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BlueCard® PPO
Plan Benefits

ALDA Benefit Plan
In Contract With Iron Reassurance Company, LLC

BlueCard® PPO Gold

Effective September 1, 2018

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Hospital Choice Network

The Blue Cross and Blue Shield of Alabama Hospital Choice Network is a local Alabama effort to evaluate cost, quality and patient experience in member hospitals. Hospitals are categorized into either Lower Member Cost Share or Higher Member Cost Share, based on their performance.

Only Alabama general acute care hospitals are eligible for participation in the Hospital Choice Network. Rehabilitation hospitals, psychiatric hospitals, specialty facilities, out-of-state hospitals, VA hospitals and long-term care hospitals are exempt from Hospital Choice Network scoring.

All hospitals are evaluated annually with changes made effective January 1. In addition, reviews are completed on a quarterly basis allowing hospitals to improve their status. To review the evaluation criteria for all hospitals and/or the level of Member Cost Share for a particular hospital, please use the "Find a Doctor" tool on our website at **AlabamaBlue.com.** The Member Cost Share level will be included in the information provided for each hospital that participates in the Hospital Choice Network. For more information on the evaluation criteria, click on the name of the hospital and then click on the "Cost", "Quality" or "Patient Experience" tabs. If you have any questions, please call the Customer Service number on the back of your ID card.

Prescription Drugs: ValueONE Network

ValueONE Network Facts:

- 36,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Network. This includes many national pharmacies you may already be using.
- Pharmacies that participate in the ValueONE Network can fill up to a 90-day supply of certain medications at the same location.
- 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/Pharmacy**. Click on "Find a Pharmacy by Name or Location" located under *Find a Pharmacy.* When searching for a participating pharmacy, make sure "ValueONE Network" is listed under "Network Participation" located to the right of the pharmacy address.

ALDA Benefit Plan
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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.		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar Year Deductible The in-network and out-of-network calendar year deductibles are separate and do not apply to each other	$600 individual; $1,200 family	$600 individual; $1,200 family
Calendar Year Out-of-Pocket Maximum (including in-network calendar year deductible) 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 individual; $12,000 family 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	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); 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	**Lower Member Cost Share:** Covered at 100% of the allowed amount after $240 per day hospital copay days 1-5 for each admission **Higher Member Cost Share:** Covered at 100% of the allowed amount after $500 per day hospital copay days 1-5 for each admission	Covered at 80% of the allowed amount after $800 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 80% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services covered at 80% 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 and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	**Lower Member Cost Share:** Covered at 100% of the allowed amount after $240 hospital copay **Higher Member Cost Share:** Covered at 100% of the allowed amount after $500 hospital copay	Covered at 80% 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 $250 hospital copay	Covered at 100% of the allowed amount after $250 hospital copay and subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after $250 hospital copay**
Emergency Room (Accident) **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 100% of the allowed amount after $250 hospital copay	Covered at 100% of the allowed amount after $250 hospital copay and subject to calendar year deductible when services are rendered within 72 hours of the accident; 80% of the allowed amount subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Physician	Covered at 100% of the allowed amount after $50 physician copay	Covered at 100% of the allowed amount after $50 physician copay and subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after $50 physician copay**
Outpatient Diagnostic Lab, X-ray & Pathology	**Lower Member Cost Share:** Covered at 100% of the allowed amount after $240 hospital copay **Higher Member Cost Share:** Covered at 100% of the allowed amount after $500 hospital copay	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health and Substance Abuse	Covered at 100% of the allowed amount after $50 per day hospital copay	Covered at 80% 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 and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
IN-NETWORK SERVICES *NOT* SUBJECT TO $600 CALENDAR YEAR DEDUCTIBLE		
Office Visits & In-Person Consultations	Covered at 100% of the allowed amount after $35 primary care physician copay or $50 specialist physician copay	Covered at 80% of the allowed amount subject to calendar year deductible
Second Surgical Opinion	Covered at 100% of the allowed amount after $50 physician copay	Covered at 80% 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 $250 copay per procedure	Covered at 80% of the allowed amount subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible
IN-NETWORK SERVICES SUBJECT TO $600 CALENDAR YEAR DEDUCTIBLE		
Surgery & Anesthesia	Covered at 100% of the allowed amount subject to calendar year deductible	Covered at 80% 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 80% of the allowed amount subject to calendar year deductible
Note: In Alabama, out-of-network physician services covered at 50% of the allowed amount subject to calendar year deductible		
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • 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/pharmacy** 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
PEDIATRIC VISION BENEFITS		
Pediatric Eye Exam Limited to one exam (including refraction) per calendar year up to the end of the month in which the member turns 19.	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Pediatric Glasses or Contact Lenses Limited to one pair of prescription glasses per calendar year; contact lenses are limited to one 12-month supply per calendar year. Benefits are available up to the end of the month in which the member turns 19.	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
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.		
Prescription Drug Card • The pharmacy network for the plan is the **ValueONE Network** • Prescription drugs (other than Maintenance Drugs) – up to a 30-day supply • Maintenance Drugs – up to a 90-day supply may be purchased but copay applies for each 30-day supply • Some copays may be combined for diabetic supplies • Tier 5 & 6 (Specialty) Drugs – up to a 30-day supply • Certain Tier 5 & 6 (Specialty) Drugs can only be dispensed by the **Pharmacy Select Network** • View the SourceRx 2.0 Drug List, Maintenance Drug List and Specialty Drug List at **AlabamaBlue.com/DrugList** • Locate a **ValueONE Network** Pharmacy at **AlabamaBlue.com/Pharmacy**	Covered at 100% of the allowed amount after the following copays: **Tier 1 Drugs:** $10 copay per prescription **Tier 2 Drugs:** $20 copay per prescription **Tier 3 Drugs:** $40 copay per prescription **Tier 4 Drugs:** $80 copay per prescription **Tier 5 (Preferred Specialty) Drugs:** $125 copay per prescription **Tier 6 (Non-Preferred Specialty) Drugs:** $250 copay per prescription	Not covered
Mail Order Pharmacy Service • Up to 90-day supply with one copay • Mail Order drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/Pharmacy** or call **1-800-391-1886**) **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 service.	Covered at 100% of the allowed amount after the following copays: **Tier 1 Drugs*:*** $25 copay per prescription **Tier 2 Drugs:** $50 copay per prescription **Tier 3 Drugs:** $100 copay per prescription **Tier 4 Drugs:** $200 copay per prescription **Tier 5 (Preferred Specialty) Drugs:** Not covered **Tier 6 (Non-Preferred Specialty) Drugs:** Not covered	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 80% of the allowed amount subject to calendar year deductible
Ambulance Service	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Chiropractic Services Limited to 15 visits per calendar year	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per year	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per year	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible
Autism-Related Rehabilitative and Habilitative Occupational and Speech Therapy Children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, covered at 50% of the allowed amount subject to calendar year deductible
Home Health and Hospice	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible; in Alabama, not covered
HEALTH MANAGEMENT AND ADDITIONAL 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**.	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
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 Services	Air ambulance service, at no charge, to a network hospital of the member's choice near their home if hospitalized while traveling more than 150 miles from home; limited to two air medical transports per member per year. To arrange transportation, call AirMed at **1-877-872-8624**.	

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 Blue Cross and Blue Shield of Alabama or another 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 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 Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan. 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.*
- *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.*

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 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。