We cover what matters.

BlueCard® PPO
Plan Benefits

City of Huntsville
High Deductible Health Plan
Group 92751

Effective January 1, 2022

Visit our website at
AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescription Drugs: PreferredONE Network

Locate a PreferredONE Retail Network pharmacy at AlabamaBlue.com/pharmacy

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.

City of Huntsville
High Deductible Health Plan
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BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Benefit payments are based on the amount of the provider's charge that Blue Cross and Blue Shield recognizes for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.		
GENERAL PROVISIONS **Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.**		
Calendar Year Deductible For self-only coverage, no benefits, except preventive care, are paid by the plan until medical expenses paid by the individual equal the deductible amount. For family coverage, no benefits, except preventive care, are paid by the plan to any family member until that individual family member meets the individual deductible amount of $1,000 or the total medical expenses paid by the family equal the family deductible amount.	Self only coverage: $1,000 Family coverage: $3,500	
Annual Medical Out-of-Pocket Maximum After you reach your self-only calendar year out-of-pocket maximum applicable expenses for you will be covered at 100% for remainder of calendar year	Self-only coverage: $3,000 Family coverage: $6,000 **In-Network Services:** Deductibles, copays, coinsurance and mental health and substance abuse apply to the out-of-pocket maximum **Out-of-Network Services:** Out-of-Network services do not apply to the out-of-pocket maximum.	
Annual Prescription Drug Out-of-Pocket Maximum	$2,000 individual annual out-of-pocket maximum; $4,000 annual out-of-pocket maximum per family. **In-Network Services:** Prescription drug copays and coinsurance apply to the out-of-pocket maximum, 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-Network Services:** Out-of-Network services do not apply to the out-of-pocket maximum.	
INPATIENT HOSPITAL FACILITY SERVICES **Precertification is required for inpatient admissions (except medical emergency services, maternity and as required by applicable 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 Facility Coverage (including maternity)	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible **Note**: In Alabama, available only for medical emergency and accidental injury
OUTPATIENT HOSPITAL FACILITY SERVICES **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.**		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Emergency Room (Medical Emergency)	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 90% of the allowed amount subject to calendar year deductible
Emergency Room (Accident)	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 90% of the allowed amount subject to calendar year deductible.
Diagnostic Lab, X-ray, IV Therapy, Pathology, Hemodialysis, Chemotherapy and Radiation Therapy	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PHYSICIAN SERVICES		
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.		
Office Visits and Second Surgical Opinions	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Emergency Room Physician Fees	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 90% of the allowed amount subject to calendar year deductible
Surgery, Anesthesia, Inpatient Visits, & Inpatient Consultations	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Maternity	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Diagnostic X-rays and Lab Exams	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Chemotherapy and Radiation Therapy	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
TELEHEALTH SERVICES		
Telehealth Services	Covered at 90% of the allowed amount subject to calendar year deductible	Not Covered.
PREVENTIVE CARE SERVICES		
Preventive Immunizations and Routine Services • See **AlabamaBlue.com/preventiveservices and AlabamaBlue.com/SourceRXACAPreventriveDrugList** for a listing of the specific 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%; 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 (PPO)	OUT-OF-NETWORK (NON-PPO)
OTHER COVERED SERVICES		
Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Chiropractor Services	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Physical Therapy	Covered at 90% of the allowed amount, subject to the calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Occupational Therapy	Covered at 90% of the allowed amount, subject to the calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Speech Therapy	Covered at 90% of the allowed amount, subject to the calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18	Covered at 90% of the allowed amount, subject to the calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Durable Medical Equipment	Covered at 90% of the allowed amount, subject to the calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Temporomandibular Joint Disorders	Covered at 90% of the allowed amount, subject to the calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Allergy Testing & Treatment	Covered at 90% of the allowed amount, subject to the calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Medical Nutritional Therapy Services For adults and children, limited to 6 hours per member per calendar year	Covered at 90% of the allowed amount, subject to the calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Home Health and Hospice	Covered at 90% of the allowed amount subject to calendar year deductible Precertification required for services rendered outside of Alabama. Call 1 800 821-7231.	Covered at 70% of the allowed amount subject to calendar year deductible Precertification required. Call 1 800 821-7231. **Non-Preferred in Alabama:** No benefits are available if a non-Preferred provider is used.
Home Infusion	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Ambulance Services	Covered at 90% of the allowance, subject to the calendar year deductible	Covered at 90% of the allowance, subject to the calendar year deductible
Removal of Impacted Wisdom Teeth	Covered at 90% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS		
Retail Prescription Drug Card Benefits • The retail pharmacy network for the plan is the **PreferredONE Retail Network** • Some copays combined for diabetic supplies • Prescription drugs-up to 34 day supply • The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Pharmacy Select Network**, visit **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList** • View the **SourceRx 2.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** Locate a **PreferredONE Retail Network** pharmacy at **AlabamaBlue.com/PreferredOneRetailPharmacyLocator** • Certain specialty drugs are listed on the Specialty Drug Coupon Program List at **AlabamaBlue.com/specialty couponProgramdruglist** • 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	**Non Maintenance – Up to a 34 day supply** **Tier 1:** $10 copay per prescription **Tier 2:** $50 copay per prescription **Tier 3**: $75 copay per prescription **Tier 4:** $125 copay per prescription **Diabetic/Insulin medications and supplies will have a $25 copay per prescription regardless of tier** **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 monitors will always require a separate copay.	**Non-Participating Pharmacy in Alabama:** No benefits are available for prescriptions purchased in a non-Participating Pharmacy in Alabama.
Extended Supply Prescription Drug Card Benefits • The extended supply pharmacy network for the plan is the **PreferredONE ESN Network** • Some copays combined for diabetic supplies • Only maintenance prescription drugs can be purchased through this extended supply pharmacy service-up to 90 day supply • View the **SourceRx 2.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** Locate a **PreferredONE Retail Network** pharmacy at **AlabamaBlue.com/PreferredONEESNPharmacyLocator**	**Maintenance – Up to a 90 day supply** **Tier 1:** $20 copay per prescription **Tier 2:** $100 copay per prescription; **Tier 3:** $150 copay per prescription **Diabetic/Insulin medications and supplies will have a $25 copay per prescription regardless of tier** **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 monitors will always require a separate copay.	**Non-Participating Pharmacy in Alabama:** No benefits are available for prescriptions purchased in a non-Participating Pharmacy in Alabama.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Mail Order Pharmacy Benefit • Up to a 90 day supply of maintenance medication • Mail Order drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/HomeDeliveryNetwork** View the **SourceRx 2.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList**	**Tier 1:** $20 copay per prescription **Tier 2:** $100 copay per prescription **Tier 3:** $150 copay per prescription **Tier 4:** Not covered Includes oral contraceptives	No benefits available.
HEALTH MANAGEMENT AND ADDITIONAL BENEFITS		
Baby Yourself®	A maternity program; For more information, please call 1 800 222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself**	
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.	
American Cancer Society Quit for Life® Smoking Cessation Program	A tobacco cessation program for employees, spouses, and dependents age 18 and over that provides support to participants through telephone-based counseling and nicotine replacement therapy. Call 1 888 768-7848 for participation information.	
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	

Please note: Providers/Specialists may be listed in a PPO directory or on the provider finder web site (AlabamaBlue.com), but not covered as PPO benefits by this group health plan (i.e., DME, Ambulance, Allergists). Please check your benefit matrix or Summary Plan Description to determine coverage.

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

10/13/2021 HW
Group# 92751