2026 Benefit Comparison of Health Plans

For Small Business

Blue Choice®	*Blue Access®*	*Blue Secure*	*Blue Saver®*	*Blue Secure*	*Blue HSA*	*Blue Saver®*
PLATINUM	**GOLD**	**GOLD**	**GOLD**	**SILVER**	**SILVER**	**BRONZE**
For Business	For Business	For Business	For Business	For Business	For Business	For Business

	Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business

SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)

CALENDAR YEAR DEDUCTIBLE

The in-network and out-of-network calendar year deductibles are separate and do not apply to each other.

	Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business
In-Network:	$100 Individual $200 Family	$600 Individual $1,200 Family	$1,100 Individual $2,200 Family	$2,500 Individual $5,000 Family	$4,200 Individual $8,400 Family	$4,000 Self-Only $8,000 Family	$9,100 Individual $18,200 Family
Out-of-Network:	$100 Individual $200 Family	$600 Individual $1,200 Family	$1,100 Individual $2,200 Family	$2,500 Individual $5,000 Family	$4,200 Individual $8,400 Family	$4,000 Self-Only $8,000 Family	$18,200 Individual $36,400 Family

Blue HSA Silver for Business: For family coverage, no benefits, except preventive care, are paid by the plan to any family member until the total medical expenses paid by the family equal the family deductible amount subject to the self-only calendar year out-of-pocket maximum.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM (including in-network calendar year deductible) – 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

	Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business
In-Network:	$4,000 Individual $8,000 Family	$6,000 Individual $12,000 Family	$6,500 Individual $13,000 Family	$6,750 Individual $13,500 Family	$9,200 Individual $18,400 Family	$6,100 Self-Only $12,200 Family	$9,100 Individual $18,200 Family
Out-of-Network:	There is no out-of-pocket maximum for out-of-network services 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	There is no out-of-pocket maximum for out-of-network services 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	There is no out-of-pocket maximum for out-of-network services 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	There is no out-of-pocket maximum for out-of-network services 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	There is no out-of-pocket maximum for out-of-network services 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	There is no out-of-pocket maximum for out-of-network services After you reach your self-only 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 remainder of calendar year	There is no out-of-pocket maximum for out-of-network services 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

INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)

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.

INPATIENT HOSPITAL – In Alabama, inpatient benefits for out-of-network hospitals available only for medical emergency services and accidental injury

	Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business
In-Network:	100% of allowed amount after $150 per day hospital copay days 1-5 for each admission	**Lower Member Cost Share:** 100% of allowed amount after $250 per day hospital copay days 1-5 for each admission **Higher Member Cost Share:** 100% of allowed amount after $500 per day hospital copay days 1-5 for each admission	**Lower Member Cost Share:** 100% of allowed amount after $300 per day hospital copay days 1-5 for each admission **Higher Member Cost Share:** 100% of allowed amount after $600 per day hospital copay days 1-5 for each admission	**Lower Member Cost Share:** 100% of allowed amount after $300 per day hospital copay days 1-5 for each admission **Higher Member Cost Share:** 100% of allowed amount after $600 per day hospital copay days 1-5 for each admission	**Lower Member Cost Share:** 100% of allowed amount after $700 per day hospital copay days 1-5 for each admission **Higher Member Cost Share:** 100% of allowed amount after $1,000 per day hospital copay days 1-5 for each admission	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount after $300 per admission deductible	80% of allowed amount after $800 per admission deductible	80% of allowed amount after $1,000 per admission deductible	80% of allowed amount after $1,000 per admission deductible	50% of allowed amount after $1,500 per admission deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible

	Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)							
INPATIENT PHYSICIAN VISITS AND CONSULTATIONS – Note: In Alabama, out-of-network physician services covered at 50% of allowed amount subject to calendar year deductible.							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
Mental Health Disorders and Substance Abuse Services							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount; no copay or deductible	80% of allowed amount; no copay or deductible	80% of allowed amount; no copay or deductible	80% of allowed amount; no copay or deductible	50% of allowed amount; no copay or deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)							
Precertification is required for some outpatient hospital benefits and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.							
OUTPATIENT SURGERY – (Including Ambulatory Surgical Centers)							
In-Network:	100% of allowed amount after $150 hospital copay	**Lower Member Cost Share:** 100% of allowed amount after $250 hospital copay **Higher Member Cost Share:** 100% of allowed amount after $500 hospital copay	**Lower Member Cost Share:** 100% of allowed amount after $300 hospital copay **Higher Member Cost Share:** 100% of allowed amount after $600 hospital copay	**Lower Member Cost Share:** 100% of allowed amount after $300 hospital copay **Higher Member Cost Share:** 100% of allowed amount after $600 hospital copay	**Lower Member Cost Share:** 100% of allowed amount after $650 hospital copay **Higher Member Cost Share:** 100% of allowed amount after $950 hospital copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered
EMERGENCY ROOM – (Medical Emergency)							
In-Network:	100% of allowed amount after $150 hospital copay	100% of allowed amount after $250 hospital copay	100% of allowed amount after $300 hospital copay	100% of allowed amount after $300 hospital copay	100% of allowed amount after $650 hospital copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	100% of allowed amount after $150 hospital copay	100% of allowed amount after $250 hospital copay	100% of allowed amount after $300 hospital copay	100% of allowed amount after $300 hospital copay	100% of allowed amount after $650 hospital copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Mental Health Disorders and Substance Abuse Services - (In-Network and Out-of-Network)							
	100% of allowed amount after $150 hospital copay	100% of allowed amount after $250 hospital copay	100% of allowed amount after $300 hospital copay	100% of allowed amount after $300 hospital copay	100% of allowed amount after $650 hospital copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible

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EMERGENCY ROOM – (Accident) **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **Emergency Room (Medical Emergency)**.							
In-Network:	100% of allowed amount after $150 hospital copay	100% of allowed amount after $250 hospital copay	100% of allowed amount after $300 hospital copay	100% of allowed amount after $300 hospital copay	100% of allowed amount after $650 hospital copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	100% of the allowed amount, after a $150 hospital copay when services are rendered within 72 hours of the accident; 80% of the allowed amount, subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan	100% of the allowed amount, after a $250 hospital copay when services are rendered within 72 hours of the accident; 80% of the allowed amount, subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan	100% of the allowed amount, after a $300 hospital copay when services are rendered within 72 hours of the accident; 80% of the allowed amount, subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan	100% of the allowed amount, after a $300 hospital copay when services are rendered within 72 hours of the accident; 80% of the allowed amount, subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan	100% of the allowed amount, after a $650 hospital copay when services are rendered within 72 hours of the accident; 50% of the allowed amount, subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan	80% of the allowed amount, subject to calendar year deductible when services are rendered within 72 hours of the accident; 50% of the allowed amount, subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan	100% of the allowed amount, subject to calendar year deductible when services are rendered within 72 hours of the accident; 50% of the allowed amount, subject to calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
EMERGENCY ROOM PHYSICIAN							
In-Network:	100% of allowed amount after $30 physician copay	100% of allowed amount after $50 physician copay	100% of allowed amount after $60 physician copay	100% of allowed amount after $60 physician copay	100% of allowed amount after $90 physician copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	100% of allowed amount after $30 physician copay	100% of allowed amount after $50 physician copay	100% of allowed amount after $60 physician copay	100% of allowed amount after $60 physician copay	100% of allowed amount after $90 physician copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Mental Health Disorders and Substance Abuse Services - (In-Network and Out-of-Network)							
	100% of allowed amount after $30 physician copay	100% of allowed amount after $50 physician copay	100% of allowed amount after $60 physician copay	100% of allowed amount after $60 physician copay	100% of allowed amount after $90 physician copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
OUTPATIENT DIAGNOSTIC LAB, X-RAY & PATHOLOGY							
In-Network:	100% of allowed amount; no copay or deductible	**Lower Member Cost Share:** 100% of allowed amount after $250 hospital copay **Higher Member Cost Share:** 100% of allowed amount after $500 hospital copay	**Lower Member Cost Share:** 100% of allowed amount after $300 hospital copay **Higher Member Cost Share:** 100% of allowed amount after $600 hospital copay	**Lower Member Cost Share:** 100% of allowed amount after $300 hospital copay **Higher Member Cost Share:** 100% of allowed amount after $600 hospital copay	**Lower Member Cost Share:** 100% of allowed amount after $650 hospital copay **Higher Member Cost Share:** 100% of allowed amount after $950 hospital copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered

	Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business
OUTPATIENT DIALYSIS, IV THERAPY, CHEMOTHERAPY & RADIATION THERAPY							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered
INTENSIVE OUTPATIENT SERVICES AND PARTIAL HOSPITALIZATION FOR MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE							
In-Network:	100% of allowed amount after $30 per day hospital copay	100% of allowed amount after $50 per day hospital copay	100% of allowed amount after $60 per day hospital copay	100% of allowed amount after $60 per day hospital copay	100% of allowed amount after $90 per day hospital copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible;in Alabama, not covered	80% of allowed amount subject to calendar year deductible;in Alabama, not covered	80% of allowed amount subject to calendar year deductible;in Alabama, not covered	80% of allowed amount subject to calendar year deductible;in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)							
Precertification is required for some physician benefits and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.							
Note: In Alabama, out-of-network physician services covered at 50% of allowed amount subject to calendar year deductible							
OFFICE VISITS & CONSULTATIONS							
In-Network:	100% of allowed amount after $20 primary care physician copay or $30 specialist physician copay	100% of allowed amount after $30 primary care physician copay or $50 specialist physician copay	100% of allowed amount after $35 primary care physician copay or $60 specialist physician copay	100% of allowed amount after $35 primary care physician copay or $60 specialist physician copay	100% of allowed amount after $45 primary care physician copay or $90 specialist physician copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount after $45 primary care physician copay or $90 specialist physician copay
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
TELEPHONE AND ONLINE VIDEO PHYSICIAN CONSULTATIONS PROGRAM - MEDICAL AND BEHAVIORAL HEALTH							
To enroll in the telephone and online video consultations program, go to **AlabamaBlue.com/Teleconsultation** or call **1-800-997-6196**. Telephone and online video consultations are available to diagnose, treat and prescribe medication (when necessary) for certain medical and behavioral health issues.							
In-Network:	100%, subject to a $20 payment per consultation	100%, subject to a $30 payment per consultation	100%, subject to a $35 payment per consultation	100%, subject to a $35 payment per consultation	100%, subject to a $45 payment per consultation	80%, subject to calendar year deductible	100%, subject to a $45 payment per consultation
Out-of-Network:	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
SECOND SURGICAL OPINION							
In-Network:	100% of allowed amount after $30 physician copay	100% of allowed amount after $50 physician copay	100% of allowed amount after $60 physician copay	100% of allowed amount after $60 physician copay	100% of allowed amount after $90 physician copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount after $45 primary care physician copay or $90 specialist physician copay
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible

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SURGERY & ANESTHESIA							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
BARIATRIC SURGERY (Surgeon, Assistant Surgeon, Physician Assistant, Nurse Practitioner & Anesthesia)							
In-Network:	80% of allowed amount; no copay or deductible	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Out-of-Network:	In Alabama, 50% of allowed amount subject to calendar year deductible; outside Alabama, 80% of allowed amount subject to calendar year deductible	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
MATERNITY CARE							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
DIAGNOSTIC X-RAY							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount after $10 copay per procedure	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
CAT SCAN, MRI, PET/SPECT, ERCP, ANGIOGRAPHY/ARTERIOGRAPHY, CARDIAC CATH/ARTERIOGRAPHY, COLONOSCOPY, UGI ENDOSCOPY, MUGA-GATED CARDIAC SCAN							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount after $250 copay per visit	100% of allowed amount after $300 copay per visit	100% of allowed amount after $300 copay per visit	100% of allowed amount after $650 copay per visit	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
DIAGNOSTIC LAB & PATHOLOGY							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible

	Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business
DIALYSIS, IV THERAPY, CHEMOTHERAPY & RADIATION THERAPY							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
PREVENTIVE CARE BENEFITS							
ROUTINE IMMUNIZATIONS AND PREVENTIVE SERVICES							
• See **AlabamaBlue.com/PreventiveServices** and **AlabamaBlue.com/StandardACAPreventiveDrugList** for a listing of specific immunizations and preventive services or call our Customer Service Department at **1-800-292-8868** for a printed copy.							
• Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network. A list of eligible vaccines these pharmacies may provide can be found at: **AlabamaBlue.com/VaccineNetworkDrugList**							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible
Out-of-Network:	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
ROUTINE VISION BENEFITS							
ADULT EYE EXAM – Limited to $75 maximum for exam and refraction per member per calendar year for adults age 19 and over.							
In-Network:	100% of allowed amount; no copay or deductible	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Out-of-Network:	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
PEDIATRIC EYE EXAM – Limited to one exam (including refraction) per member per calendar year up to the end of the month in which the member turns 19; includes dilation if medically necessary.							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
PEDIATRIC GLASSES OR CONTACT LENSES – Limited to one pair of prescription glasses per member per calendar year; contact lenses are limited to one 12-month supply per member per calendar year. Benefits are available up to the end of the month in which the member turns 19.							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible

Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business

Prescription Drug Benefits (Includes Mental Health Disorders and Substance Abuse)

Some drugs require precertification. If precertification is not obtained, no benefits are available.

RETAIL PRESCRIPTION PREPAID DRUG BENEFITS

The retail pharmacy network for the plan is the **ValueONE Retail Network.**

- Locate a **ValueONE Retail Network** Pharmacy at **AlabamaBlue.com/ValueONERetailPharmacyLocator**

Prescription drugs (other than Maintenance Drugs) can be dispensed for up to a 30-day supply.

- View the Source+Rx 1.0 or Source+Rx 2.0 Drug lists that apply to the plan at **AlabamaBlue.com/2026SourcePlusRx1DrugList** or **AlabamaBlue.com/2026SourcePlusRx2DrugList**

Maintenance prescription drugs can be dispensed for up to a 30-day supply.

- View the Maintenance Drug List at **AlabamaBlue.com/MaintenanceDrugList**
- Some copays may be combined for diabetic supplies

Specialty Drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Specialty Drugs is the **Pharmacy Select Network**.

- View the Specialty Drug List at **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList**

Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network.

- A list of eligible vaccines these pharmacies may provide can be found at **AlabamaBlue.com/VaccineNetworkDrugList**

Covered Insulin Cost Share Cap - a maximum $99 cost share will be implemented for covered Insulin products for each 30-day supply.

- **HSA-Qualified HDHPs** - when a covered Insulin product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a covered Insulin product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met.

Tier 1 Drugs:	$10 copay per prescription	$10 copay per prescription	$10 copay per prescription	$10 copay per prescription	$15 copay per prescription	80% of allowed amount subject to calendar year deductible	$20 copay per prescription
Tier 2 Drugs:	$20 copay per prescription	$20 copay per prescription	$20 copay per prescription	$20 copay per prescription	$30 copay per prescription	80% of allowed amount subject to calendar year deductible	$35 copay per prescription
Tier 3 Drugs:	$35 copay per prescription	$40 copay per prescription	$50 copay per prescription	$50 copay per prescription	$75 copay per prescription	80% of allowed amount subject to calendar year deductible	0% coinsurance subject to calendar year deductible
Tier 4 Drugs:	$75 copay per prescription	$80 copay per prescription	$90 copay per prescription	$90 copay per prescription	$100 copay per prescription	80% of allowed amount subject to calendar year deductible	0% coinsurance subject to calendar year deductible
Tier 5 Drugs:	$100 copay per prescription	$125 copay per prescription	$200 copay per prescription	$200 copay per prescription	$250 copay per prescription	80% of allowed amount subject to calendar year deductible	0% coinsurance subject to calendar year deductible
Tier 6 Drugs:	$200 copay per prescription	$250 copay per prescription	$300 copay per prescription	$300 copay per prescription	40% coinsurance	80% of allowed amount subject to calendar year deductible	0% coinsurance subject to calendar year deductible
Out-of-Network:	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Formulary:	Source+Rx 2.0	Source+Rx 1.0	Source+Rx 1.0	Source+Rx 1.0	Source+Rx 1.0	Source+Rx 1.0	Source+Rx 1.0

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EXTENDED SUPPLY PRESCRIPTION PREPAID DRUG BENEFITS

The Extended Supply Pharmacy Network for the plan is the **ValueONE ESN Network.**

- Locate a **ValueONE ESN** Pharmacy at **AlabamaBlue.com/ValueONEESNPharmacyLocator**

Only Maintenance Prescription Drugs can be purchased through this Extended Supply Pharmacy service-up to a 90-day supply with one copay for each 30-day supply.

- View the Maintenance Drug List that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList**
- View the Source+Rx 1.0 or Source+Rx 2.0 Drug lists that apply to the plan at **AlabamaBlue.com/2026SourcePlusRx1DrugList** or **AlabamaBlue.com/2026SourcePlusRx2DrugList**

Covered Insulin Cost Share Cap - a maximum $99 cost share will be implemented for covered Insulin products for each 30-day supply.

- **HSA - Qualified HDHPs** - when a covered Insulin product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a covered Insulin product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met.

Tier 1 Drugs:	$10 copay per prescription	$10 copay per prescription	$10 copay per prescription	$10 copay per prescription	$15 copay per prescription	80% of allowed amount subject to calendar year deductible	$20 copay per prescription
Tier 2 Drugs:	$20 copay per prescription	$20 copay per prescription	$20 copay per prescription	$20 copay per prescription	$30 copay per prescription	80% of allowed amount subject to calendar year deductible	$35 copay per prescription
Tier 3 Drugs:	$35 copay per prescription	$40 copay per prescription	$50 copay per prescription	$50 copay per prescription	$75 copay per prescription	80% of allowed amount subject to calendar year deductible	0% coinsurance subject to calendar year deductible
Tier 4 Drugs:	$75 copay per prescription	$80 copay per prescription	$90 copay per prescription	$90 copay per prescription	$100 copay per prescription	80% of allowed amount subject to calendar year deductible	0% coinsurance subject to calendar year deductible
Tier 5 Drugs:	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Tier 6 Drugs:	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Network:	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Formulary:	Source+Rx 2.0	Source+Rx 1.0	Source+Rx 1.0	Source+Rx 1.0	Source+Rx 1.0	Source+Rx 1.0	Source+Rx 1.0

SELECT GENERIC SPECIALTY AND BIOSIMILAR DRUGS

Select Generic Specialty and Biosimilar drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Select 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**
- Select Generic Specialty and Biosimilar drugs are not available through the **Home Delivery Network**.

In-Network:	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	100% of the allowed amount, subject to calendar year deductible	$0 copay
Out-of-Network:	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

MAIL ORDER PRESCRIPTION DRUG BENEFITS

Mail order drugs are available through **Home Delivery Network** (Enroll at **AlabamaBlue.com/HomeDeliveryNetwork**).

Up to a 90-day supply can be dispensed with one copay.

Covered Insulin Cost Share Cap - a maximum $99 cost share will be implemented for covered Insulin products for each 30-day supply.

Tier 1 Drugs:	$25 copay per prescription	$25 copay per prescription	$25 copay per prescription	$25 copay per prescription	$37.50 copay per prescription	Not Covered	Not Covered
Tier 2 Drugs:	$50 copay per prescription	$50 copay per prescription	$50 copay per prescription	$50 copay per prescription	$75 copay per prescription	Not Covered	Not Covered
Tier 3 Drugs:	$87.50 copay per prescription	$100 copay per prescription	$125 copay per prescription	$125 copay per prescription	$187.50 copay per prescription	Not Covered	Not Covered
Tier 4 Drugs:	$187.50 copay per prescription	$200 copay per prescription	$225 copay per prescription	$225 copay per prescription	$250 copay per prescription	Not Covered	Not Covered
Tier 5 Drugs:	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Tier 6 Drugs:	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

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BENEFITS FOR 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.							
ALLERGY TESTING & TREATMENT							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
AMBULANCE SERVICE							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
CHIROPRACTIC SERVICES – Limited to 15 visits per member per calendar year							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered
DURABLE MEDICAL EQUIPMENT (DME)							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
HOME HEALTH AND HOSPICE							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	80% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered	50% of allowed amount subject to calendar year deductible; in Alabama, not covered

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HOME INFUSION							
In-Network:	100% of allowed amount, no copay or deductible	100% of allowed amount, no copay or deductible	100% of allowed amount, no copay or deductible	100% of allowed amount, no copay or deductible	100% of allowed amount, no copay or deductible	80% subject to calendar year deductible	100% subject to calendar year deductible
Out-of-Network:	80% of the allowed amount subject to the deductible; in Alabama not covered	80% of the allowed amount subject to the deductible; in Alabama not covered	80% of the allowed amount subject to the deductible; in Alabama not covered	80% of the allowed amount subject to the deductible; in Alabama not covered	50% of the allowed amount subject to the deductible; in Alabama not covered	50% of the allowed amount subject to the deductible; in Alabama not covered	50% of the allowed amount subject to the deductible; in Alabama not covered
MEDICAL NUTRITION THERAPY SERVICES For adults and children, 6 hours each calendar year							
In-Network:	100% of the allowed amount after a $20 physician visit copay	100% of the allowed amount after a $30 physician visit copay	100% of the allowed amount after a $35 physician visit copay	100% of the allowed amount after a $35 physician visit copay	100% of the allowed amount after a $45 physician visit copay	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
REHABILITATIVE OCCUPATIONAL, PHYSICAL & SPEECH THERAPY Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
HABILITATIVE OCCUPATIONAL, PHYSICAL & SPEECH THERAPY Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible

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AUTISM-RELATED REHABILITATIVE AND HABILITATIVE OCCUPATIONAL & SPEECH THERAPY Children ages 0-18 with an autism diagnosis are allowed unlimited visits for occupational and speech therapy							
In-Network:	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	80% of allowed amount subject to calendar year deductible; in Alabama, 50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible
PEDIATRIC DENTAL BENEFITS **Note:** Benefits are available up to the end of the month in which the member turns 19. See your benefit booklet for visit and treatment limits.							
DIAGNOSTIC AND PREVENTIVE SERVICES **Examples include:** Dental exams, routine cleanings, fluoride treatment, bitewing x-rays, full mouth x-rays and panoramic film, tooth sealants and topical fluoride varnish							
In-Network:	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount; no copay or deductible	100% of allowed amount subject to calendar year deductible	100% of allowed amount; no copay or deductible
Out-of-Network:	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
BASIC SERVICES **Examples include:** Tooth color and silver amalgam fillings, simple tooth extractions, non-surgical root canal, emergency treatment for pain and repairs to crowns, inlays, onlays and dentures							
In-Network:	80% of allowed amount; no copay or deductible	80% of allowed amount; no copay or deductible	80% of allowed amount; no copay or deductible	80% of allowed amount; no copay or deductible	80% of allowed amount; no copay or deductible	80% of allowed amount subject to calendar year deductible	100% of allowed amount; no copay or deductible
Out-of-Network:	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
MAJOR SERVICES **Examples include:** Oral surgery, general anesthesia, periodontic exams, removal of diseased gum tissue and bone, crowns, onlays, core buildup, dentures, implants and bridges							
In-Network:	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
MEDICALLY NECESSARY ORTHODONTIC SERVICES							
In-Network:	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	50% of allowed amount subject to calendar year deductible	100% of allowed amount subject to calendar year deductible
Out-of-Network:	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

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MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE NETWORK

BLUE CHOICE BEHAVIORAL HEALTH NETWORK

In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. In most cases, benefits will mirror medical benefits. See specific categories for more details.

ADDITIONAL 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, chronic obstructive pulmonary disease and other specialized conditions. For more information call **1-888-841-5741** or email **membermanagement@bcbsal.org**.

BABY YOURSELF®

A maternity program; for more information, please call **1-800-222-4379**. You can also enroll online at **AlabamaBlue.com/BabyYourself**.

AIR MEDICAL TRANSPORTATION

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	Air medical transportation at no charge, to a network hospital of the member's choice near their home if hospitalized while traveling more than 150 miles from home; limited to two air medical transports per member per year. To arrange transportation, call AirMed at **1-877-872-8624**.	Air medical transportation at no charge, to a network hospital of the member's choice near their home if hospitalized while traveling more than 150 miles from home; limited to two air medical transports per member per year. To arrange transportation, call AirMed at **1-877-872-8624**.	Air medical transportation at no charge, to a network hospital of the member's choice near their home if hospitalized while traveling more than 150 miles from home; limited to two air medical transports per member per year. To arrange transportation, call AirMed at **1-877-872-8624**.	Air medical transportation at no charge, to a network hospital of the member's choice near their home if hospitalized while traveling more than 150 miles from home; limited to two air medical transports per member per year. To arrange transportation, call AirMed at **1-877-872-8624**.	Air medical transportation at no charge, to a network hospital of the member's choice near their home if hospitalized while traveling more than 150 miles from home; limited to two air medical transports per member per year. To arrange transportation, call AirMed at **1-877-872-8624**.	Not covered	Air medical transportation at no charge, to a network hospital of the member's choice near their home if hospitalized while traveling more than 150 miles from home; limited to two air medical transports per member per year. To arrange transportation, call AirMed at **1-877-872-8624**.

NURSE ADVICE LINE

	Blue Choice® Platinum For Business	Blue Access® Gold For Business	Blue Secure Gold For Business	Blue Saver® Gold For Business	Blue Secure Silver For Business	Blue HSA Silver For Business	Blue Saver® Bronze For Business
	The toll free nurse line at **1-855-453-5183** gives you access to a registered nurse 24 hours a day, seven days a week, 365 days a year.	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

NOTES

BlueCross BlueShield of Alabama

Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

Air medical transport services are provided through a contract with AirMed International, LLC. AirMed International, LLC is an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical services terminate if coverage by your health plan ends.

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