





Plan Benefits

BlueCard® PPO

USA Choice Plan

BlueCard® PPO

Effective January 1, 2026

Visit our website:
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BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

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BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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 **The in and out-of-network deductibles do not cross apply**	$125 individual; $250 family (no member will pay more than the $125 individual deductible on a family contract); deductible applies to both USA and PPO networks and both networks apply to each other.	$250 individual; $500 family (no member will pay more than the $250 individual deductible on a family contract).
Prescription Drug Deductible	$100 individual; $300 family maximum (no member will pay more than the $100 individual deductible)	Prescription drugs not covered out-of-network.
Annual Out-of-Pocket Maximum	$2,750 individual; $5,000 family maximum All copays, deductibles, and coinsurance apply to the out-of-pocket maximum including prescription drugs and excluding cyberknife treatment, bariatric services, vision up to age 19 and skilled nursing facilities; payments made by drug manufacturer assistance programs may not apply towards the deductible or out-of-pocket maximum. For members up to the end of the month in which the member turns age 19, deductibles and coinsurance for in-network dental services under the group's dental benefits apply to the out-of-pocket The plan will pay 100% of medical benefits for the remainder of the calendar year after the Medical Out-of-Pocket Maximum amounts are met.	There is no out-of-network out-of-pocket maximum.
INPATIENT HOSPITAL FACILITY SERVICES (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.		
Inpatient Facility and Residential Treatment Facilities Coverage (including maternity)	**USA Health Network Facility:** Covered at 100% of the allowed amount subject to calendar year deductible. **Other PPO Facilities:** Covered at 100% of the allowed amount, after $1,000 per admission deductible and $100 copay days 2-5. **Residential Treatment Facilities:** Covered at 100% of the allowed amount subject to calendar year deductible. Coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	**Out-of-Network coverage available only for medical emergencies or accidental injuries.** **Non-PPO Provider Outside Alabama:** Covered at 100% of the allowed amount, after $1,000 per admission deductible and $100 copay days 2-5 only for medical emergency or accidental injury; otherwise, not covered. **Non-PPO Provider In Alabama:** Covered at 100% of the allowed amount, after $1,000 per admission deductible and $100 copay days 2-5 only for medical emergency or accidental injury; otherwise, not covered. Coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
Note: In Alabama, inpatient hospital benefits are paid only if received from a Blue Cross and Blue Shield provider. Outside, Alabama inpatient hospital benefits are paid only if received from a BlueCard PPO provider except in cases of medical emergency or accidental injury.		
OUTPATIENT HOSPITAL FACILITY SERVICES (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.		
Surgery	**USA Health Network Facility:** Covered at 100% of the allowed amount, after $150 facility copay and subject to the calendar year deductible. **Other PPO Facilities:** Covered at 100% of the allowed amount, subject to a $350 facility copay and subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 100% of the allowed amount, subject to a $350 facility copay and subject to calendar year deductible when due to medical emergency or accidental injury; otherwise not covered. **Non-PPO Provider In Alabama:** Not covered.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
CyberKnife Treatment **Note:** CyberKnife services subject to coverage limitations.	**USA Mitchell Cancer Center Facility:** Covered at 100% of the allowed amount subject to the calendar year deductible **Other PPO Facilities:** Not covered.	Not covered.
Medical Emergency	**USA Health Network Facility:** Covered at 100% of the allowed amount, after $200 facility copay and subject to the calendar year deductible. when meets medical emergency criteria. Copay waived if admitted. **Other PPO Facilities:** Covered at 100% of the allowed amount, subject to a $200 facility copay and subject to the calendar year deductible when meets medical emergency criteria. Copay waived if admitted. **Other PPO Facilities Mental Health Disorders and Substance Abuse:** Covered at 100% of the allowed amount, subject to a $200 facility copay and the calendar year deductible. Copay waived if admitted. **Note**: Use of an Emergency Room for treatment that is not a medical emergency or injury as determined by the claims administrator will be paid according to the major medical benefits schedule at 80% of the allowed amount subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 100% of the allowed amount, subject to a $200 facility copay and subject to the calendar year deductible when meets medical emergency criteria. Copay waived if admitted. **Non-PPO Provider In Alabama:** Covered at 100% of the allowed amount, subject to a $200 facility copay and subject to the calendar year deductible when due to medical emergency and when meets medical emergency criteria; otherwise, not covered. Copay waived if admitted. **Non-PPO Facilities Mental Health Disorders and Substance Abuse:** Covered at 100% of the allowed amount, subject to a $200 facility copay and the calendar year deductible. Copay waived if admitted. **Non-PPO Provider Outside Alabama:** **Note**: Use of an Emergency Room for treatment that is not a medical emergency or injury as determined by the claims administrator will be paid according to the major medical benefits schedule at 80% of the allowed amount subject to the calendar year deductible.
Accidental Injury	**USA Health Network:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Facilities:** Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 100% of the allowed amount subject to the calendar year deductible.
Diagnostic X-ray	**USA Health Network Facility:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Facilities:** Covered at 100% of the allowed amount, after a $50 facility copay and subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 100% of the allowed amount, after a $50 facility copay and subject to the calendar year deductible only for medical emergency or accidental injury; otherwise, not covered. **Non-PPO Provider In Alabama:** Covered at 100% of the allowed amount, after a $50 facility copay and subject to the calendar year deductible only for medical emergency or accidental injury; otherwise, not covered.
Diagnostic Lab and Pathology	**USA Health Network Facility:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Facilities:** Covered at 100% of the allowed amount subject to the calendar year deductible. .	**Non-PPO Provider Outside Alabama:** Covered at 100% of the allowed amount subject to the calendar year deductible for medical emergency or accidental injury; otherwise, not covered. **Non-PPO Provider In Alabama:** Covered at 100% of the allowed amount subject to the calendar year deductible for medical emergency or accidental injury; otherwise, not covered.
Dialysis, IV Therapy Chemotherapy and Radiation Therapy	**USA Health Network Facility:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Facilities:** Covered at 100% of the allowed amount after a $40 facility copay and subject to the calendar year deductible.	Not covered.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowed amount, subject to the calendar year deductible.	Covered at 80% of the allowed amount, subject to the calendar year deductible.
Note: In Alabama, outpatient benefits for non-member hospitals are available **only** in cases of medical emergency or accidental injury.		
PHYSICIAN SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Office Visits and Outpatient Consultations	**USA Health Network Physician:** Covered at 100% of the allowed amount after $15 physician copay and subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount, subject to a $40 office visit copay and subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.
Telephone and online video consultations program A service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4549.	Covered at 100%, no copay per consultation.	Not covered
Emergency Room Physician Fees	**USA Health Network Physician:** Covered at 100% of the allowed amount, after $15 physician copay and subject to the calendar year deductible. **Other PPO Physician** Covered at 100% of the allowed amount, after a $40 physician copay and subject to the calendar year deductible. **Other PPO Facilities Mental Health Disorders and Substance Abuse c**overed at 100% of the allowed amount, after $15 physician copay and subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 100% of the allowed amount, after a $40 physician copay and subject to the calendar year deductible. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered. **Non-PPO Facilities Mental Health Disorders and Substance Abuse c**overed at 100% of the allowed amount, after $15 physician copay and subject to the calendar year deductible.
Urgent Care	**USA Health Network Physician:** Covered at 100% of the allowed amount, after $50 physician copay and subject to the calendar year deductible. **Other PPO Physician** Covered at 100% of the allowed amount, subject to a $50 office visit copay and subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.
Surgery	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. Covered same as in-network Other PPO Physician for medical emergency or accidental injury. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Bariatric Surgery (Surgeon, Assistant Surgeon & Anesthesia) Limited to a lifetime max of one procedure per person.	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.	Not covered
Anesthesia	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. Covered same as in-network Other PPO Physician for medical emergency or accidental injury. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.
Second Surgical Opinions	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.	Not covered.
Inpatient Visits and Inpatient Consultations	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Mental Health Disorders and Substance Abuse services** covered at 100% of the allowed amount, no deductible or copay.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. Covered same as in-network Other PPO Physician for medical emergency or accidental injury. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered. **Mental Health Disorders and Substance Abuse services** covered at 100% of the allowed amount, no deductible or copay.
Maternity	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. Covered same as in-network Other PPO Physician for medical emergency or accidental injury. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.
Diagnostic X-rays	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. Covered same as in-network Other PPO Physician for medical emergency or accidental injury. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.
Diagnostic Lab Exams	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. Covered same as in-network Other PPO Physician for medical emergency or accidental injury. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Dialysis, IV Therapy Chemotherapy and Radiation Therapy	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. Covered same as in-network Other PPO Physician for medical emergency or accidental injury. **Non-PPO Provider In Alabama:** Covered same as in-network Other PPO Physician only for medical emergency or accidental injury; otherwise, not covered.
TMJ Phase I	**USA Health Network Physician:** Covered at 100% of the allowed amount subject to the calendar year deductible.**Other PPO Physician** Covered at 100% of the allowed amount subject to a $40 office visit copay and the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 100% of the allowed amount, after a $40 office visit copay and subject to the calendar year deductible. Covered same as in-network Other PPO Physician for medical emergency or accidental injury. **Non-PPO Provider In Alabama:** Not covered.
Note: In Alabama, physician benefits for non-member hospitals are available **only** in cases of medical emergency or accidental injury.		
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 SERVICES		
Routine Preventive Services and Immunizations • See **AlabamaBlue.com/ PreventiveServices and AlabamaBlue.com/SourceRxACAPreventiveDrugList** for listing of 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. **In addition to the standard, the following exceptions apply:** • Routine urinalysis - when necessary • Routine TB skin test - when necessary • Routine CBC - when necessary • Routine total cholesterol - once per calendar year • Blood Pressure Monitor, for members with a diagnosis of hypertension, with a maximum of one every 5 calendar years. • Peak Flow Meter for members with a diagnosis of asthma, with a maximum of one per person per calendar year • International Normalized Ratio (INR) testing, for members with a diagnosis of liver disorder and/or bleeding disorder, with a maximum of 15 per person per calendar year. • Lipoprotein (LDL) testing for members with a diagnosis of heart disease, with a maximum of five per person per calendar year. • Hemoglobin A1C testing for members with a diagnosis of diabetes, with a maximum of four per person per calendar year. • Retinopathy screening for members with a diagnosis of diabetes, with a maximum of three per person per calendar year.	Not covered.
Vision One routine eye examination (including refraction per member each benefit period)	Covered at 100% of the allowed amount, subject to a $40 office visit copay and the calendar year deductible.	Not covered.
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.		
Retail Prescription Prepaid Benefits The retail pharmacy network for the plan is **Prime Participating Network** • Locate a Prime Participating Retail Network pharmacy at **AlabamaBlue.com/ Prime ParticipatingPharmacyLocator** Maintenance drugs - up to 90-day supply with two copays • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** Prescription drugs (other than maintenance drugs) - up to a 31-day supply with one copay • Some copays combined for diabetic supplies (waive copay and deductible on glucose monitors on select products) • View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList6T** The only in-network pharmacy for some Tier 5 and 6 (specialty) drugs is the **Pharmacy Select Network and MCI (Mitchell Cancer Institute in-house pharmacy)** • Tier 5 and 6 (specialty) drugs can be dispensed for up to a 30-day supply • View the Specialty Drug List at **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList** • Fertility, weight loss, cosmetic alternation, and over the counter drugs are not covered • 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**. • Certain drugs are part of the FlexAccess Program. See list at **AlabamaBlue.com/FlexAccessDrugList**	Covered at 100% of the allowed amount, subject to the prescription drug deductible ($100 individual; $300 family maximum-no member will pay more than the $100 individual deductible) and the following copays: **Tier 1 (preferred generic):** $10 copay per prescription **Tier 2 (non-preferred generic)**: $10 copay per prescription **Tier 3 (preferred brand)**: $50 copay per prescription **Tier 4 (non-preferred brand)**: $75 copay per prescription **Tier 5 (preferred specialty):** $150 copay per prescription **Tier 6 (non-preferred specialty):** 50% coinsurance 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.	Not covered.
Extended Supply Prescription Drug Card • The extended supply pharmacy network for the plan is the **Prime Participating Network** • Locate a Prime Participating Retail Network pharmacy at **AlabamaBlue.com/ Prime ParticipatingPharmacyLocator** • Maintenance drugs – up to a 90-day supply may be purchased with two copays • View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList6T**	Covered at 100% of the allowed amount, subject to the prescription drug deductible ($100 individual; $300 family maximum-no member will pay more than the $100 individual deductible) and the following copays: **Tier 1 (preferred generic):** $10 copay per prescription **Tier 2 (non-preferred generic)**: $10 copay per prescription **Tier 3 (preferred brand)**: $50 copay per prescription **Tier 4 (non-preferred brand)**: $75 copay per prescription	Not covered.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
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.	100% of the allowed amount, no deductible or copay.	Not covered.
Mail Order Pharmacy Benefits (Voluntary program) • Up to a 90-day supply with two copays • Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/ HomeDeliveryNetwork** Only maintenance drugs can be purchased through this mail order pharmacy service • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** • View the SourceRx 1.0 drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList6T** **Note:** If you have less than a 90-day supply, you will pay the same copay as a 90-day supply when using this mail order program	Covered at 100% of the allowed amount, subject to the prescription drug deductible ($100 individual; $300 family maximum-no member will pay more than the $100 individual deductible) and the following copays: **Tier 1 (preferred generic):** $10 copay per prescription **Tier 2 (non-preferred generic)**: $10 copay per prescription **Tier 3 (preferred brand)**: $50 copay per prescription **Tier 4 (non-preferred brand)**: $75 copay per prescription	Not covered.
OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse) **Precertification is required for some other covered services; please see your benefit booklet.** **If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.**		
Participating Chiropractor Services *Limited to 60 visits per member each benefit period*	**USA Health Network Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible. **Other PPO Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible.	**Non-PPO Provider Outside Alabama:** Covered at 80% of the allowed amount, subject to the calendar year deductible. **Non-PPO Provider In Alabama:** Not covered.
Rehabilitative Occupational, Physical and Speech Therapy *Limited to 60 visits per member per therapy each benefit period*	**USA Health Network Provider:** Covered at 100% of the allowed amount, after $15 copay and subject to the calendar year deductible. **Other PPO Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible.	Covered at 80% of the allowed amount, subject to the calendar year deductible.
Habilitative Occupational, Physical and Speech Therapy *Limited to 60 visits per member per therapy each benefit period*	**USA Health Network Provider:** Covered at 100% of the allowed amount, after $15 copay and subject to the calendar year deductible. **Other PPO Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible	Covered at 80% of the allowed amount, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Autism Spectrum Disorder Benefit **Prior authorization required** Care as determined to be medically necessary including: • Evaluation and assessment services; • Habilitative and Rehabilitative outpatient services including speech, physical and occupational therapy for ages 0-18 (no visit limits); • Behavior training and management and Applied Behavior Analysis; • Psychiatric care; • Psychological care including family counseling; • Therapeutic Care	**USA Health Network Provider:** Covered at 100% of the allowed amount, subject to the calendar year deductible. **Other PPO Provider**: Covered at 100% of the allowed amount, subject to the calendar year deductible.	Covered at 80% of the allowed amount, subject to the calendar year deductible.
Durable Medical Equipment (DME) *Orthotic devices are limited to a maximum benefit of two pair every 12 consecutive months*	**USA Health Network Provider:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Provider:** Covered at 100% of the allowed amount subject to the calendar year deductible.	Not covered.
Home Health *Precertification is only required for home health care services when services are rendered by a provider outside of the state of Alabama. Call 1-800-821-7231*	Covered at 100% of the allowed amount subject to the calendar year deductible for services rendered by a Participating Home Health Agency in Alabama.	Not covered.
Hospice Limited to a lifetime maximum of 180 days	Covered at 100% of the allowed amount subject to the calendar year deductible.	Not covered.
Home Infusion Services	Covered at 100% of the allowed amount subject to the calendar year deductible.	Not covered.
Skilled Nursing Facility • Up to 60 days per member each benefit period (combined in and out-of-network) • Precertification required – call 1-800-821-7321 • Admission occurs within 14 days of hospital discharge • Medicare approved facility • Must be engaged in providing skilled care under supervision of physicians and R.N.; maintain clinical records; provide 24-hr nursing services; dispense and administer drugs	Covered at 100% of the allowed amount subject to the calendar year deductible.	
Ambulance Services	Covered at 80% of the allowed amount, subject to the calendar year deductible.	
Allergy Testing	**USA Health Network Provider:** Covered at 100% of the allowed amount subject to the calendar year deductible. **Other PPO Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible.	Not covered.
Allergy Treatment	**USA Health Network Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible. **Other PPO Provider:** Covered at 80% of the allowed amount, subject to the calendar year deductible.	Not covered.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Medical Nutrition Therapy For Adults and Children, 6 hours per member per calendar year	100% of the allowed amount subject to the calendar year deductible.	Not covered.
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	A program to assist employees and their families in coordinating care in the event of a lengthy illness.	
Chronic Condition Management	A program for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease and other specialized conditions. For more information, please call 1-888-841-5741.	
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: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.	
PIVOT® Tobacco Cessation	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. Call 1-650-249-3959 for participation information.	

Please note: Providers/Specialists may be listed in the PPO directory, but not covered as PPO benefits by this group health plan (i.e. DME, Ambulance, Midwives, Allergists). Some of these benefits may be covered under Other Covered Services or not at all. Please check your benefit matrix or benefit booklet to determine coverage.

Note: In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network.

Note: Teladoc Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

Note: Pivot, an independent company, provides a smoking cessation and digital health coaching platform for members of Blue Cross and Blue Shield of Alabama.

All non-participating hospitals will not be covered.

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

Group 78380
Revised 9-29-2025 afr

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 બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को 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.