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BlueCard® PPO
Plan Benefits

Imperial Akron Union and Imperial Middleport Union
Group 91317, 91318
BlueCard® PPO

Effective January 01, 2023

BlueCross BlueShield of Alabama

Prescription Drugs: ValueONE Network

ValueONE Network Facts:

- 51,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Retail Network. This includes many national pharmacies you may already be using.
- 50,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Extended Supply Network (ESN). This includes many national pharmacies you may already be using.
- Generally, ValueONE Retail Network pharmacies can fill up to a 30-day supply of retail drugs while ValueONE ESN Network pharmacies can fill up to a 90-day supply of certain medications (prescription must be written for up to a 90-day supply). Refer to your benefit booklet for the specific day supply permitted by your benefit plan. Since the type of pharmacy differs within the ValueONE Network, be sure to check your specific pharmacy.
- If you do not use a ValueONE Network pharmacy, you may be responsible for the full cost of your prescription medication. Benefits may not be provided for out-of-network pharmacies.
- To maximize your pharmacy benefits, you will need to transfer all your prescriptions to a ValueONE Network pharmacy.

Find a ValueONE Network Pharmacy

You can locate all of the participating pharmacies in your area at **AlabamaBlue.com/ValueONERetailPharmacyLocator.** Click on “Find a Pharmacy by Name or Location” located under Find a Pharmacy. When searching for a participating pharmacy, make sure either “ValueONE Retail Network” or “ValueONE ESN Network” is listed under “Network Participation” located to the right of the pharmacy address.

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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.		
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	$250 individual; $500 family The in-network calendar year deductible will *NOT* apply to the out-of-network out-of-pocket maximum	$500 individual; $1,000 family The out-of-network out-of-pocket maximum *WILL* apply to the in-network out-of-pocket maximum
Calendar Year Out-of-Pocket Maximum After you reach your individual Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year	$1,100 individual; $2,200 family All deductibles, copays and coinsurance for in-network services and out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum, **including prescription drugs** Available manufacturer or provider cost share assistance program payments made with respect to the specialty drugs on the Specialty Drug Coupon Program List do not apply to the in-network out-of-pocket maximum The in-network out-of-pocket maximum does *NOT* apply to the out-of-network out-of-pocket maximum	$2,200 individual; $4,400 family Deductibles and coinsurance for out-of-network services (excluding out-of-network mental health disorders and substance abuse emergency services) apply to the out-of-network out-of-pocket maximum, **including prescription drugs** Available manufacturer or provider cost share assistance program payments made with respect to the specialty drugs on the Specialty Drug Coupon Program List do not apply to the out-of-network out-of-pocket maximum The out-of-network out-of-pocket maximum *WILL* apply to the in-network out-of-pocket maximum
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
All hospital admissions require preadmission certification, except maternity admissions as required by Federal law. Emergency admissions require certification within 48 hours of admission except as required by Federal law. For preadmission certification, call 1-800-248-2342.		
Inpatient Hospital and Residential Treatment Facilities **Including:** Residential Treatment Facilities, Skilled Nursing Facilities, Rehabilitation Hospital and Sub-Acute Facilities	Covered at 90% of the allowed amount, subject to calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries	Covered at 70% of the allowed amount, subject to calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries
Human Organ and Tissue Transplant Services (Bone Marrow/Stem Cell)	Covered at 100% of the allowance, no deductible or copay. (*Physician's Office Visit will be subject to applicable copay per visit)*	Covered at 70% of the allowance subject to the calendar year deductible
Inpatient Physician Visits and Consultations	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Emergency Room (Medical Emergency) (Copay waived if admitted)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to in-network calendar year deductible **Out-of-network Mental Health and Substance Abuse services apply to the in-network out-of-pocket maximum**

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Facility/Outpatient Facility (Copay waived if admitted)	Covered at 100% of the allowed amount, after $10.00 copay per visit copay and subject to calendar year deductible	Covered at 100% of the allowed amount, after $10.00 copay per visit copay and subject to calendar year deductible
Emergency Room (Accident) (Copay waived if admitted)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to in-network calendar year deductible
Emergency Room (Physician)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to in-network calendar year deductible **Out-of-network Mental Health and Substance Abuse Services apply to the in-network out-of-pocket maximum**
Outpatient Diagnostic Lab, Pathology & X-ray/ER Services (When performed at the Emergency Room)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible
Outpatient Diagnostic Lab, Pathology & X-ray/Urgent Care (When performed at an Urgent Care Facility)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible
Outpatient Diagnostic Lab, Pathology & X-ray/Non-ER Services (Includes Pre-admission testing)	Covered at 90% of the allowed amount, subject to calendar year deductible (*Physician's Office Visit is subject to applicable copay per visit*)	Covered at 70% of the allowed amount, subject to calendar year deductible
Chemotherapy, Dialysis, IV Therapy & Radiation Therapy	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Angiography/Arteriography, Cardiac cath/arteriography, CAT Scan, ERCP, MRI, muga-gated cardiac scan & colonoscopy, PET/SPECT & UGI endoscopy (When performed at the Emergency Room)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible
Angiography/Arteriography, Cardiac cath/arteriography, CAT Scan, ERCP, MRI, muga-gated cardiac scan & colonoscopy, PET/SPECT & UGI endoscopy (When performed at an Urgent Care Facility)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services **Note:** Preadmission Certification is required. Call 1-800-248-2342	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits, Urgent Care Clinics and Consultations **Includes:** • Diagnosis for obesity • Surgery performed in the Physician's Office • Second Opinion Consultations • Allergy Treatment/Injections • Allergy serum (dispensed by the Physician in the office) • Specialist office visit	Covered at 100% of the allowed amount after a $10.00 office visit copay per visit with general practitioner, family practitioner, internist, OB/GYN, pediatrician, geriatrics, mental health and substance abuse provider and nurse practitioner or physician's assistant under the direction of above listed providers	Covered at 70% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program A service, through Teladoc™ to diagnose, treat and prescribe medication (when necessary) for certain medical issues. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4549	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Surgery & Anesthesia	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Maternity Care (Includes Dependents)	Covered at 90% of the allowed amount, subject to calendar year deductible (100% no deductible or copay for routine prenatal services)	Covered at 70% of the allowed amount, subject to calendar year deductible
Angiography/Arteriography, Cardiac cath/Arteriography, CAT Scan, Colonoscopy, ERCP, MRI, Muga-gated cardiac scan, PET/SPECT & UGI endoscopy	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy **Note:** Preadmission Certification is required. Call 1-800-248-2342	Covered at 100% of the allowed amount after a $10.00 office visit copay per visit for Behavioral Therapy services	Covered at 70% of the allowed amount, subject to calendar year deductible
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
PREVENTIVE CARE BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/PreventiveServices** 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.	Covered at 100% of the allowed amount, no copay or deductible	Covered at 70% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Additional Routine Services • Urinalysis – limited to one per calendar year • Complete Blood Count (CBC) – limited to one per calendar year • Cholesterol – limited to one each per calendar year (Includes cholesterol, HDL, LDL, VLDL & Triglycerides) • Blood Glucose and Hemoglobin A1C – limited to one each per calendar year	Covered at 100% of the allowed amount, no copay or deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
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 **ValueONE Retail Network** • Locate a **ValueONE Retail** Network pharmacy at **AlabamaBlue.com/ ValueONERetailPharmacyLocator** • View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** • Retail drugs may be dispensed up to a 30-day supply *New prescriptions require a 30-day fill at retail prior to getting a maintenance day supply* • Subsequent fills limited to a 90-day supply for 3 (three) copays • The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Pharmacy Select Network** • View the Tier 4 (specialty) Drug List at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList** and **AlabamaBlue.com/ProviderAdministered SpecialtyDrugList** • Certain specialty drugs are listed on the Specialty Drug Coupon Program List at **AlabamaBlue.com/SpecialtyCouponProgramDrugList** • Tier 4 (specialty) Drugs, or biotech drugs, are generally high cost self-administered drugs Value Based drugs are covered 100% of the allowed amount; no coinsurance or deductible. View the Value Based Drugs that apply to the plan at **AlabamaBlue.com/StandardVBDDrugList** **Diabetic Supplies:** Preferred Brand and Generic Diabetic Supplies/Insulin are covered at 100%; no coinsurance or deductible	**Tier 1 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 2 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 3 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 4 (specialty) drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible Drugs on the Specialty Drug Coupon Program List must be purchased at a pharmacy in the Pharmacy Select Network and are subject to the greater of the applicable Tier coinsurance or the full manufacturer cost share assistance program payments	**Tier 1 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 2 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 3 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 4 (specialty) drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible Drugs on the Specialty Drug Coupon Program List must be purchased at a pharmacy in the Pharmacy Select Network and are subject to the greater of the applicable Tier coinsurance or the full manufacturer cost share assistance program payments

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Extended Supply Prescription Prepaid Benefits • The extended supply pharmacy network for the plan is the **ValueONE ESN Network** • Locate a **ValueONE ESN** Network Pharmacy at **AlabamaBlue.com/ ValueONEESNPharmacyLocator** • Prescription drugs can be purchased through this extended supply pharmacy service - Maintenance prescription drugs can be dispensed for up to a 90-day supply but the copayment is applicable for each 30-day supply • 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/ SourceRx1DrugList4T** • Tier 4 (specialty) drugs are not available through extended supply pharmacy service • Value Based drugs are covered 100% of the allowed amount; no coinsurance or deductible. View the Value Based Drugs that apply to the plan at **AlabamaBlue.com/StandardVBDDrugList** **Diabetic Supplies:** • Preferred Brand and Generic Diabetic Supplies/Insulin are covered with no coinsurance or deductible	**Tier 1 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 2 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 3 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 4 (specialty) drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible	**Tier 1 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 2 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 3 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 4 (specialty) drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible
Mail Order Pharmacy Benefits • Up to 90-day supply • Mail Order drugs are available through the Home Delivery Network (Enroll online at **AlabamaBlue.com/HomeDeliveryNetwork** or call 1-855-793-5326) • Maintenance and Non-Maintenance drugs can be purchased through mail order pharmacy • Tier 4 (specialty) drugs are not available through this pharmacy service Value Based drugs are covered 100% of the allowed amount; no coinsurance or deductible. View the Value Based Drugs that apply to the plan at **AlabamaBlue.com/SourceRxVBDDrugList** **Diabetic Supplies:** • Preferred Brand and Generic Diabetic Supplies/Insulin are covered at 100%; no coinsurance or deductible	**Tier 1 drugs*:*** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 2 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 3 drugs:** Covered at 80% of the allowed amount **not** subject to calendar year deductible **Tier 4 (specialty) drugs:** Not covered	**Non-Participating Pharmacy:** There are no benefits available for prescription drugs purchased from a Non-Participating Pharmacy
Medications required as part of preventive care services are covered at 100% with no coinsurance or deductible. See *www.healthcare.gov* for more information.		
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Ambulance Service	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services Limited to 60 visits per member per calendar year	Covered at 100% of the allowed amount, after $10.00 copay per visit	Covered at 70% of the allowed amount, subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	Covered at 100% of the allowed amount, no copay or deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Obesity/Bariatric Surgery (Subject to medical necessity and clinical guidelines) **Note:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc. • Only the Surgical Services accumulate to the lifetime maximum • $10,000 lifetime maximum will apply to Surgical Professional Services	Covered at 90% of the allowed amount, subject to calendar year deductible *(Physician's Office Visit will be subject to applicable copay per visit)*	Covered at 70% of the allowed amount, subject to calendar year deductible
Genetic Testing/Counseling Genetic Counseling limited to 3 visits per member per calendar year for pre and post-genetic testing	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational, Physical and Speech Therapy • Limited to a maximum of 60 visits per member per calendar year for each therapy • No age or visit limitations for autism spectrum disorders	Covered at 100% of the allowed amount, after $10.00 copay per visit	Covered at 70% of the allowed amount, subject to calendar year deductible
Habilitative Occupational, Physical and Speech Therapy • Limited to a maximum of 60 visits per member per calendar year for each therapy • No age or visit limitations for autism spectrum disorders	Covered at 100% of the allowed amount, after $10.00 copay per visit	Covered at 70% of the allowed amount, subject to calendar year deductible
Pulmonary Rehabilitation & Cognitive Therapy Limited to a combined maximum of 180 days per member per calendar year	Covered at 100% of the allowed amount, after $10.00 per visit copay	Covered at 70% of the allowed amount, subject to calendar year deductible
Cardiac Rehabilitation Therapy Limited to a maximum of 36 days per member per calendar year	Covered at 100% of the allowed amount, after $10.00 per visit copay	Covered at 70% of the allowed amount, subject to calendar year deductible
TMJ Surgical and Non-Surgical • Excludes appliances and orthodontic treatment • $1,000 lifetime maximum per member will apply to Non-Surgical TMJ Services	Covered at 90% of the allowed amount, subject to calendar year deductible *(Physician's Office Visit will be subject to applicable copay per visit)*	Covered at 70% of the allowed amount, subject to calendar year deductible
Diabetic Education Limited to 3 visits per member per calendar year	Covered at 90% of the allowed amount, subject to calendar year deductible *(Physician's Office Visit will be subject to applicable copay per visit)*	Covered at 70% of the allowed amount, subject to calendar year deductible
Hospice (Includes Bereavement Counseling) Precertification required. Call 1-800-821-7231. Services must be authorized by physician	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Home Health (Includes outpatient private duty nursing when approved as medically necessary) Precertification required. Call 1-800-821-7231.	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Home Infusion	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Foot Care (Podiatry) Excluding routine foot care	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Travel and Lodging (Organ Transplants)	Travel and Lodging will be provided for members that live more than 50 miles from approved facilities such as a Center of Excellence or Blue Distinction Center for the treatment of Congenital Heart Disease (CHD), obesity surgery, transplants and cancer related treatments. If the patient is covered by Medicare, benefits for travel and lodging will not be covered. Coverage is allowed for the patient and one companion unless the patient is an enrolled dependent minor child, then the patient and two companions are eligible. Benefits are paid at a per diem rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion or two companions if the patient is a dependent minor child. A combined overall maximum of $10,000 per member in a lifetime. Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.	

HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)	
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.**
Contraceptive Management	Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website* ***(AlabamaBlue.com)*** *or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-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.*
- *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.*
- *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.*

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.