Plan Benefits

BlueCard® PPO

USA Select Plan

BlueCard® PPO

Effective January 1, 2026

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BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

USA Select Plan
BlueCard® PPO
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BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
SUMMARY OF COST SHARING PROVISIONS **(Includes Mental Health Disorders and Substance Abuse)**		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
In-Network Calendar Year Deductible	$125 individual; $250 family (no member will pay more than the $125 individual deductible on a family contract). Applies to both the USA Health Network and Other PPO. The in and out-of-network deductibles are separate and do not cross apply.	
Out-of-Network Deductible (for services outside the USA Health Network or PPO Network)	$250 individual; $500 family (no member will pay more than the $250 individual deductible on a family contract). The in and out-of-network deductibles are separate and do not cross apply.	
Prescription Drug Deductible	$100 individual; $300 family maximum (no member will pay more than the $100 individual deductible on a family contract).	
Annual Out-of-Pocket Maximum	$8,500 individual; $17,000 family maximum All copays, deductibles, and coinsurance apply to the out-of-pocket maximum including prescription drugs; payments made by drug manufacturer assistance programs may not apply towards the deductible or out-of-pocket maximum. For members up to the end of the month in which the member turns age 19, deductibles and coinsurance for in-network dental services under the group's dental benefits apply to the out-of-pocket. The plan will pay 100% of medical benefits for the remainder of the calendar year after the Medical Out-of-Pocket Maximum amounts are met.	
INPATIENT HOSPITAL FACILITY SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services, maternity and as required by Federal Law); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342.		
Inpatient Facility Coverage and Residential Treatment Facilities (including maternity)	Covered at 100% of the allowed amount subject to the calendar year deductible. Coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.	Covered at 70% of the allowed amount subject to the calendar year deductible. Coverage for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.
Note: In Alabama, inpatient hospital benefits are paid only if received from a Blue Cross and Blue Shield provider. Outside, Alabama inpatient hospital benefits are paid only if received from a BlueCard PPO provider except in cases of medical emergency or accidental injury.		
OUTPATIENT HOSPITAL FACILITY SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Surgery	Covered at 100% of the allowed amount, after $150 facility copay and subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
CyberKnife Treatment **Note:** CyberKnife services subject to coverage limitations.	Covered at 100% of the allowed amount subject to the calendar year deductible.	Not covered.
Medical Emergency	Covered at 100% of the allowed amount after $200 copay and subject to the calendar year deductible. Copay waived if admitted.	Covered at 100% of the allowed amount after $200 copay and subject to the calendar year deductible. Copay waived if admitted. Mental Health Disorders and Substance Abuse covered at 100% of the allowed amount subject to the calendar year deductible.
Medical Emergency (does not meet medical emergency criteria)	Covered at 70% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Accidental Injury	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 100% of the allowed amount subject to the calendar year deductible.
Diagnostic X-ray	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.

BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
Diagnostic Lab and Pathology	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Hemodialysis, IV Therapy Chemotherapy and Radiation Therapy	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
PHYSICIAN SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Office Visits and Outpatient Consultations	Covered at 100% of the allowed amount, after $15 physician copay and subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Telephone and online video consultations program A service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4549.	Covered at 100% of the allowed amount per consultation.	Covered at 100% of the allowed amount per consultation.
Emergency Room Physician Fees	Covered at 100% of the allowed amount after $15 copay and subject to the calendar year deductible.	Covered at 100% of the allowed amount after $15 copay and subject to the calendar year deductible. **Mental Health Disorders and Substance Abuse** covered at 100% of the allowed amount subject to the calendar year deductible.
Emergency Room Physician (does not meet medical emergency criteria)	Covered at 70% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Urgent Care	Covered at 100% of the allowed amount after $50 copay and subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Surgery	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Bariatric Surgery (Surgeon, Assistant Surgeon & Anesthesia) Limited to a lifetime max of one procedure per person.	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Anesthesia	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Second Surgical Opinions	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Inpatient Visits and Inpatient Consultations	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Maternity *Dependent maternity not covered*	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Diagnostic X-rays	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Diagnostic Lab Exams	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.

BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
Hemodialysis, IV Therapy Chemotherapy and Radiation Therapy	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
TMJ Phase I	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
TELEHEALTH SERVICES **(Includes Mental Health Disorders and Substance Abuse)**		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and applicable covered out-of-network services, when services rendered are performed within the scope of the health care provider's license and deemed medically necessary.		
PREVENTIVE CARE SERVICES		
Routine Preventive Services and Immunizations See **AlabamaBlue.com/ PreventiveServices or AlabamaBlue.com/SourceRxACAPreventiveDrugList** for listing of immunizations and preventive services or call our Customer Service Department for a printed copy. • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/VaccineNetwork DrugList** for more information.	100% of the allowed amount, no deductible or copay. **In addition to the standard, the following exceptions apply:** • Routine urinalysis - when necessary • Routine TB skin test - when necessary • Routine CBC - when necessary • Routine total cholesterol - once per calendar year • Blood Pressure Monitor, for members with a diagnosis of hypertension, with a maximum of one every 5 calendar years. • Peak Flow Meter for members with a diagnosis of asthma, with a maximum of one per person per calendar year • International Normalized Ratio (INR) testing, for members with a diagnosis of liver disorder and/or bleeding disorder, with a maximum of 15 per person per calendar year. • Lipoprotein (LDL) testing for members with a diagnosis of heart disease, with a maximum of five per person per calendar year. • Hemoglobin A1C testing for members with a diagnosis of diabetes, with a maximum of four per person per calendar year. • Retinopathy screening for members with a diagnosis of diabetes, with a maximum of three per person per calendar year.	100% of the allowed amount, no deductible or copay. **In addition to the standard, the following exceptions apply:** • Routine urinalysis - when necessary • Routine TB skin test - when necessary • Routine CBC - when necessary • Routine total cholesterol - once every calendar year • Blood Pressure Monitor, for members with a diagnosis of hypertension, with a maximum of one every 5 calendar years. • Peak Flow Meter for members with a diagnosis of asthma, with a maximum of one per person per calendar year • International Normalized Ratio (INR) testing, for members with a diagnosis of liver disorder and/or bleeding disorder, with a maximum of 15 per person per calendar year. • Lipoprotein (LDL) testing for members with a diagnosis of heart disease, with a maximum of five per person per calendar year. • Hemoglobin A1C testing for members with a diagnosis of diabetes, with a maximum of four per person per calendar year. • Retinopathy screening for members with a diagnosis of diabetes, with a maximum of three per person per calendar year.
Vision *One routine eye examination (including refraction per member each benefit period)*	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 100% of the allowed amount subject to the calendar year deductible.
OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Participating Chiropractor Services Limited to 60 visits per member each benefit period	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.

BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
Rehabilitative Occupational, Physical and Speech Therapy Limited to 60 visits per member per therapy each benefit period	Covered at 100% of the allowed amount, after $15 copay and subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible .
Habilitative Occupational, Physical and Speech Therapy Limited to 60 visits per member per therapy each benefit period	Covered at 100% of the allowed amount, after $15 copay and subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Cardiac Rehabilitation Limited to 36 visits per episode	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Autism Spectrum Disorder Benefit **Prior authorization required** Care as determined to be medically necessary including: • Evaluation and assessment services; • Habilitative and Rehabilitative outpatient services including speech, physical and occupational therapy for ages 0-18 (no visit limits); • Behavior training and management and Applied Behavior Analysis; • Psychiatric care; • Psychological care including family counseling; • Therapeutic Care	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Durable Medical Equipment (DME) Orthotic devices are limited to a maximum benefit of two pair every 12 consecutive months	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Home Health Limited to 60 visits per calendar year	Covered at 100% of the allowed amount subject to the calendar year deductible for services rendered by a Participating Home Health Agency affiliated with USA Health.	Covered at 70% of the allowed amount subject to the calendar year deductible. for services rendered by a Participating Home Health Agency in Alabama.
Home Infusion Services	Covered at 100% of the allowed amount subject to the calendar year deductible for services rendered by a Participating Home Health Agency affiliated with USA Health.	Covered at 70% of the allowed amount subject to the calendar year deductible. for services rendered by a Participating Home Health Agency in Alabama.
Hospice Limited to a lifetime maximum of 180 days	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Skilled Nursing Facility • Up to 60 days per member each benefit period (combined in and out-of-network) • Precertification required – call 1-800-821-7321 • Admission occurs within 14 days of hospital discharge • Medicare approved facility • Must be engaged in providing skilled care under supervision of physicians and R.N.; maintain clinical records; provide 24-hr nursing services; dispense and administer drugs	Covered at 70% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Ambulance Services Must be medically necessary	Covered at 70% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Allergy Testing	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Allergy Treatment	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.

BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
Diabetes Self-Management Education	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Sleep Disorders	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Transplant Services	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 70% of the allowed amount subject to the calendar year deductible.
Medical Nutrition Therapy For Adults and Children, 3-hours of Medical Nutrition Therapy Services for all members regardless of age and 3-hours of Medical Nutrition Therapy Services for specific covered diagnoses.	Covered at 100% of the allowed amount subject to the calendar year deductible.	Covered at 100% of the allowed amount subject to the calendar year deductible.
PRESCRIPTION DRUGS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.		
Retail Prescription Prepaid Benefits The retail pharmacy network for the plan is **Prime Participating Network** • Locate a Prime Participating Retail Network pharmacy at **AlabamaBlue.com/ Prime ParticipatingPharmacyLocator** Maintenance drugs - up to 31-day supply with one copay • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** Prescription drugs (other than maintenance drugs) - up to a 31-day supply with one copay • Some copays combined for diabetic supplies (waive copay and deductible on glucose monitors on select products) • View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList6T** The only in-network pharmacy for some Tier 5 and 6 (specialty) drugs is the **Pharmacy Select Network and MCI (Mitchell Cancer Institute in-house pharmacy)** • Tier 5 and 6 (specialty) drugs can be dispensed for up to a 30-day supply • View the Specialty Drug List at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList** • Fertility, weight loss, cosmetic alternation, and over the counter drugs are not covered • Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network. A list of the eligible vaccines these pharmacies may provide can be found at: **AlabamaBlue.com/ VaccineNetworkDrugList**. • Certain drugs are part of the FlexAccess Program. See list at **AlabamaBlue.com/FlexAccessDrugList**	Covered at 100% of the allowed amount, subject to the prescription drug deductible ($100 individual; $300 family maximum-no member will pay more than the $100 individual deductible) and the following copays: **Tier 1 (preferred generic):** $10 copay per prescription **Tier 2 (non-preferred generic)**: $10 copay per prescription **Tier 3 (preferred brand)**: $50 copay per prescription **Tier 4 (non-preferred brand)**: $75 copay per prescription **Tier 5 (preferred specialty):** $150 copay per prescription **Tier 6 (non-preferred specialty):** 50% coinsurance For drugs on the FlexAccess Drug List, cost share may vary based on available drug manufacturer assistance. If assistance is available, the amount member pays out-of-pocket will be set by the drug manufacturer assistance program.	

BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
Extended Supply Prescription Drug Card • The extended supply pharmacy network for the plan is the **Prime Participating Network** • Locate a Prime Participating Retail Network pharmacy at **AlabamaBlue.com/ Prime ParticipatingPharmacyLocator** • Maintenance drugs – up to a 90-day supply may be purchased with two copays • View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList6T**	Covered at 100% of the allowed amount, subject to the prescription drug deductible ($100 individual; $300 family maximum-no member will pay more than the $100 individual deductible) and the following copays: **Tier 1 (preferred generic):** $10 copay per prescription **Tier 2 (non-preferred generic)**: $10 copay per prescription **Tier 3 (preferred brand)**: $50 copay per prescription **Tier 4 (non-preferred brand)**: $75 copay per prescription	
Select Generic Specialty and Biosimilar drugs Generic specialty and biosimilar drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some generic specialty and biosimilar drugs is the Pharmacy Select Network. • View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at AlabamaBlue.com/SelectGenericSpecialtyandBiosimilarDrugList. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	Covered at 100% of the allowed amount, no deductible or copay.	
Mail Order Pharmacy Benefits (Voluntary program) • Up to a 90-day supply with two copays • Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/ HomeDeliveryNetwork** Only maintenance drugs can be purchased through this mail order pharmacy service • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** • View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList6T** **Note:** If you have less than a 90-day supply, you will pay the same copay as a 90-day supply when using this mail order program	Covered at 100% of the allowed amount, subject to the prescription drug deductible ($100 individual; $300 family maximum-no member will pay more than the $100 individual deductible) and the following copays: **Tier 1 (preferred generic):** $10 copay per prescription **Tier 2 (non-preferred generic)**: $10 copay per prescription **Tier 3 (preferred brand)**: $50 copay per prescription **Tier 4 (non-preferred brand)**: $75 copay per prescription	

BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	A program to assist employees and their families in coordinating care in the event of a lengthy illness.	
Chronic Condition Management	A program for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease and other specialized conditions. For more information, please call 1-888-841-5741.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself**.	
Contraceptive Management	Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.	
PIVOT® Tobacco Cessation	A tobacco cessation program for (employees, spouses and dependents age 18 and over) that blends digital technology and behavioral science to help members quit tobacco use. Pivot members receive a mobile app, individual coaching, breath sensor device, and nicotine replacement therapy (when applicable). This program lasts 6 months. Call 1-650-249-3959 for participation information.	

Note: For out-of-network services:

Skilled Nursing services are covered at 70% of the allowed amount subject to the $250 individual/$500 family deductible.

Ambulance services covered at 70% of the allowed amount, subject to the in-network calendar year deductible.

Accidental Injury facility services covered at 100% of the allowed amount, subject to in-network calendar year deductible.

Medical Emegency facility services covered at 100% of the allowed amount, subject to a $200 copay and the in-network calendar year deductible.

Accidental Injury and Medical Emergency physician services covered at 100% of the allowed, subject to a $15 copay and the in-network calendar year deductible.

Mental Health Disorders and Substance Abuse for Medical Emergency and Accidental Injury covered at 100% of the allowed amount subject to the in-network calendar year deductible. Otherwise, no coverage.

Please note: Providers/Specialists may be listed in the PPO directory, but not covered as PPO benefits by this group health plan (i.e. DME, Ambulance, Midwives, Allergists). Some of these benefits may be covered under Other Covered Services or not at all. Please check your benefit matrix or benefit booklet to determine coverage.
Note: In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network.
Note: Teladoc Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.
Note: Pivot, an independent company, provides a smoking cessation and digital health coaching platform for members of Blue Cross and Blue Shield of Alabama.

All non-participating hospitals will not be covered.
This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

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Group #67307

Notice of Nondiscrimination

Discrimination is Against the Law

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY),1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.ى

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意：如果您说 普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-855-216-3144（TTY 用户请拨 711）或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

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

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

Japanese:
ご案内：日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어을(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.