We cover what matters.

BlueCard® PPO Plan Benefits

Imperial Electric Akron Union HDHP

Group 93373

BlueCard® PPO –
HSA Qualified HDHP

Effective January 01, 2024

Visit our website at
AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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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.		
HEALTH SAVINGS ACCOUNT (HSA)		
A Health Savings Account (HSA) is an account established with pre-taxed money in order to save for future medical expenses. In order to establish an HSA you must first be enrolled in an HSA-Qualified High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain government requirements for use in conjunction with a HSA. This plan is designed to meet those government requirements. Enrolling in an HDHP allows you the opportunity to make contributions to an HSA on a pre-tax basis.		
Maximum Contribution: The maximum contribution amount is indexed each year by the U.S. Treasury. The 2024 maximum contribution is **$4,150** for single coverage and **$8,300** for family coverage. If you have any questions about the benefits of an HSA, please consult your tax accountant.		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	$3,200 self-only coverage; $6,400 family coverage The in-network calendar year deductible will *NOT* apply to the out-of-network out-of-pocket maximum.	$6,400 self-only coverage; $12,800 family coverage The out-of-network out-of-pocket maximum *WILL* apply to the in-network out-of-pocket maximum.
Calendar Year Out-of-Pocket Maximum Family members meet only their individual out of pocket and then their claims will be covered at 100%; if the family out of pocket has been met prior to their individual out of pocket being met, their claims will be paid at 100%.	$3,200 self-only coverage; $6,400 family coverage 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** The in-network out-of-pocket maximum does *NOT* apply to the out-of-network out-of-pocket maximum	$7,400 self-only coverage; $13,800 family coverage Deductibles 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 The out-of-network out-of-pocket maximum *WILL* apply to the in-network out-of-pocket maximum
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
All hospital admissions require preadmission certification, except maternity admissions and as required by Federal law. Emergency admissions require certification within 48 hours of admission except as required by Federal law. For preadmission certification, call 1-800-248-2342.		
Inpatient Hospital and Residential Treatment Facilities **Including:** Residential Treatment Facilities, Skilled Nursing Facilities, Rehabilitation Hospital and Sub-Acute Facilities	Covered at 100% of the allowed amount, subject to calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries	Covered at 80% of the allowed amount, subject to calendar year deductible for semi-private room and board
Human Organ and Tissue Transplant Services (Bone Marrow/Stem Cell)	Covered at 100% of the allowance subject to the calendar year deductible	Not covered
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to in-network calendar year deductible **Out-of-network Mental Health and Substance Abuse services apply to the in-network out-of-pocket maximum**
Emergency Room (Accident)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to in-network calendar year deductible
Emergency Room (Physician)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to in-network calendar year deductible **Out-of-network Mental Health and Substance Abuse services apply to the in-network out-of-pocket maximum**
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray (When performed at the Emergency Room/Urgent Care Facility)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology/Non-ER Services (Includes pre-admission testing)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowance subject to the calendar year deductible
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services **Note:** Preadmission Certification is required. Call 1-800-248-2342	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits, Urgent Care Clinics and Consultations Includes: • Diagnosis for obesity • Surgery performed in the Physician's Office • Second Opinion Consultations • Allergy Treatment/Injections • Allergy serum (dispensed by the Physician in the office)	Covered at 100% of the allowed amount, subject to calendar year deductible with general practitioner, family practitioner, internist, OB/GYN, pediatrician, geriatrics, mental health and substance abuse provider and nurse practitioner or physician's assistant under the direction of above listed providers.	Covered at 80% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 (Includes Dependents)	Covered at 100% of the allowed amount, subject to calendar year deductible (100% no deductible or copay for routine prenatal services)	Covered at 80% of the allowed amount, subject to calendar year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy **Note:** Preadmission Certification is required. Call 1-800-248-2342	Covered at 100% of the allowed amount, subject to calendar year deductible for Behavioral Therapy services	Covered at 80% of the allowed amount, subject to 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 BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/PreventiveServices** for a listing of the specific immunizations and preventive services or call our Customer Service Department for a printed copy.	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Routine Mammogram	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
Routine PSA (Prostate Specific Antigen)	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
Routine Pap Smear	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
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 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.		
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Prescription Drugs are not administered by Blue Cross and Blue Shield of Alabama.		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Allergy Testing & Treatment	Covered at 100% 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 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services Limited to 60 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Biofeedback	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Acupuncture	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	Covered at 100% of the allowed amount, no copay or deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Obesity/Bariatric Surgery (Subject to medical necessity and clinical guidelines) **Note:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc. • Only the Surgical Services accumulate to the lifetime maximum • $10,000 lifetime maximum will apply to Surgical Professional Services	Covered at 100% of the allowed amount, subject to calendar year deductible	Not Covered
Genetic Testing/Counseling Genetic Counseling limited to 3 visits per member per calendar year for pre and post-genetic testing	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Rehabilitative Physical and Occupational Therapy Limited to a combined maximum of 60 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Habilitative Physical & Occupational Therapy Limited to a combined maximum of 60 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Rehabilitative Speech Therapy Limited to a maximum of 60 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Habilitative Speech Therapy Limited to a maximum of 60 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders (Age and visit limits do not apply) **Note:** This plan follows the State of Utah's EHB benefits package	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Pulmonary Rehabilitation & Cognitive Therapy Limited to a combined maximum of 20 days per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Cardiac Rehabilitation Therapy Limited to a maximum of 36 days per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Diabetic Education Limited to 3 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Hospice (Includes Bereavement Counseling) Precertification required. Call 1-800-821-7231. Services must be authorized by physician	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Home Health (Includes outpatient private duty nursing when approved as medically necessary) Limited to 60 days per member per calendar year Precertification required. Call 1-800-821-7231.	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Home Infusion	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Foot Care (Podiatry) Excluding routine foot 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
Travel and Lodging (Organ Transplants)	Travel and Lodging will be provided for members that live more than 50 miles from approved facilities such as a Center of Excellence or Blue Distinction Center for the treatment of Congenital Heart Disease (CHD), obesity surgery, transplants and cancer related treatments. If the patient is covered by Medicare, benefits for travel and lodging will not be covered. Coverage is allowed for the patient and one companion unless the patient is an enrolled dependent minor child, then the patient and two companions are eligible. Benefits are paid at a per diem rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion or two companions if the patient is a dependent minor child. A combined overall maximum of $10,000 per member in a lifetime. Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.	
HEALTH MANAGEMENT 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.	
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: injectables, 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 Alabama, in-network services provided by mental health disorders 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/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.*

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: 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。