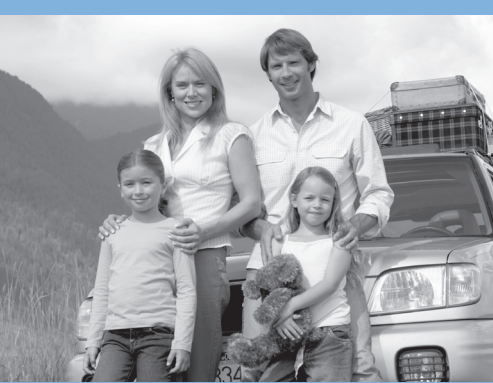


*We cover what matters.*



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**AlabamaBlue.com**

# BlueCard<sup>®</sup> PPO Plan Benefits

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

PEEHIP  
Group 14000  
BlueCard<sup>®</sup> PPO

Effective October 1, 2019-  
September 30, 2020



**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
<p><i>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.</i></p>		
<b>SUMMARY OF COST SHARING PROVISIONS</b>		
<b>Calendar Year Deductible for Major Medical Services</b>	\$300 individual; \$900 family maximum	
<b>Calendar Year Out-of-Pocket Maximums</b>	<p><b>Major Medical Maximums:</b> \$400 individual annual major medical out-of-pocket maximum (no family maximum) plus the \$300 calendar year deductible.</p> <p>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).</p> <p><b>Overall Maximums:</b> \$7,900 individual; \$15,800 family contract calendar year overall out-of-pocket maximum for 2019 and \$8,150 individual; \$16,300 family contract calendar year overall out-of-pocket maximum for 2020.</p> <p>All deductibles, copays and coinsurance for in-network services apply to the calendar year overall out-of-pocket maximum, including prescription drugs.</p> <p>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.</p>	
<b>INPATIENT HOSPITAL AND PHYSICIAN BENEFITS</b>		
<p><b>Precertification is required for inpatient admissions (except medical emergency services and maternity); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll-free) for precertification.</b></p>		
<p><b>Inpatient Hospital*</b> (including maternity) <b>Note:</b> Maternity benefits are not available to dependent children of any age.</p>	<p>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 copayment and a \$25 per day copay for days 2-5</p> <p>*Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®</p>	<p>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 copayment and a \$25 per day copay for days 2-5</p> <p><b>Note:</b> In Alabama, in-patient benefits available only for medical emergency services and accidental injury</p>
<p><b>Inpatient Physician Visits and Consultations*</b></p>	<p>Covered at 100% of the allowed amount; no copay or deductible</p> <p>*Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®</p>	<p>Covered at 80% of the allowed amount subject to calendar year deductible</p>
<b>OUTPATIENT HOSPITAL AND PHYSICIAN BENEFITS</b>		
<p><b>Precertification is required for some outpatient hospital benefits and provider-administered drugs; visit <a href="http://AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList">AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList</a>. Please see your benefit booklet. If precertification is not obtained, no benefits are available.</b></p>		
<p><b>Outpatient Surgery* (Including Ambulatory Surgical Centers)</b></p>	<p>Covered at 100% of the allowed amount after \$150 facility copay</p> <p>*Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®</p>	<p>Covered at 80% of the allowed amount subject to calendar year deductible</p> <p><b>In Alabama</b>, out-of-network facilities, not covered</p>
<p><b>Outpatient Surgery &amp; Anesthesia Physician Visits</b></p>	<p>Covered at 100% of the allowed amount; no copay or deductible</p>	<p>Covered at 80% of the allowed amount subject to the calendar year deductible</p>

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>Emergency Room (Medical Emergency) (In-Area/Out-of-Area) Facility Charge</b>	Covered at 100% of the allowed amount after \$150 facility copay for true medical emergencies.  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.  If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible.
<b>Emergency Room (Accidental Injury) (In-Area/Out-of-Area) Facility Charge</b>  <b>Note:</b> If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to <b>(Medical Emergency)</b> above.	Covered at 100% of the allowed amount after \$150 facility copay	Covered at 100% of the allowed amount after \$150 facility copay within 72 hours of the accident; 80% of the allowance, subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the Plan.
<b>Emergency Room (Physician)</b>	Covered at 100% of the allowed amount after \$35 physician copay	Covered at 100% of the allowed amount after \$35 physician copay
<b>Outpatient Diagnostic Lab &amp; Pathology</b>	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  <b>In Alabama</b> , out-of-network facilities not covered
<b>Chemotherapy, Dialysis, IV Therapy &amp; Radiation Therapy</b>	Covered at 100% of the allowed amount after \$25 facility copay	Covered at 80% of the allowed amount subject to the calendar year deductible  <b>In Alabama</b> , out-of-network facilities, not covered
<b>Outpatient Diagnostic X-ray</b>	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible  <b>In Alabama</b> , out-of-network facilities, not covered
<b>PHYSICIAN BENEFITS</b>		
<b>Precertification is required for some physician benefits and provider-administered drugs; visit <a href="http://AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList">AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList</a>. Please see your benefit booklet. If precertification is not obtained, no benefits are available.</b>		
<b>Office Visits and In-Person Consultations-Primary Care Physician</b>  (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
<b>Office Visits and In-Person Consultations-Specialist</b>	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
<b>Telephone and Online Video Physician Consultations Program</b>  A service, through Teladoc™ to diagnose, treat and prescribe medication (when necessary) for certain medical issues. To enroll, go to <a href="http://Teladoc.com/Alabama">Teladoc.com/Alabama</a> 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
<b>Outpatient Surgery &amp; Anesthesia</b>	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible

<b>BENEFIT</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Second Surgical Opinions</b>	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
<b>Diagnostic Lab &amp; Pathology</b>	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
<b>Chemotherapy, Dialysis, IV Therapy, Radiation Therapy &amp; X-ray</b>	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
<b>Maternity Care</b>	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
<b>PREVENTIVE CARE BENEFITS</b>		
<b>Routine Immunizations and Preventive Services</b> <ul style="list-style-type: none"> <li>See <a href="http://AlabamaBlue.com/PreventiveServices">AlabamaBlue.com/PreventiveServices</a> for listing of immunizations and preventive services or call our Customer Service Department for a printed copy.</li> </ul>	Covered at 100% of the allowed amount; no copay or deductible. In addition to the standard the following are covered: <ul style="list-style-type: none"> <li>Urinalysis (once by age 5 and once between ages 12 through 17)</li> <li>CBC (once each calendar year)</li> <li>Cholesterol Screening (once per calendar year for members age 18 and older)</li> <li>Glucose Screening (once per calendar year for member age 18 and older)</li> </ul>	Not Covered
<b>MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE BENEFITS</b>		
<b>Inpatient Facility Services</b>	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. Covers up to 30 days per person each plan year (10/1-9/30). Inpatient Substance Abuse limited to one admission per plan year and a maximum of two admissions per lifetime. Mental Health and Substance Abuse days are aggregate. No rollover to Major Medical.	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.
<b>Inpatient Physician Services</b>	Covered at 80% of the allowed amount subject to the calendar year deductible. Coverage is 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.
<b>Outpatient Physician Services at PEEHIP Certified Community Mental Health Centers</b>	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.
<b>Outpatient Physician Services for Blue Choice Behavioral Network Providers</b>	Covered at 100% of the allowed amount, subject to a \$50 copay per visit. Limited to 12 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. For a list of in-network Blue Choice Behavioral Health Network providers, see <a href="http://AlabamaBlue.com">AlabamaBlue.com</a> .	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.

**PRESCRIPTION DRUG BENEFITS  
(PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH MEDIMPACT)**

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
<p><b>Generic Law:</b> 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.</p>			
<p><b>Maintenance Drugs:</b> 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 days supply. The first fill of a maintenance drug will be a 30 day supply. Subsequent fills can be obtained up to a 90 days supply.</p>			
<p><b>Dispense as Written (DAW) Cost Differential:</b> 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.</p>			
<p><b>Diabetic Supplies:</b> Diabetic supplies are covered only through the pharmacy drug plan.</p>			
<p>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 MedImpact website at <a href="https://mp.medimpact.com/ala">https://mp.medimpact.com/ala</a></p>			
<p><b>Refills for Opioid and Benzodiazepine prescriptions</b> are allowed only after 90% of the previous prescription has been used.</p>			
<p><b>Non-participating pharmacies (both in-state and out-of-state):</b> Members must pay the full amount of the prescription drug and then file the claim to MedImpact 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.</p>			
<p><b>Contraceptives:</b> Generic contraceptive drugs are covered at a zero copay. Brand contraceptives are covered at the applicable brand copay.</p>			
<p><b>Flu vaccines:</b> Flu vaccines are covered at a zero copay when administered by a participating pharmacy.</p>			
<p><b>Shingrex vaccine:</b> Covered at zero copay when administered by a participating pharmacy for those aged 50 and older.</p>			
<p><b>Specialty Drugs – Copay Assistance Programs:</b> Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs. PEEHIP and MedImpact will offer copay assistance programs for certain specialty drugs so that the member copayment will normally be less than the otherwise applicable copayment.</p>			
<p><b>Infertility Drugs:</b> 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.</p>			

BENEFIT	IN-NETWORK	OUT-OF-NETWORK																
<b>BENEFITS FOR OTHER COVERED SERVICES</b>																		
Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.																		
<b>Allergy Testing &amp; Treatment</b>	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																
<b>Ambulance Service</b>	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																
<b>Participating Chiropractic Services</b>	Covered at 80% of the allowed amount; no copay or deductible <b>Note:</b> 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.																
<b>Durable Medical Equipment (DME)</b>	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.																
<b>Physical Therapy</b> Physical therapy will require precertification after 15 visits to determine medical necessity for continued therapy. Visits will accumulate regardless of provider. Call 1-800-354-7412	Covered at 80% of the allowed amount subject to the calendar year deductible.  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.  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.																
<b>Occupational Hand Therapy</b>	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to certain services related to the hand and lymphedema.  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 certain services related to the hand and lymphedema.  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.																
<b>Speech Therapy</b>	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.  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.  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.																
<b>Applied Behavioral Analysis (ABA) Therapy</b> for children aged 0-18 diagnosed with an Autism Spectrum Disorders  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:  <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Age</u></th> <th style="text-align: left;"><u>Annual Maximum</u></th> </tr> </thead> <tbody> <tr> <td>0 to 9</td> <td>\$40,000</td> </tr> <tr> <td>10 to 13</td> <td>\$30,000</td> </tr> <tr> <td>14 to 18</td> <td>\$20,000</td> </tr> </tbody> </table> <i>Preauthorization</i> is required prior to rendering ABA therapy to determine the medical necessity. <i>Preauthorization</i> 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.	<u>Age</u>	<u>Annual Maximum</u>	0 to 9	\$40,000	10 to 13	\$30,000	14 to 18	\$20,000	Covered at 100% of the allowed amount subject to a \$15 copay per visit and the following annual maximum benefits:  <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Age</u></th> <th style="text-align: left;"><u>Annual Maximum</u></th> </tr> </thead> <tbody> <tr> <td>0 to 9</td> <td>\$40,000</td> </tr> <tr> <td>10 to 13</td> <td>\$30,000</td> </tr> <tr> <td>14 to 18</td> <td>\$20,000</td> </tr> </tbody> </table> <i>Preauthorization</i> is required prior to rendering ABA therapy to determine the medical necessity. <i>Preauthorization</i> 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.	<u>Age</u>	<u>Annual Maximum</u>	0 to 9	\$40,000	10 to 13	\$30,000	14 to 18	\$20,000
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BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<b>Preferred Home Health and Hospice</b>	Covered at 100% of the allowed amount; no copay or deductible.  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.  Precertification required for services rendered outside of Alabama. Call 1-800-248-2342 <b>In Alabama</b> , out-of-network facilities, not covered
<b>Infertility Testing and Treatment</b>  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.
<b>HEALTH MANAGEMENT BENEFITS</b>		
<b>Individual Case Management</b>	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
<b>Chronic Condition Management</b>	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease and other specialized conditions. For more information, call 1-888-841-5741.	
<b>Baby Yourself®</b>	<p>A maternity program highly recommended for all pregnancies; For more information, please call 1-800-222-4379. You can also enroll online at <a href="http://AlabamaBlue.com/BabyYourself">AlabamaBlue.com/BabyYourself</a>. This group will waive the in-network and out-of-network inpatient hospital \$200 per admission copayment 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.</p> <p>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.</p>	

**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](http://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 or the average charge for care in the area.
- 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.

**Please note:** Providers/Specialists may be listed in a PPO directory or on the provider finder website ([www.bcbs.com](http://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® is an independent company providing phone and online physician consultation services to Blue Cross and Blue Shield of Alabama members.

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](http://AlabamaBlue.com/peehip)

For questions concerning prescription drugs, call MedImpact at 1-877-606-0727.

<https://mp.medimpact.com/ala>

