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BlueCard® PPO
Plan Benefits

Kato Engineering Union
Actives and Retirees
75942 Div. 001, 01S, 79450 R01,
BlueCard® PPO

Effective January 01, 2024

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Kato Engineering Union Actives and Retirees
Effective January 01, 2024

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 the 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 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. 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 All deductibles, copays and coinsurance for out-of-network services (excluding out-of-network mental health disorders and substance abuse emergency services) apply to the out-of-network out-of-pocket maximum, including prescription drugs. 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)
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** for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy.	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.		
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.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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.	
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.
PRESCRIPTION DRUGS		
Prescription Drugs are not administered by Blue Cross and Blue Shield of Alabama.		

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.

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. 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 bezplatnej 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。