



# Plan Benefits

BlueCard® PPO

**The University of Alabama  
in Huntsville  
79912  
BlueCard® PPO**

Effective January 01, 2026

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**BlueCross BlueShield  
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

**The University of Alabama in Huntsville**  
**BlueCard® PPO**  
**Effective January 01, 2026**

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 deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Medical Deductible	\$150 per individual per calendar year	
Calendar Year Pharmacy Deductible	\$150 per individual per calendar year	
Calendar Year Out-of-Pocket Maximum	<p>\$2,500 individual; \$7,150 family</p> <p>In-network: All copays, deductibles and coinsurance including copay for out-of-network mental health and substance abuse ER and ER physician services will apply to the in-network out-of-pocket maximum excluding prescription drugs. Payments made by drug manufacturer assistance programs may not apply towards the deductible or out-of-pocket maximum.</p> <p>There is a separate \$2,500 individual; \$7,150 family prescription drug out-of-pocket maximum</p> <p>After you reach your individual Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowance for the remainder of the calendar year</p> <p>Out-of-network: All copays and coinsurance for out-of-network other covered services apply to the annual out-of-pocket maximum. Applicable expenses are listed under the "BENEFITS FOR OTHER COVERED SERVICES" heading starting on page 7. Only services under this heading apply to the out of network out of pocket maximum</p> <p>In-network and out-of-network out-of-pocket amounts apply to each other</p>	
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services, maternity and as required by 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 Hospital and Residential Treatment Facilities	Covered at 100% of the allowed amount for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries, subject to \$400.00 per admission copay and subject to calendar year deductible; 365 days per confinement.	Covered at 80% of the allowed amount for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries, subject to \$400.00 per admission copay and subject to calendar year deductible; 365 days per confinement.  Note: In Alabama, available only for medical emergency and accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount, subject to calendar year deductible	In Alabama, covered at 50% of the allowed amount, subject to calendar year deductible  Outside Alabama, Covered at 80% of the allowed amount, subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, subject to \$150.00 hospital copay and 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 \$150.00 hospital copay and subject to calendar year deductible	Covered at 100% of the allowed amount, subject to \$150.00 hospital copay and subject to calendar year deductible  Mental Health Disorders and Substance Abuse Services apply to the in-network out-of-pocket maximum

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Non-Emergency	Covered at 80% of the allowed amount, subject to \$150.00 hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to \$150.00 hospital copay and subject to calendar year deductible
Emergency Room (Accident)	Covered at 100% of the allowed amount, subject to \$150.00 hospital copay and subject to calendar year deductible	Covered at 100% of the allowed amount, subject to \$150.00 hospital copay and subject to calendar year deductible
Emergency Room (Physician)	Covered at 100% of the allowed amount, subject to \$55.00 physician copay and subject to calendar year deductible	Covered at 100% of the allowed amount, subject to \$55.00 physician copay and subject to calendar year deductible  <b>Mental Health Disorders and Substance Abuse Services</b> apply to the in-network out-of-pocket maximum
Chemotherapy, Hemodialysis, IV Therapy & Radiation Therapy	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Diagnostic Lab & X-ray	Covered at 100% of the allowed amount, subject to calendar year deductible  MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 100% of the allowed amount, subject to \$125.00 copay and subject to calendar year deductible  <b>Note:</b> If there is more than one procedure done on the same date of service there will be <u>only</u> one copayment taken for the facility and <u>only</u> one copayment taken for the physician.	Covered at 80% of the allowed amount, subject to calendar year deductible  MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 80% of the allowed amount, subject to \$125.00 copay and subject to calendar year deductible  <b>Note:</b> If there is more than one procedure done on the same date of service there will be <u>only</u> one copayment taken for the facility and <u>only</u> one copayment taken for the physician.
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowed amount, subject to \$55.00 daily hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
<b>PHYSICIAN BENEFITS</b> <b>(Includes Mental Health Disorders and Substance Abuse)</b> Precertification is required for some physician benefits and provider-administered drugs; visit <a href="http://AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList">AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList</a> . Please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on <a href="http://AlabamaBlue.com/Providers/HelpScript">AlabamaBlue.com/Providers/HelpScript</a> , cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
<b>Office Visits and Outpatient Consultations Rendered by a Primary Care Physician</b>  (Includes: Internist, Family & General Practitioner, Pediatrician, OB/GYN & Geriatrician)	Covered at 100% of the allowed amount, subject to \$35.00 physician copay and subject to calendar year deductible	<b>In Alabama</b> , covered at 50% of the allowed amount, subject to calendar year deductible  <b>Outside Alabama</b> , Covered at 80% of the allowed amount, subject to calendar year deductible
<b>Office Visits and In-Person Consultations Rendered by a Specialist</b>	Covered at 100% of the allowed amount, subject to \$55.00 physician copay and subject to calendar year deductible	<b>In Alabama</b> , covered at 50% of the allowed amount, subject to calendar year deductible  <b>Outside Alabama</b> , Covered at 80% of the allowed amount, subject to calendar year deductible
<b>Second Surgical Opinions</b>	Covered at 100% of the allowed amount, subject to calendar year deductible	<b>In Alabama</b> , covered at 50% of the allowed amount, subject to calendar year deductible  <b>Outside Alabama</b> , Covered at 80% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>Nurse Practitioner/Nurse Midwife/Clinical Nurse Specialist/Mental Health Nurse Practitioner/Mental Health Clinical Nurse Specialist and Physician Assistant's Office Visits and Consultations</b>	<p>Covered at 100% of the allowed amount, subject to \$20.00 physician copay and subject to calendar year deductible</p> <p>Services must be rendered under the supervision of a PPO doctor.</p>	<p><b>In Alabama</b>, covered at 50% of the allowed amount, subject to calendar year deductible</p> <p><b>Outside Alabama</b>, Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Telephone and Online Video consultations program – Medical</b>  A service, through Doctor on Demand™ to diagnose, treat and prescribe medication (when necessary) for certain medical and behavioral health issues. To enroll, go to DoctorOnDemand.com/Alabama or call 1-800-997- 6196.	<p>Covered at 100% of the allowed amount, subject to a \$20.00 copayment per consultation</p>	<p>Not Covered</p>
<b>Telephone and Online Video consultations program – Behavioral Health</b>  A service, through Doctor on Demand™ to diagnose, treat and prescribe medication (when necessary) for certain medical and behavioral health issues. To enroll, go to DoctorOnDemand.com/Alabama or call 1-800-997- 6196.	<p><b>Therapy short visit:</b> 100% of the allowed amount, after a \$35.00 copayment oer consultation and subject to calendar year deductible</p> <p><b>Therapy long visit:</b> 100% of the allowed amount, after a \$35.00 copayment per consultation and subject to calendar year deductible</p> <p><b>Psychiatry initial visit:</b> 100% of the allowed amount, after a \$55.00 copayment per consultation and subject to calendar year deductible</p> <p><b>Psychiatry visit:</b> 100% of the allowed amount, after a \$55.00 copayment per consultation and subject to calendar year deductible</p>	<p>Not Covered</p>
<b>Surgery Performed in a Physician's Office</b>	<p>Covered at 100% of the allowed amount, subject to \$35.00 office visit copay and subject to calendar year deductible if performed by a Primary Care Physician</p> <p>Covered at 100% of the allowed amount subject to \$55.00 office visit copay and subject to calendar year deductible if performed by a Specialist</p>	<p><b>In Alabama</b>, covered at 50% of the allowed amount, subject to calendar year deductible</p> <p><b>Outside Alabama</b>, Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Surgery &amp; Anesthesia</b>	<p>Covered at 100% of the allowed amount, subject to calendar year deductible</p>	<p><b>In Alabama</b>, covered at 50% of the allowed amount, subject to calendar year deductible</p> <p><b>Outside Alabama</b>, Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Maternity Care</b>	<p>Covered at 100% of the allowed amount, subject to calendar year deductible</p>	<p><b>In Alabama</b>, covered at 50% of the allowed amount, subject to calendar year deductible</p> <p><b>Outside Alabama</b>, Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Hemodialysis, Chemotherapy, Radiation Therapy &amp; IV Therapy</b>	<p>Covered at 100% of the allowed amount, subject to calendar year deductible</p>	<p><b>In Alabama</b>, covered at 50% of the allowed amount, subject to calendar year deductible</p> <p><b>Outside Alabama</b>, Covered at 80% of the allowed amount, subject to calendar year deductible</p>

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>Diagnostic Lab &amp; X-ray</b>  	Covered at 100% of the allowed amount, subject to calendar year deductible  However MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 100% of the allowed amount, subject to a \$35.00 copay and subject to calendar year deductible.  <u><b>Note:</b></u> If there is more than one procedure done on the same date of service there will be <u><b>only</b></u> one copayment taken for the facility and <u><b>only</b></u> one copayment taken for the physician.	<b>In Alabama</b> , covered at 50% of the allowed amount, subject to calendar year deductible.  However MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 50% of the allowed amount, subject to a \$35.00 copay and subject to calendar year deductible  <b>Outside Alabama</b> , covered at 80% of the allowed amount, subject to calendar year deductible.  However MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 80% of the allowed amount, subject to a \$35.00 copay and subject to calendar year deductible  <u><b>Note:</b></u> If there is more than one procedure done on the same date of service there will be <u><b>only</b></u> one copayment taken for the facility and <u><b>only</b></u> one copayment taken for the physician.
<b>Applied Behavioral Analysis (ABA) Therapy</b>  Limited to ages 0-18 for autism spectrum disorders	Covered at 100% of the allowed amount after \$55 copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
TELEHEALTH SERVICES		
<b>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.</b>		
PREVENTIVE CARE BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
<b>Routine Immunizations and Preventive Services</b>  See <a href="http://AlabamaBlue.com/PreventiveServices">AlabamaBlue.com/PreventiveServices</a> and <a href="http://AlabamaBlue.com/NetResultsACAPreventiveDrugList">AlabamaBlue.com/NetResultsACAPreventiveDrugList</a> 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 <a href="http://AlabamaBlue.com/VaccineNetworkDrugList">AlabamaBlue.com/VaccineNetworkDrugList</a> for more information	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
<b>Note:</b> 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
<b>PRESCRIPTION DRUG BENEFITS</b> <b>(Includes Mental Health Disorders and Substance Abuse)</b>		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.		
<b>Retail Prescription Prepaid Benefits</b> <ul style="list-style-type: none"> <li>The pharmacy network for the plan is <b>Prime Participating Network</b></li> <li>Maintenance and non-maintenance drugs can be purchased through Retail</li> <li>Some copays combined for diabetic supplies</li> <li>Fertility medications are covered</li> <li>Maintenance drugs – up to a 90-day supply may be purchased but one copay applies for up to a 31-day supply, 2 copays apply for days 32-90 day supply</li> <li>Prescription drugs (other than maintenance) - up to a 31-Day supply</li> <li>The only in-network pharmacy for some Tier 4 (specialty) drugs is the <b>Pharmacy Select Network</b>; view the Specialty Drug Lists at <a href="http://AlabamaBlue.com/SelfAdministeredSpecialtyDrugList">AlabamaBlue.com/SelfAdministeredSpecialtyDrugList</a></li> <li>View the <b>NetResults 1.0 (Up to 4 Tier)</b> drug lists that apply to the plan at <a href="http://AlabamaBlue.com/NetResults1DrugList4T">AlabamaBlue.com/NetResults1DrugList4T</a></li> <li>Certain drugs are part of the FlexAccess Program. See list at <a href="http://AlabamaBlue.com/FlexAccessDrugList">AlabamaBlue.com/FlexAccessDrugList</a></li> <li>Locate a <b>Prime Participating Network</b> pharmacy at <a href="http://AlabamaBlue.com/PrimeParticipatingPharmacyLocator">AlabamaBlue.com/PrimeParticipatingPharmacyLocator</a></li> </ul> <p>Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network. A list of the eligible vaccines these pharmacies may provide can be found at: <a href="http://AlabamaBlue.com/VaccineNetworkDrugList">AlabamaBlue.com/VaccineNetworkDrugList</a></p>	<p>Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 drugs subject to separate \$150 prescription drug deductible per person per calendar year and the following copays:</p> <p><b>Tier 1 Drugs:</b> \$20 copay per prescription</p> <p><b>Tier 2 Drugs:</b> \$45 copay per prescription</p> <p><b>Tier 3 Drugs:</b> \$65 copay per prescription</p> <p><b>Tier 4 (specialty) Drugs:</b> \$125 copay per prescription</p> <p>For drugs on the FlexAccess Drug List, cost share may vary based on available drug manufacturer assistance. If assistance is available, the amount member pays out-of-pocket will be set by the drug manufacturer assistance program.</p> <p><b>Separate Annual Out-of-Pocket Maximum:</b> \$2,500 per person \$7,150 per family</p> <p>If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay</p>	<p>Not Covered</p>

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<p><b>Extended Supply Prescription Prepaid Benefits</b></p> <ul style="list-style-type: none"> <li>The extended supply pharmacy network for the plan is the <b>Extended Supply Network</b></li> <li>Maintenance and non-maintenance prescription drugs can be purchased through the Extended Supply Network</li> <li>Prescription drugs-up to 31-day supply (other than maintenance)</li> <li>Maintenance drugs – up to a 90-day supply may be purchased but one copay applies for up to a 31-day supply, 2 copays apply for days 32-90 day supply</li> <li>Tier 4 (specialty) drugs are not available through extended supply pharmacy service</li> <li>View the <b>NetResults 1.0 (Up to 4 Tier)</b> and maintenance drug lists that apply to the plan at <b>AlabamaBlue.com/AlabamaBlue.com/NetResults1DrugList4T</b></li> <li>Locate a <b>Prime Participating Network ESN Network</b> pharmacy at <b>AlabamaBlue.com/PrimeParticipatingPharmacyLocator</b></li> </ul>	<p>Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 subject to separate \$150 prescription drug deductible per person per calendar year and the following copays:</p> <p><b>Tier 1 Drugs:</b> \$20 copay per prescription</p> <p><b>Tier 2 Drugs:</b> \$45 copay per prescription</p> <p><b>Tier 3 Drugs:</b> \$65 copay per prescription</p> <p><b>Tier 4 (specialty) Drugs:</b> Not Covered</p> <p><b>Separate Annual Out-of-Pocket Maximum:</b> \$2,500 per person \$7,150 per family</p> <p>If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay</p>	<p>Not Covered</p>
<p><b>Select Generic Specialty and Biosimilar Drugs</b></p> <p>Generic specialty and biosimilar drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some generic specialty and biosimilar drugs is the <b>Pharmacy Select Network</b>.</p> <ul style="list-style-type: none"> <li>View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at <b>AlabamaBlue.com/SelectGenericSpecialtyandBiosimilarDrugList</b>.</li> </ul> <p>Generic specialty and biosimilar drugs are not available through the Home Delivery Network.</p>	<p>100% of the allowed amount, no deductible or copayment</p>	<p>Not Covered</p>



BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>Mail Order Pharmacy Benefits</b> <ul style="list-style-type: none"> <li>• Prescription drugs up to a 90- day supply with 2 copays</li> <li>• Only Maintenance prescription drugs can be purchased through Mail Order</li> <li>• Mail Order Drugs are available through <b>Home Delivery Network</b> (Enroll online at <b>AlabamaBlue.com</b> or call 1-855-793-5326)</li> <li>• View the maintenance drug list that applies to the plan at <b>AlabamaBlue.com/Maintenance DrugList</b></li> <li>• View the NetResults 1.0 (Up to 4 Tier) drug lists that apply to the plan at <b>AlabamaBlue.com/NetResults 1DrugList4T</b></li> </ul>	<p>Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 subject to separate \$150 prescription drug deductible per person per calendar year and the following copays:</p> <p><b>Tier 1 Drugs:</b> \$15 copay per prescription</p> <p><b>Tier 2 Drugs:</b> \$35 copay per prescription</p> <p><b>Tier 3 Drugs:</b> \$55 copay per prescription</p> <p><b>Tier 4 (specialty) Drugs:</b> Not covered</p> <p><b>Separate Annual Out-of-Pocket Maximum:</b> \$2,500 per person \$7,150 per family</p> <p>If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay</p>	<p>Not Covered</p>
<b>BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)</b>		
<p><b>Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on <a href="http://AlabamaBlue.com/Providers/HelpScript">AlabamaBlue.com/Providers/HelpScript</a>, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.</b></p>		
<b>Allergy Testing &amp; Treatment</b>	<p>Covered at 100% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Ambulance Service</b>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Participating Chiropractic Services</b> Limited to a maximum of 24 visits per person each calendar year	<p>Covered at 80% of the allowed amount, subject to calendar year deductible when services are provided by a participating in network chiropractor</p>	<p><b>In Alabama</b>, covered at 50% of the allowed amount, subject to calendar year deductible when services are provided by a non-Participating Chiropractor</p> <p><b>Outside Alabama</b>, covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Durable Medical Equipment (DME)</b>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Rehabilitative Occupational and Speech Therapy</b> Occupational and speech therapy limited to a maximum of 35 visits per person per therapy each calendar year	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Habilitative Occupational and Speech Therapy</b> Occupational and speech therapy limited to a maximum of 35 visits per person per therapy each calendar year	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>
<b>Rehabilitative Physical Therapy</b> Limited to a maximum of 35 visits per person each calendar year	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>



BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>Habilitative Physical Therapy</b> Limited to a maximum of 35 visits per person each 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
<b>Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18</b>	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
<b>Nutritionist Visits</b> No visit limits Note: Employee is also responsible for any charges above the allowance.	Covered at 100% of the allowed amount, subject to \$20.00 physician copay and subject to calendar year deductible	Covered at 100% of the allowed amount, subject to \$20.00 physician copay and subject to calendar year deductible
<b>Preferred Home Health and Hospice</b>	Covered at 100% of the allowed amount, subject to calendar year deductible	<b>In Alabama</b> , no benefits available if a non-preferred provider is used  <b>Outside Alabama</b> , covered at 80% of the allowed amount, subject to calendar year deductible  Precertification is required for services rendered outside Alabama. Call 1-800-821-7231
<b>Home Infusion</b>	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
<b>HEALTH MANAGEMENT BENEFITS</b> <b>(Includes Mental Health Disorders and Substance Abuse)</b>		
<b>Individual Case Management</b>	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
<b>Chronic Condition Management</b>	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease and other specialized conditions.	
<b>Baby Yourself®</b>	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at <a href="http://AlabamaBlue.com/BabyYourself">AlabamaBlue.com/BabyYourself</a> .	
<b>Contraceptive Management</b>	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.	
<b>Air Medical Transport</b>	Air medical transportation to a network hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624.	
<b>Pivot Tobacco Cessation</b>	A tobacco cessation program for (employees, spouses and dependents age 18 and over) that blends digital technology and behavioral science to help members quit tobacco use. PIVOT members receive a mobile app, individual coaching, breath sensor device, and nicotine replacement therapy (when applicable) This program lasts 6 months. Visit <a href="http://pivot.co/bcbsal6">pivot.co/bcbsal6</a> for participation information.	
<b>Wondr Health®</b>	Wondr Health® is an online clinical behavioral weight loss program.	

#### **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-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 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.
- Please refer to your benefit book or contact Blue Cross directly about coverage for your hospital charges and other related medical services. Approval for air medical services does not mean that hospitalization and other medical expenses will be covered. All coverage determinations for medical benefits are subject to the terms, conditions, limitations and exclusions of the health plan. Air medical transport services are provided through a contract with AirMed International, LLC, an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical services terminate if coverage by your health plan ends.
- Prime Therapeutics LLC® is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.
- Pivot, an independent company, provides a smoking cessation and digital health coaching platform for members of Blue Cross and Blue Shield of Alabama.
- Doctor on Demand by Included Health is an independent company that provides a telehealth mobile app and health services on behalf of Blue Cross and Blue Shield of Alabama.

**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

### Discrimination is Against the Law

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 (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary 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 assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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>.

### Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English:** ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.

**Arabic:** انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتيسقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

**Chinese:** 请注意: 如果您说普通话, 我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以易读格式向您提供信息。请拨打 1-855-216-3144 (TTY 用户请拨 711) 或致电客户服务部。

**French:** À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

**Gujarati:** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ કરો (TTY: 711).

**Hindi:** ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

**Japanese:** ご案内: 日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

**Korean:** 주의: 한국어(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144 (TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

**Lao:** ຄຳໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນອັງສາມາດໃຊ້ໄດ້ດ້ວຍບໍ່ສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຜ່ານບໍລິການລູກຄ້າ.

**Portuguese:** ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

**Russian:** ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

**Spanish:** ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

**Tagalog:** ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

**Turkish:** DİKKAT: Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

**Vietnamese:** CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.