Plan Benefits

BlueCard® PPO

East Alabama Health

Healthlinks Voluntary Employee Benefit Association Trust

Effective January 1, 2027

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BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

East Alabama Medical Center-Healthlinks
Voluntary Employee Benefit Association Trust
Effective January1, 2027

BENEFIT	Tier 1: DPN, EAMC Hospital, UAB and Children's Hospital (Services rendered at UAB/Children's Hospitals can only be considered Tier 1 if the service can't be provided at EAMC.)	Tier 2: In-State/In-Network BCBS AL PCP's and Facilities	Tier 3: All Out of State/In-Network BCBS Providers and Facilities	Out-of-Network
Benefit payments are based on the amount of the provider's charge that Blue Cross and Blue Shield of Alabama recognizes for payment of benefits. The allowed amount may vary depending upon the type provider and where services are rendered. Some services require a copay, coinsurance, calendar year deductible or deductible for each admission, visit or service.				
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 Tiers 1, 2 and Tier 3 Calendar Year Deductibles cross apply.	$500 individual; $1,000 family	$1,000 individual; $3,000 family	$2,000 individual; $4,000 family	There is no deductible for out-of-network services.
Pharmacy Deductible	$150 per person; $300 per family	n/a	n/a	n/a
Calendar Year Out-of-Pocket Maximum Tiers 1, 2 and 3 Calendar Year Out-of-Pocket cross apply.	$2,000 individual; $4,000 family All deductibles, copays and coinsurance apply to the Tier 1 out-of-pocket maximum including out-of-network emergency services for mental health disorders and substance abuse and prescription drugs Payments made by drug manufacturer assistance programs may not apply towards the deductible or out-of-pocket maximum After you reach your individual Calendar Year Out-of-Pocket Maximum, applicable expenses covered at 100% for remainder of calendar year	$4,000 individual; $8,000 family All deductibles, copays and coinsurance apply to the Tier 2 out-of-pocket maximum including prescription drugs but excluding out-of-network emergency services for mental health disorders and substance abuse. After you reach your individual Calendar Year Out-of-Pocket Maximum, applicable expenses covered at 100% for remainder of calendar year	$6,000 individual; $12,000 family All deductibles, copays and coinsurance apply to the Tier 3 out-of-pocket maximum including prescription drugs but excluding out-of-network emergency services for mental health disorders and substance abuse. After you reach your individual Calendar Year Out-of-Pocket Maximum, applicable expenses covered at 100% for remainder of calendar year	There is no out-of-pocket maximum for out-of-network services.
Calendar Year Out-of-Pocket Maximum The in-network and PPO Calendar Year Out-of-Pocket cross apply.				
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)				
Inpatient Hospital (Including Maternity) **and Residential Treatment Facilities**	100% of the allowed amount subject to calendar year deductible	100% of the allowed amount, subject to a $500 copay per day for days 1-4 and subject to calendar year deductible	70% for the allowed amount, subject to calendar year deductible	Not covered

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Inpatient Physician Visits and Consultations	100% of the allowed amount; no copay or deductible	70% of the allowed amount, subject to calendar year deductible	50% for the allowed amount, subject to calendar year deductible	Not covered
Bariatric Surgery **Note:** Coverage is limited to the physicians and services provided at Princeton Baptist Medical Center and Grandview Medical Center. Physician services for Bariatric procedures receive Tier 1 level of benefits for each type of service Please contact Blue Cross and Blue Shield customer service for additional guidelines/requirements.	80% of the allowed amount, subject to a $1,000 deductible per admission	Not covered	Not covered	Not covered
Preadmission Certification	Not required at EAMC and EAMC Designated Providers. Required for all Blue Cross and Blue Shield of Alabama Participating Facilities in Alabama. Member is responsible for obtaining; if not obtained, a $500 penalty will be applied. Call 1-800-248-2342 for precertification.	Required for all admissions except maternity and emergency hospital admissions. Member is responsible for obtaining; if not obtained, a $500 penalty will be applied. Call 1-800-248-2342 for precertification.	Required for all admissions except maternity and emergency hospital admissions. Member is responsible for obtaining; if not obtained, a $500 penalty will be applied. Call 1-800-248-2342 for precertification.	Not applicable
In Alabama, benefits for Non-Participating hospitals are available only in cases of accidental injury and medical emergency.				
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)				
Precertification is required for some outpatient hospital benefits. Precertification is required for some provider-administered drugs; please see your benefit booklet. If precertification is not obtained, a $10 penalty will apply.				
Outpatient Surgery Facility (Including Ambulatory Surgical Centers) **Pain Center Coverage EAMC only.**	100% of the allowed amount, subject to calendar year deductible	100% of the allowed amount, subject to $300 facility copay and subject to calendar year deductible	70% of the allowed amount, subject to the calendar year deductible	Not covered
Emergency Room (Medical Emergency)	100% of allowed amount, subject to $100 facility copay and subject to Tier 1 calendar year deductible	100% of allowed amount, subject to $100 facility copay and subject to Tier 1 calendar year deductible	100% of the allowed amount, subject to a $100 facility copay and subject to Tier 1 calendar year deductible	100% of the allowed, amount subject to a $100 facility copay and subject to Tier 1 calendar year deductible
Emergency Room (Accident)	100% of allowed amount, subject to $100 facility copay and subject to Tier 1 calendar year deductible	100% of allowed amount, subject to $100 facility copay and subject to Tier 1 calendar year deductible	100% of allowed amount, subject to $100 facility copay and subject to Tier 1 calendar year deductible	100% of allowed amount, subject to $100 facility copay and subject to Tier 1 calendar year deductible

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Emergency Room (Non-Emergency)	100% of allowed amount, subject to $500 facility copay and subject to calendar year deductible	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
Facility Charges for Outpatient Diagnostic Lab, Pathology and X-ray	100% of the allowed amount, subject to calendar year deductible	100% of allowed amount, subject to a $150 facility copay and subject to calendar year deductible	70% of the allowed amount, subject to the calendar year deductible	Not covered
Facility Charges for Outpatient Hemodialysis, IV Therapy, Chemotherapy and Radiation Therapy	100% of the allowed amount, subject to calendar year deductible	100% of allowed amount, subject to a $150 facility copay and subject to calendar year deductible	70% of the allowed amount, subject to the calendar year deductible	Not covered
Facility Charges for Injections/Medications (not related to ER visit, outpatient X-ray/Lab/Pathology or IV Chemo/Radiation Therapy)	100% of the allowed amount, subject to calendar year deductible	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) Precertification is required	100% of the allowed amount, after $40 daily hospital copay and subject to calendar year deductible	100% of the allowed amount, after $60 daily hospital copay and subject to calendar year deductible	100% of the allowed amount, after $100 daily hospital copay and subject to calendar year deductible	Not covered
Note: In Alabama, benefits for non-participating hospitals available only in case of accidental injury and medical emergency.				
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)				
Precertification is required for some physician benefits. Precertification is required for some provider-administered drugs; please see your benefit booklet. If precertification is not obtained, a $10 penalty will apply. For provider-administered drugs listed on AlabamaBlue.com/Providers/HelpScript, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.				
Office Visits and Consultations • **include telehealth** • **include Urgent Care**	100% of the allowed amount, subject to a $30 copay for primary care physicians; $40 for specialists	100% of the allowed amount, subject to a $40 copay for primary care physicians; $60 for specialists	100% of the allowed amount, subject to a $60 copay for primary care physicians; $100 for specialists	Not covered
Office Visits and Consultations for Mental Health Disorders and Substance Abuse Services • **includes telehealth** • **includes Blue Choice providers in Alabama and BlueCard PPO providers outside Alabama**	100% of the allowed amount, subject to a $25 copay	100% of the allowed amount, subject to a $25 copay	100% of the allowed amount, subject to a $25 copay	Not covered
Second Surgical Opinions	100% of the allowed amount, no deductible or copay	100% of the allowed amount, subject to a $60 copay	100% of the allowed amount, subject to a $100 copay	Not covered

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Surgery and Anesthesia	100% of the allowed amount, no deductible or copay	70% of allowed amount, subject to calendar year deductible	50% of allowed amount, subject to calendar year deductible.	Not covered
Emergency Room Physician	100% of the allowed amount, subject to a $40 copay and subject to Tier 1 calendar year deductible	100% of the allowed amount, subject to a $40 copay and subject to Tier 1 calendar year deductible	100% of the allowed amount, subject to a $40 copay and subject to Tier 1 calendar year deductible	100% of the allowed amount, subject to a $40 copay and subject to Tier 1 calendar year deductible
Maternity Care (Prenatal, Delivery and Postnatal Care)	100% of the allowed amount, no deductible or copay	70% of the allowed amount, subject to the calendar year deductible.	50% of the allowed amount, subject to the calendar year deductible	Not covered
Diagnostic X-rays and Lab Exams (In the physician's office) **Coverage for Tier 1 at EAMC Designated Provider Network only**	100% of the allowed amount, no deductible or copay.	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
MRI's, CT Scans and Echocardiograms (In the Physician's office) **Coverage for Tier 1 at EAMC Designated Provider Network only**	100% of the allowed amount, subject to a $150 annual copay and subject to calendar year deductible	60% of the allowed amount, subject to the calendar year deductible	40% of the allowed amount, subject to the calendar year deductible	Not covered
Chemotherapy, Dialysis, Radiation and IV Therapy	100% of the allowed amount, no deductible or copay.	70% of the allowed amount, subject to the calendar year deductible.	50% of the allowed amount, subject to the calendar year deductible	Not covered
Allergy Testing & Treatment	100% of the allowed amount, no deductible or copay.	70% of the allowed amount, not subject to the calendar year deductible.	50% of the allowed amount, not subject to the calendar year deductible	Not covered
Temporomandibular Joint Disorders (Phase I only)	100% of the allowed amount, no deductible or copay	70% of the allowed amount, not subject to the calendar year deductible.	50% of the allowed amount, not subject to the calendar year deductible	Not covered
Applied Behavioral Analysis (ABA) Therapy • Limited to ages 0-18 for autism spectrum disorders • Precertification is required	100% of the allowed amount, no deductible or copay	100% of the allowed amount, no deductible or copay	100% of the allowed amount, no deductible or copay	Not covered
TELEHEALTH SERVICES				
Benefits are provided for Telehealth Services subject to applicable cost-sharing (see Office Visits and Consultations, above) 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.				

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PREVENTIVE 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/VaccineNetworkDrugList** for more information	100% of the allowed amount, no deductible or copay	100% of the allowed amount, no deductible or copay	100% of the allowed amount, no deductible or copay	Not covered

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Additional Routine Preventive Services **Note:** All colonoscopies (including the Cologuard stool test) will be paid at 100% of the allowed amount, not subject to deductible, regardless of diagnosis for tiers 1, 2 and 3 **Note:** DEXA scans are limited to once every 2 years and a day and copay is waived when performed at EAMC.	100% of the allowed amount, no deductible or copay • Urinalysis (when necessary) • CBC (when necessary) • TB skin testing (when necessary) • Metabolic profile • Thyroid profile • Renal profile • Liver profile • Lipid profile • Iron profile • A1C • Phosphorus • Bilirubin • TSH • Thyroid screen • Urine drug screen • Hepatitis B panel • Hepatitis panel acute • Vitamin D • B12 • Glucose Screening • Transferrin Test • Colonoscopies (including Cologuard stool test) • DEXA Scan (regardless of diagnosis)	100% of the allowed amount, no deductible or copay • Urinalysis (when necessary) • CBC (when necessary) • TB skin testing (when necessary) • Metabolic profile • Thyroid profile • Renal profile • Liver profile • Lipid profile • Iron profile • A1C • Phosphorus • Bilirubin • TSH • Thyroid screen • Urine drug screen • Hepatitis B panel • Hepatitis panel acute • Vitamin D • B12 • Glucose Screening • Transferrin Test • Colonoscopies (including Cologuard stool test)	100% of the allowed amount, no deductible or copay • Urinalysis (when necessary) • CBC (when necessary) • TB skin testing (when necessary) • Metabolic profile • Thyroid profile • Renal profile • Liver profile • Lipid profile • Iron profile • A1C • Phosphorus • Bilirubin • TSH • Thyroid screen • Urine drug screen • Hepatitis B panel • Hepatitis panel acute • Vitamin D • B12 • Glucose Screening • Transferrin Test • Colonoscopies (including Cologuard stool test	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.				

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PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)				
Prescription Drug Card • Prescription drugs (other than Specialty Drugs) - 90 day supply may be purchased but copay applies for each 30 day supply • 30 day initial fill for all prescription medications • Tiers 5 & 6 (Specialty) drugs - up to a 30 day supply. Must be purchased at East Alabama Apothecary, EAMC Apothecary Specialty Pharmacy or EAMC Cancer Center • View the Specialty Drug List at **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList** • Generic drugs mandatory when available • The pharmacy network for the plan is **East Alabama Apothecary** • View **SourceRx 1.0** and maintenance drug lists at **AlabamaBlue.com/SourceRx1DrugList6T** • Certain drugs are part of the FlexAccess Program. See list at **AlabamaBlue.com/FlexAccessDrugList** 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: **AlabamaBlue.com/VaccineNetworkDrugList**.	**Separate Pharmacy Deductible:** $150 per person; $300 per family **All Prescriptions Purchased at East Alabama Apothecary:** Covered at 100% subject to drug deductible and the following copays: **Tier 1:** $10 (preferred generics) **Tier 2:** $15 (non-preferred generics) **Tier 3:** $45 (preferred brands) **Tier 4:** $45 (non-preferred brands) **Tier 5:** $100 (preferred specialty) **Tier 6:** $100 (non-preferred specialty) **Maintenance Drugs Purchased at a Blue Cross and Blue Shield Participating Pharmacy:** Prescription drugs are subject to the tier 3 deductible ($2,000 individual/$4,000 family): **Tier 1:** 80% of the allowed amount **Tier 2:** 60% of the allowed amount **Tier 3:** 60% of the allowed amount **Tier 4:** 60% of the allowed amount **Tier 5:** Not Covered **Tier 6:** Not Covered **Non- Maintenance Drug Prescriptions Purchased at a Blue Cross and Blue Shield Participating Pharmacy:** Prescription drugs are subject to the tier 3 deductible ($2,000 individual/$4,000 family): **Tier 1:** 80% of the allowed amount **Tier 2:** 60% of the allowed amount **Tier 3:** 60% of the allowed amount **Tier 4:** 60% of the allowed amount **Tier 5:** Only covered at EAMC Apothecary. For specialty medications EAMC Apothecary is unable to provide, the $100 copay will apply as if provided by EAMC Apothecary; these will be approved and directed by EAMC. **Tier 6:** Only covered at EAMC Apothecary. For specialty medications EAMC Apothecary is unable to provide, the $100 copay will apply as if provided by EAMC Apothecary; these will be approved and directed by EAMC. For drugs on the FlexAccess Drug List, cost share may vary based on available drug manufacturer assistance. If assistance is available, the amount members pays towards out-of-pocket will be set by the drug manufacturer assistance program.			Not covered

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Select Generic Specialty and Biosimilar drugs 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 Pharmacy Select Network. • View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at AlabamaBlue.com/SelectGenericSpecialtyandBiosimilarDrugList. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	Covered at 100% of the allowed amount, no copay or deductible			Not covered
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)				
Precertification is required for some other covered services and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, a $10 penalty will apply. For provider-administered drugs listed on AlabamaBlue.com/Providers/HelpScript, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero. Pre-benefit counseling is required for some services. Contact customer service at 1-888-311-3944 for pre-benefit counseling.				
Chiropractic Services **Limited to a maximum of 12 visits per member per calendar year**	50% of the allowed amount, and subject to calendar year deductible	50% of the allowed amount, and subject to calendar year deductible	Not covered	Not covered
Occupational Therapy **Note:** Therapy for children ages 0-18 is subject to Tier 1 benefit regardless of the provider.	90% of the allowed amount, subject to calendar year deductible **Designated providers for Tier 1 are RehabWorks and EAMC**	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
Physical Therapy **Note:** Therapy for children ages 0-18 is subject to Tier 1 benefit regardless of the provider.	90% of the allowed amount, subject to calendar year deductible **Designated providers for Tier 1 are Orthopedic Clinic, RehabWorks and EAMC**	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
Speech Therapy **Note:** Therapy for children ages 0-18 is subject to Tier 1 benefit regardless of the provider.	90% of the allowed amount, subject to calendar year deductible **Designated providers for Tier 1 are RehabWorks and EAMC**	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18 Precertification is required	100% of the allowed amount, no deductible or copay	100% of the allowed amount, no deductible or copay	100% of the allowed amount, no deductible or copay	Not covered

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Durable Medical Equipment, (DME), Prosthetic Devices and Supplies	**VieMed-EAMC DME (including The Orthopedic Clinic):** 90% of the allowed amount, no deductible **Precision Medical - those items not carried by VieMed-EAMC DME** **The Boutique at Spencer Cancer Center is the only authorized fitter and provider for mastectomy prosthesis and other supplies for breast cancer patients** **Medtronic aka Minimed is a Tier 1 provider for insulin pumps** **Southeast Diabetes, Inc. – Tier 1 supplier for diabetic supplies**	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
Transplants (Heart, liver, lungs, pancreas, kidney, bone marrow, heart-valve, skin, cornea and small bowel) **Pre-benefit counseling required**	100% of the allowed amount for physician's surgical services and 100% of the allowed amount for inpatient hospital services subject to inpatient deductible and copayments	70% of the allowed amount, subject to the calendar year deductible, for physician's surgical services and inpatient hospital services	50% of the allowed amount, subject to the calendar year deductible, for physician's surgical services and inpatient hospital services	Not covered
Cardiac and Pulmonary Rehabilitation **Pre-benefit counseling required**	90% of the allowed amount, subject to calendar year deductible	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
Private Duty Nursing Limited to a $10,000 lifetime maximum **Pre-benefit counseling required**	80% of the allowed amount, subject to calendar year deductible	70% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible	Not covered
Assisted Reproductive Technology, Infertility Testing & Treatment • ART and Infertility Treatment are limited to $15,000 in a lifetime for treatment-you must be employed one year before benefits are available. • Benefit is only available to subscribers and spouse • Members will receive Tier 1 coverage at a BCBS PPO Network Provider • **Pre-benefit counseling required**	100% of the allowed amount, no deductible **Members will receive Tier 1 coverage at a Blue Cross Blue Shield PPO network provider**	100% of the allowed amount, no deductible	100% of the allowed amount, no deductible	Not covered

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Skilled Nursing Facility Covered at East Alabama Medical Center only • Long Term Care Rehab- Only covered at EAMC –Lanier • Precertification is required • **Pre-benefit counseling required**	80**%** of the allowed amount, subject to a $300 deductible per admission and subject to calendar year deductible; limited to 120 days per person each calendar year	Not covered	Not covered	Not covered
Routine Hearing Exam	100% of the allowed amount, subject to calendar year deductible when provided by an Audiologist. Includes coverage for routine hearing tests for newborns.	70% of the allowed amount, subject to calendar year deductible when provided by an Audiologist. Includes coverage for routine hearing tests for newborns.	Not covered	Not covered
Hearing Aids Limited to $3,000 per ear; $6,000 per lifetime **Pre-benefit counseling required**	**East Alabama ENT (Exclusive Provider):** 100% of the billed amount, no deductible or copay	Not covered	Not covered	Not covered
Ambulance	**100**% of the allowed amount; no deductible			
Home Health and Hospice Care LHC and Compassus exclusive providers	100% of the allowed amount, subject to calendar year deductible; through Participating Providers Non-participating providers in Alabama are not covered	Not covered	Not covered	Not covered
Home Infusion	100% of the allowed amount, no deductible or copay	Not covered	Not covered	Not covered
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per calendar year	100% of the allowed amount, subject to a $30 copay and subject to calendar year deductible	100% of the allowed amount, subject to a $30 copay and subject to calendar year deductible	100% of the allowed amount, subject to a $30 copay and subject to calendar year deductible	Not covered

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HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)				
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury.			
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and 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 **AlabamaBlue.com/BabyYourself.**			
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. IUDs limited to one every three years.			

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

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.

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.ى

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات 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 Sprachassistenzdienste 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 નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (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।.

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: 한국어을(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: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

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.