*We cover what matters.*

# BlueCard® PPO
## Plan Benefits

## Public Education Employees' Health Insurance Plan (PEEHIP)

Group 14000
BlueCard® PPO

Effective October 1, 2022-
September 30, 2023

Visit our website at
**AlabamaBlue.com**

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

# Public Education Employees' Health Insurance Plan (PEEHIP)
## BlueCard® PPO

| 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** | | |
| **Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.** | | |
| **Calendar Year Deductible for Major Medical Services** | $300 individual; $900 family maximum | |
| **Calendar Year Out-of-Pocket Maximums** | **Major Medical Maximums:** $400 individual annual major medical out-of-pocket maximum (no family maximum) plus the $300 calendar year deductible.<br><br>In-network Other Covered Services are the only expenses applicable to the calendar year major medical out-of-pocket maximum (includes Participating Chiropractor Services, Physical Therapy, DME, Occupational Hand Therapy, Speech Therapy, Allergy Testing and Treatment, Infertility Services, Preferred Home Health and Hospice, and Ambulance services).<br><br>**Overall Maximums:** $8,700 individual; $17,400 family contract calendar year overall out-of-pocket maximum for 2022 and $9,100 individual; $18,200 family contract calendar year overall out-of-pocket maximum for 2023<br><br>All deductibles, copays and coinsurance for in-network services apply to the calendar year overall out-of-pocket maximum, including prescription drugs.<br><br>After you reach your individual Calendar Year Out-of-Pocket Maximum (even if you are covered under family coverage), applicable expenses for you will be covered at 100% of the allowed amount for the remainder of the calendar year. | |
| **INPATIENT FACILITY AND PHYSICIAN BENEFITS** | | |
| **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 1-800-354-7412 for precertification.** | | |
| **Inpatient Hospital*** (including maternity)<br>**Note:** Maternity benefits are not available to dependent children of any age. | Covered at 100% of the allowed amount for semi-private room and board; intensive care units, general nursing services and usual hospital ancillaries after a $200 per admission deductible and a $25 per day copay for days 2-5<br><br>*Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®. More information is available at https://www.bcbs.com/blue-distinction-center/facility | Covered at 80% of the allowed amount for semi-private room and board; intensive care units, general nursing services and usual hospital ancillaries after a $200 per admission deductible and a $25 per day copay for days 2-5<br><br>**Note:** In Alabama, in-patient benefits available only for medical emergency services and accidental injury |
| **OUTPATIENT FACILITY BENEFITS** | | |
| **Precertification is required for some outpatient hospital benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList.** Certain medications require enrollment in the HealthSmartRx program. For questions, please call 1-833-798-6733. Additional information and the applicable drug list is available at AlabamaBlue.com/Providers/HealthSmartRx. **Please see your benefit booklet. If precertification is not obtained, no benefits are available.** Select procedures that require precertification include but are not limited to implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, surgery for obstructive sleep apnea, reduction mammoplasty, rhinoplasty and surgery for varicose veins. | | |
| **Outpatient Surgery* (Including Ambulatory Surgical Centers)** | Covered at 100% of the allowed amount after $150 facility copay<br><br>*Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®. More information is available at https://www.bcbs.com/blue-distinction-center/facility | Covered at 80% of the allowed amount subject to calendar year deductible<br><br>**In Alabama,** out-of-network facilities, not covered |
| **Outpatient Surgery & Anesthesia Physician Visits** | Covered at 100% of the allowed amount; no copay or deductible | Covered at 80% of the allowed amount subject to the calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Emergency Room (Medical Emergency) (In-Area/Out-of-Area) Facility Charge** | Covered at 100% of the allowed amount after $150 facility copay for true medical emergencies.<br><br>If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible. | Covered at 100% of the allowed amount after $150 facility copay for true medical emergencies.<br><br>If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible. |
| **Emergency Room (Accidental Injury) (In-Area/Out-of-Area) Facility Charge**<br><br>**Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **(Medical Emergency)** above. | Covered at 100% of the allowed amount after $150 facility copay | Covered at 100% of the allowed amount after $150 facility copay |
| **Outpatient Diagnostic Lab & Pathology**<br>Genetic laboratory testing requires precertification. For precertification, call 1-800-248-2342. Certain testing may require precertification to be payable under the plan. | Covered at 100% of the allowed amount after $5 copay per test | Covered at 80% of the allowed amount subject to the calendar year deductible;<br><br>**In Alabama,** out-of-network facilities not covered |
| **Chemotherapy, Dialysis, IV Therapy & Radiation Therapy**<br>Radiation therapy management services requires precertification. For precertification, call 1-866-803-8002. If precertification is not obtained, no benefits will be payable under the plan for the services. | Covered at 100% of the allowed amount after $25 facility copay | Covered at 80% of the allowed amount subject to the calendar year deductible<br><br>**In Alabama,** out-of-network facilities, not covered |
| **Outpatient Diagnostic X-ray** | Covered at 100% of the allowed amount; no copay or deductible | Covered at 80% of the allowed amount subject to the calendar year deductible<br><br>**In Alabama,** out-of-network facilities, not covered |
| **Advanced Imaging (i.e., MRA, MRI, PET, CT and CTA)**<br>**Precertification required-**If precertification is not obtained, no benefits will be payable under the plan for the services. For precertification, call 1-866-803-8002. | Covered at 100% of the allowed amount; no copay or deductible | Covered at 80% of the allowed amount subject to the calendar year deductible<br><br>**In Alabama,** out-of-network facilities, not covered |
| **PHYSICIAN BENEFITS** | | |
| Precertification is required for some physician benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Certain medications require enrollment in the HealthSmartRx program. For questions, please call 1-833-798-6733. Additional information and the applicable drug list is available at Alabamablue.com/Providers/HealthSmartRx. Please see your benefit booklet. If precertification is not obtained, no benefits are available. Select procedures that require precertification include but are not limited to implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, surgery for obstructive sleep apnea, reduction mammoplasty, rhinoplasty and surgery for varicose veins. | | |
| **Inpatient Physician Visits and Consultations*** | Covered at 100% of the allowed amount; no copay or deductible<br><br>*Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®. More information is available at https://www.bcbs.com/blue-distinction-center/facility | Covered at 80% of the allowed amount subject to calendar year deductible |
| **Office Visits and In-Person Consultations-Primary Care Physician**<br><br>(Includes Urgent Care, Internal Medicine, Family Practice, General Practice, Physician Assistant, Clinic, Gynecology, Obstetrics, Certified Nurse Practitioner, Midwives, and Pediatrician) | Covered at 100% of the allowed amount after a $30 office visit copay | Covered at 80% of the allowed amount subject to the calendar year deductible |
| **Office Visits and In-Person Consultations-Specialist** | Covered at 100% of the allowed amount after a $35 office visit copay | Covered at 80% of the allowed amount subject to the calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Telephone and Online Video Physician Consultations Program**<br>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 | Group 14000 members have access to Teladoc® nationwide. Teleconsultation providers other than Teladoc® are not covered |
| **Emergency Room (Physician)** | Covered at 100% of the allowed amount after $35 physician copay | Covered at 100% of the allowed amount after $35 physician copay |
| **Outpatient Surgery & Anesthesia** | Covered at 100% of the allowed amount; no copay or deductible | Covered at 80% of the allowed amount subject to calendar year deductible |
| **Second Surgical Opinions** | Covered at 100% of the allowed amount; no copay or deductible | Covered at 80% of the allowed amount subject to the calendar year deductible |
| **Diagnostic Lab & Pathology**<br>Genetic laboratory testing requires precertification. For precertification, call 1-800-248-2342. Certain testing may require precertification to be payable under the plan. | Covered at 100% of the allowed amount after a $5 copay per test | Covered at 80% of the allowed amount subject to the calendar year deductible |
| **Chemotherapy, Dialysis, IV Therapy, Radiation Therapy & X-ray**<br>Radiation therapy management services requires precertification. For precertification, call 1-866-803-8002. If precertification is not obtained, no benefits will be payable under the plan for the services. | Covered at 100% of the allowed amount; no copay or deductible | Covered at 80% of the allowed amount subject to the calendar year deductible |
| **Advanced Imaging (i.e., MRA, MRI, PET, CT and CTA)**<br>**Precertification required-**If precertification is not obtained, no benefits will be payable under the plan for the services. For precertification, call 1-866-803-8002 (toll free). | Covered at 100% of the allowed amount; no copay or deductible | Covered at 80% of the allowed amount subject to the calendar year deductible |
| **Maternity Care** | Covered at 100% of the allowed amount; no copay or deductible | Covered at 80% of the allowed amount subject to the 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** | | |
| **Routine Immunizations and Preventive Services**<br>• See **AlabamaBlue.com/ PreventiveServices** for listing of immunizations and preventive services or call our Customer Service Department for a printed copy. | Covered at 100% of the allowed amount; no copay or deductible. In addition to the standard the following are covered:<br>• Urinalysis (once by age 5 and once between ages 12 through 17)<br>• CBC (once each calendar year)<br>• Cholesterol Screening (once per calendar year for members age 18 and older)<br>• Glucose Screening (once per calendar year for member age 18 and older) | Not Covered |
| **MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE BENEFITS** | | |
| **Inpatient Facility Services** | Covered at 100% of the allowed amount subject to the following copays: No charge for days 1-9; $15 per day for days 10-14; $20 per day for days 15-19; $25 per day for days 20-24; $30 per day for days 25-30. No lifetime admission maximum.<br>Mental Health – No inpatient day limit per plan year.<br>Substance Abuse – 30-day inpatient limit per plan year; no lifetime admission maximum. Mental health inpatient days do not aggregate with substance abuse days. Precertification required. | Covered at 100% of the allowed amount subject to a $200 per admission copayment and a $25 per day copay for days 2-5. Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital. Precertification is required. |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Inpatient Physician Services** | Covered at 100% of the allowed amount subject to a $0 copay.<br>Mental Health – No inpatient day limit on coverage availability during a covered admission.<br>Substance Abuse – Coverage available only during a covered admission up to 30 days per plan year. | Covered at 80% of the allowed amount, subject to the calendar year deductible. Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital. Precertification is required. |
| **Outpatient Facility Services** | Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) covered at 100% of the allowed amount subject to $150 copay per treatment episode. Precertification required. | Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) covered at 100% of the allowed amount subject to $150 copay per treatment episode. Precertification required. |
| **Outpatient Physician Services at PEEHIP Certified Community Mental Health Centers** | Covered at 100% of the allowed amount subject to a $10 copay per visit. Limited to 20 visits per member each plan year. Maximum visits are combined for mental and substance abuse. | Not applicable. All PEEHIP Certified Community Mental Health Centers are in-network. |
| **Outpatient Physician Services for Blue Choice Behavioral Network Providers** | Covered at 100% of the allowed amount, subject to a $15 copay per visit. Limited to 24 visits per member each plan year for in-network; deductible does not apply and no balance billing when using a Blue Choice Behavioral Network provider. Maximum visits are combined for mental and substance abuse. Additional visits covered if deemed clinically appropriate. For a list of in-network Blue Choice Behavioral Health Network providers, see **AlabamaBlue.com**. | Covered at 50% of the allowed amount, subject to the calendar year deductible; limited to a maximum of 10 visits per member per plan year for out-of-network. Maximum visits are combined for mental and substance abuse. |
| **Residential Treatment Facilities**<br>**Required precertification and approval through case management (NDBH)** | Covered at 100% of the allowed amount after $20 copay per day | Not covered |

## PRESCRIPTION DRUG BENEFITS
## (PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH EXPRESS SCRIPTS)

**Prior Authorization, Step Therapy and/or Quantity Limits may apply for some drugs.**

| | Up to a 30-day supply | 31-60 day supply | 61-90 day supply |
|---|---|---|---|
| **Tier 1 – Generic Drugs** | **$6** | **$12** | **$12** |
| **Tier 2 – Preferred Brand Drugs** | **$40** | **$80** | **$120** |
| **Tier 3 – Non-preferred Brand Drugs** | **$60** | **$120** | **$180** |
| **Specialty Drugs** | **20% coinsurance per prescription, with a minimum of $100 copay and maximum of $150 copay** | **Days supplies greater than 30 are not allowed for specialty drugs** | **Days supplies greater than 30 are not allowed for specialty drugs** |

**Generic Law: Pharmacists must dispense a generic equivalent medication when one is available unless the physician indicates in longhand writing on the prescription, indicates by mark or signature in the appropriate place on the prescription, or indicates in an electronic prescription the following: "medically necessary" "dispense as written," or "do not substitute." The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent, contain the same active ingredient or ingredients, and shall be of the same dosage form and strength.**

**Maintenance Drugs: To obtain a supply greater than 30 days, the drug must be on PEEHIP's Maintenance Drug List and must be prescribed for up to a 90-day supply. The first fill of a maintenance drug will be up to a 30-day supply. Subsequent fills can be obtained up to a 90--day supply.**

**Dispense as Written (DAW) Cost Differential: Members will be subject to the difference between the cost of the brand drug and its generic equivalent, regardless of whether the physician indicates the brand must be taken.**

**Diabetic Supplies: Certain diabetic supplies are covered only through the pharmacy drug plan. Some examples include needles and syringes for insulin, glucometers and lancets.**

**Certain prescription drugs are excluded from PEEHIP coverage. Mail order for Retail drugs is excluded. To verify the drug formulary coverage status of a medication, please visit the Express Scripts website at express-scripts.com.**

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Non-participating pharmacies (both in-state and out-of-state): Members must pay the full amount of the prescription drug and then file the claim to Express Scripts to be reimbursed at the participating pharmacy rate less the applicable copay. All PEEHIP clinical utilization management programs will apply. Out-of-pocket costs will be higher if you use a non-participating pharmacy.** | | |
| **Contraceptives: Generic contraceptive drugs are covered at a zero copay. Brand contraceptives are covered at the applicable brand copay.** | | |
| **Flu vaccines: Eligible flu vaccines are covered at a zero copay when administered by a participating pharmacy.** | | |
| **Shingrex vaccine: Covered at zero copay when administered by a participating pharmacy for those aged 50 and older.** | | |
| **Specialty Drugs – Copay Assistance Programs: Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs. PEEHIP and Express Scripts and their partner SaveOnSP will offer copay assistance programs for certain specialty drugs so that the member copayment will normally be less than the otherwise applicable copayment.** | | |
| **Infertility Drugs: Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP member contract. Members will pay 100% of the cost of the medications after the $2,500 lifetime maximum is reached.** | | |
| **BENEFITS FOR OTHER COVERED SERVICES** | | |
| **Precertification is required for some other covered services and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.** | | |
| **Allergy Testing & Treatment** | 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 |
| **Ambulance Service** | 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 |
| **Participating Chiropractic Services** | Covered at 80% of the allowed amount; no copay or deductible<br>**Note:** In Alabama, more than 18 visits in a calendar year rendered by a Participating Chiropractor require precertification. | Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 12 visits in a calendar year. |
| **Durable Medical Equipment (DME)**<br>Precertification is required for certain durable medical equipment (i.e., motorized/power wheelchairs). Medically necessary insulin pumps and cartridges are covered. Medically necessary diabetic supplies (syringes, needles for insulin, glucometers and lancets) are covered under the medical plan benefit when Medicare is primary. | 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. |
| **Physical Therapy**<br>Physical therapy will require precertification after 15 visits to determine medical necessity for continued therapy. Visits will accumulate regardless of provider. Call 1-800-248-2342 | Covered at 80% of the allowed amount subject to the calendar year deductible.<br><br>Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan. | Covered at 80% of the allowed amount subject to the calendar year deductible.<br><br>Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan. |
| **Occupational Therapy**<br>Occupational Therapy will require precertification. Call 1-800-248-2342 | Covered at 80% of the allowed amount subject to the calendar year deductible.<br><br>Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan. | Covered at 80% of the allowed amount subject to the calendar year deductible.<br><br>Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan. |
| **Speech Therapy** | Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 30 sessions per person per calendar year combined in and out-of-network.<br><br>Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan. | Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 30 sessions per person per calendar year combined in and out-of-network.<br><br>Note: Full benefits and unlimited visits for the treatment of autism for children aged 0-18 diagnosed with an autism spectrum disorder. Precertification is required and must be included in the ABA treatment plan. |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Applied Behavioral Analysis (ABA) Therapy** for children aged 0-18 diagnosed with an Autism Spectrum Disorders<br><br>Annual dollar maximums are combined for both in and out-of-network | Covered at 100% of the allowed amount subject to a $15 copay per visit and the following annual maximum benefits:<br><br>Age — Annual Maximum<br>0 to 9 — $40,000<br>10 to 13 — $30,000<br>14 to 18 — $20,000<br><br>*Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied. | Covered at 100% of the allowed amount subject to a $15 copay per visit and the following annual maximum benefits:<br><br>Age — Annual Maximum<br>0 to 9 — $40,000<br>10 to 13 — $30,000<br>14 to 18 — $20,000<br><br>*Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied. |
| **Preferred Home Health and Hospice** | Covered at 100% of the allowed amount; no copay or deductible.<br><br>Precertification required for services rendered outside of Alabama. Call 1-800-248-2342 | Covered at 80% of the allowed amount subject to the calendar year deductible.<br><br>Precertification required for services rendered outside of Alabama. Call 1-800-248-2342<br>**In Alabama,** out-of-network services, not covered |
| **Home Infusion Services**<br><br>Some Home Infusion medications require enrollment in the HealthSmartRx program. For questions, please call 1-833-798-6733. Additional information and the applicable drug list is available at AlabamaBlue.com/Providers/HealthSmartRx. | Covered at 100% of the allowed amount; no copay or deductible. | Covered at 80% of the allowed amount subject to the calendar year deductible.<br><br>**In Alabama,** out-of-network services, not covered |
| **Infertility Testing and Treatment**<br><br>Limited to a lifetime maximum of 8 artificial insemination attempts (whether successful or not). Benefits are not provided for IVF (in-vitro fertilization), ART or GIFT (gamete intrafallopian transfer). | Covered at 100% of the allowed amount; no copay or deductible. | Covered at 80% of the allowed amount subject to the calendar year deductible. |
| **HEALTH MANAGEMENT BENEFITS** | | |
| **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 and chronic obstructive pulmonary disease and other specialized conditions. For more information, call 1-888-841-5741. | |
| **Baby Yourself®** | A maternity program highly recommended for all pregnancies; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.** This group will waive the in-network and out-of-network inpatient hospital $200 per admission deductible for maternity admissions for the delivery of a baby for members participating in Baby Yourself. The member must enroll in the program in the first trimester and complete the program. The $25 per day copay will still apply for days 2-5, if applicable.<br><br>Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact PEEHIP at 1-877-517-0020 and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. | |

***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).*
- *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 as required by applicable Federal Law.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*

**Please note:** Providers/Specialists may be listed in a PPO directory or on the provider finder website (**www.bcbs.com**), but not covered as PPO benefits by this group health plan (i.e., DME, Ambulance, Allergists). Please check your benefit matrix or benefit booklet to determine coverage.
This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract.
Check your benefit booklet for more detailed coverage information.
PEEHIP members who use non-participating hospitals, providers or outpatient facilities will incur additional out-of-pocket costs.
To maximize your benefits, always use network providers.
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.
If you have any questions concerning your PEEHIP hospital / medical benefits or a claim, call 1-800-327-3994.
To certify emergency or maternity admission, call 1-800-354-7412.
To certify home health and hospice services, call 1-800-821-7231.
To take advantage of the Baby Yourself® program, call 1-800-222-4379.
Visit our website at **AlabamaBlue.com/peehip**
For questions concerning prescription drugs, call Express Scripts at 1-800-363-9389 or visit **express-scripts.com**.

**G**roup 14000
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