPO Plan Benefits



Kato Engineering Union Actives and Retirees

Group 79450 75942 Div. 001, 01S & R01

BlueCard® PPO

Effective January 01, 2023

Visit our website at
AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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 (PPO)	OUT-OF-NETWORK (NON-PPO)
GENERAL PROVISIONS		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with Federal law.		
Calendar Year Deductible	$600 per person each calendar year; $1,200 maximum per family. Deductible amounts met in-network will not apply to the out-of-network deductible.	$1,200 per person each calendar year. Does not Include In-network deductible. Deductible amounts met out-of-network will not apply to the in-network deductible.
Annual Out-of-Pocket Maximum After you reach your individual calendar year out-of-pocket maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year.	$5,200 individual; $12,700 family out-of-pocket maximum each calendar year, which includes deductible, copays and coinsurance. Available manufacturer or provider cost share assistance program payments made with respect to the specialty drugs on the Specialty Drug Coupon Program List do not apply to the in-network out-of-pocket maximum. Out-of-pocket amounts met in-network will not apply to the out-of-network out-of-pocket maximum	$13,275 individual out-of-pocket maximum each calendar year, which includes deductible and medical copays. Out-of-pocket amounts met out-of-network will not apply to the in-network out-of-pocket maximum
INPATIENT HOSPITAL FACILITY SERVICES		
Inpatient Facility Coverage (including maternity)	Covered at 80% of the allowance subject to the calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	Covered at 60% of the allowance subject to the calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
Preadmission Certification	All hospital admissions require preadmission certification, except maternity admissions as required by Federal law. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1-800-248-2342. If preadmission certification is not obtained, a $500 penalty will apply.	
OUTPATIENT HOSPITAL FACILITY SERVICES		
Precertification is required for physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Surgery	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Medical Emergency (Illness)	Covered at 80% of the allowance subject to a $200 copay and the in-network calendar year deductible.	
Accidental Injury	Covered at 80% of the allowance subject to a $200 copay and the in-network calendar year deductible.	
Diagnostic Lab, X-ray and Pathology	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Hemodialysis, IV Therapy, Chemotherapy and Radiation Therapy	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
PHYSICIAN SERVICES (Copays do not apply to deductible)		
Precertification is required for physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits, Outpatient Consultations by a Primary Care Physician (PCP) and Urgent Care Clinics (Includes General Practitioner, Family Practitioner, Internist, OB/GYN, Pediatrician, Nurse Practitioner, Physician Assistant) **Includes:** **> diagnosis for obesity**	Covered at 100% of the allowance after $35 copay.	Covered at 60% of the allowance subject to the calendar year deductible.
Office Visits and Outpatient Consultations rendered by a Specialist	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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 1-855-477-4549	Covered at 100% of the allowance no deductible or copay.	Not covered.
Emergency Room Physician Fees	Covered at 80% of the allowance subject to the in-network calendar year deductible.	
Surgery and Anesthesia	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Second Surgical Opinion	Covered at 100% of the allowance no deductible or copay.	
Inpatient Visits and Inpatient Consultations	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Maternity (includes dependents)	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Diagnostic X-rays and Lab Exams	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Applied Behavioral Analysis (ABA) Therapy **Note:** Preadmission Certification is required. Call 1-800-248-2342	Covered at 100% of the allowance after $35 copay for Behavioral Therapy services.	Covered at 60% 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.		
PREVENTIVE CARE SERVICES		
Routine Immunizations and Preventive Services	Covered at 100% of the allowance with no deductible or copay. See **AlabamaBlue.com/PreventiveServices** and **AlabamaBlue.com/SourceRxACAPreventiveDrugList** 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.	Not covered
Additional Routine Services • Urinalysis – limited to one per calendar year • Complete Blood Count (CBC) – limited to one per calendar year • Cholesterol – limited to one each per calendar year (Includes cholesterol, HDL, LDL, VLDL & Triglycerides) • Blood Glucose and Hemoglobin A1C – limited to one each per calendar year	Covered at 100% of the allowance with no deductible or copay.	Not covered
Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Inpatient facility covered at 80% of the allowance subject to the calendar year deductible.	Inpatient facility covered at 60% of the allowance subject to the calendar year deductible.
Inpatient Physician Services	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Outpatient Physician Services	Covered at 100% of the allowance after $35 copay.	Covered at 60% of the allowance subject to the calendar year deductible.
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 contraceptive methods and counseling. FDA approved contraceptive devices are covered under the **Preventive Care Services** benefits. Oral contraceptives are covered under the **Prescription Drugs** benefits. Both 1) Generic oral contraceptives and 2) Preferred Brand name oral contraceptives when Generic is not available do not require a copay. Both 1) Non-Preferred Brand name oral contraceptives and 2) Preferred Brand name oral contraceptives when a Generic is available are subject to the prescription drug copays.	
OTHER COVERED SERVICES		
Participating Chiropractor Services	Covered at 100% of the allowance after $35 copay.	Covered at 60% of the allowance subject to the calendar year deductible.
Allergy Testing and Treatment	Covered at 80% of the allowance subject to the in-network calendar year deductible.	
Occupational Therapy	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Physical Therapy	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Speech Therapy	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders	Covered at 80% of the allowance subject to the calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Durable Medical Equipment	Covered at 80% of the allowance subject to the in-network calendar year deductible.	Covered at 60% of the allowance subject to the calendar year deductible.
Biofeedback	Covered at 80% of the allowance subject to the in-network calendar year deductible.	
Acupuncture	Covered at 80% of the allowance subject to the in-network calendar year deductible.	
Ambulance Services	Covered at 80% of the allowance subject to the in-network calendar year deductible.	
Skilled Nursing Facility	Covered at 80% of the allowance subject to the calendar year deductible. Precertification required. Call 1-800-821-7231.	Covered at 60% of the allowance subject to the calendar year deductible. Precertification required. Call 1-800-821-7231.
HOME HEALTH AND HOSPICE		
Home Health	Covered at 80% of the allowance subject to the calendar year deductible. Precertification required. Call 1-800-821-7231.	Covered at 60% of the allowance subject to the calendar year deductible. Precertification required. Call 1-800-821-7231.
Home Infusion	Covered at 80% of the allowance subject to the calendar year deductible. Precertification required. Call 1-800-821-7231.	Covered at 60% of the allowance subject to the calendar year deductible. Precertification required. Call 1-800-821-7231.
Hospice	Covered at 80% of the allowance subject to the calendar year deductible. Precertification required. Call 1-800-821-7231. Services must be authorized by physician.	Covered at 60% of the allowance subject to the calendar year deductible. Precertification required. Call 1-800-821-7231. Services must be authorized by physician.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS		
Retail Prescription Drug Card Benefits The retail pharmacy network for the plan is **ValueONE Retail Network** • Locate a **ValueONE Retail** Network pharmacy at **AlabamaBlue.com/ ValueONERetailPharmacyLocator** • View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** • Retail drugs may be dispensed up to a 30-day supply • Value Based drugs are covered 100% of the allowance; no copay or deductible. • View the Value Based Drugs that apply to the plan at **AlabamaBlue.com/SourceRxVBDDrugList** Drugs on the Specialty Drug Coupon Program List are subject to the greater of the applicable Tier copay or the full amount of the available manufacturer cost share assistance program payments • Certain specialty drugs are listed on the Specialty Drug Coupon Program List at **AlabamaBlue.com/SpecialtyCouponProgramDrugList**	**Participating Pharmacy:** Prescription drugs will be covered at 100% after the following copays. **Tier 1 Drugs:** The greater of $10 copay or 10% (maximum of $40) **Tier 2 Drugs:** The greater of $30 copay or 25% (maximum of $100) **Tier 3 Drugs:** The greater of $60 copay or 35% (maximum of $400)	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy.

Additional Retail Pharmacy Information

- The only in-network pharmacy for specialty drugs is the **Pharmacy Select Network**. Go to **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList** and **AlabamaBlue.com/ProviderAdminsteredSpecialtyDrugList** for a list of these specialty drugs
- From time to time, certain drugs in certain drug categories on the **SourceRx Drug** list are excluded from coverage under the plan. View the **Drug Exclusion Strategy-Alternative Drug List** that also applies to the plan at **AlabamaBlue.com/DrugList.** This list will be updated periodically.
- View the **SourceRx Prescription Drug** list that applies to the plan at **AlabamaBlue.com/SourceRx1DrugList4T**
- Non-sedating antihistamines and Proton Pump Inhibitors (PPIs) will require a 100% copay from the member.

Diabetic Supplies
(copays apply)
- Diabetic Supplies are covered only through the Prescription Drug Card Program.
- Copays are combined for some products if purchased on the same day.
- Insulin, insulin needles and syringes purchased on the same day will require only one copay
- Blood glucose strips and lancets purchased on the same day will require only one copay
- Glucose monitor will always require a separate copay

<table>
<tr><th>BENEFIT</th><th>IN-NETWORK (PPO)</th><th>OUT-OF-NETWORK (NON-PPO)</th></tr>
<tr><td>Extended Supply Prescription Drug Card Benefits

The extended supply pharmacy network for the plan is the ValueONE ESN Network

• Locate a ValueONE ESN Pharmacy at AlabamaBlue.com/ ExtendedSupplyNetwork PharmacyLocator

Prescription drugs can be purchased through this extended supply pharmacy service

• Maintenance and non-maintenance drugs can also be purchased through the extended supply pharmacy service up to a 90-day supply with a copay for each 30-day supply
• View the maintenance drug list that applies to the plan at AlabamaBlue.com/Maintenance DrugList
• View the SourceRx 1.0 drug list that applies to the plan at AlabamaBlue.com/ SourceRx1DrugList4T
• Specialty drugs are not available through extended supply pharmacy service</td><td>Participating Pharmacy: Prescription drugs will be covered at 100% after the following copays.

Tier 1 Drugs:
The greater of $10 copay or 10% (maximum of $40)

Tier 2 Drugs:
The greater of $30 copay or 25% (maximum of $100)

Tier 3 Drugs:
The greater of $60 copay or 35% (maximum of $400)</td><td>Non-Participating Pharmacy: There are no benefits available for prescription drugs purchased from a non-Participating Pharmacy.</td></tr>
<tr><td>Mail Order Drug Program
Home Delivery Network
Call 1-855-793-5326
• Up to 90-day supply

• Value Based drugs are covered 100% of the allowed amount; no copay or deductible. View the Value Based Drugs that apply to the plan at AlabamaBlue.com/SourceRxVB DDrugList

• Specialty drugs are not available through this pharmacy service</td><td colspan="2">Covered at 100% after the following copays:

Tier 1 Drugs:
The greater of $25 copay or 10% (maximum of $100)

Tier 2 Drugs:
The greater of $75 copay or 25% (maximum of $250)

Tier 3 Drugs:
The greater of $150 copay or 35% (maximum of $1,000)</td></tr>
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Please note: Providers/Specialists may be listed in a PPO directory or on the provider finder web site (www.bcbs.com), but not covered as PPO benefits by this group health plan (i.e., DME, Ambulance, Midwives, Allergists). Please check your benefit matrix or benefit booklet to determine coverage.

In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network.

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.