BlueCross BlueShield of Alabama

: PR Employer -Blue Saver

Coverage Period: Beginning on or after 01/01/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage For:** Individual + Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at AlabamaBlue.com or by calling 1-800-292-8868.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3000** person **/ $6000** family in-network. **$3000** person **/ $6000** family out-of-network. Does not apply to preventive services, physician, noncovered services, most copays, balance-billed charges and pre-certification penalties.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network **$6000** person **/ $12000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits and pre-certification penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses in-network providers. For a list of in-network providers, see AlabamaBlue.com or call 1-800-810-BLUE.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-292-8868 or visit us at AlabamaBlue.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-292-8868 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance & $30 copay	Not Covered	The first three illness related visits are subject to $30 copay; thereafter, subject to 20% coinsurance and overall deductible
	Specialist visit	0% coinsurance & $30 copay	Not Covered	The first three illness related visits are subject to $30 copay; thereafter, subject to 20% coinsurance and overall deductible
	Other practitioner office visit	20% coinsurance for chiropractor	Not Covered	Subject to overall deductible; limited to a maximum of 15 visits per member per calendar year
	Preventive care/screening/immunization	No Charge	Not Covered	Please see AlabamaBlue.com/preventiveservices
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	Benefits listed are physician services; subject to overall deductible
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Benefits listed are physician services; subject to overall deductible; precertification may be required for coverage

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at AlabamaBlue.com/pharmacy.	Tier 1 drugs	0% coinsurance & $15 copay	Not Covered	Prior authorization required for specific drugs; generic drugs mandatory when available
	Tier 2 drugs	0% coinsurance & $50 copay	Not Covered	Prior authorization required for specific drugs; generic drugs mandatory when available
	Tier 3 drugs	0% coinsurance & $70 copay	Not Covered	Prior authorization required for specific drugs; generic drugs mandatory when available
	Tier 4 drugs	0% coinsurance & $395 copay	Not Covered	Prior authorization required for specific drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Subject to overall deductible
	Physician/surgeon fees	20% coinsurance	Not Covered	Subject to overall deductible
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Subject to overall deductible; physician charges may apply
	Emergency medical transportation	20% coinsurance	50% coinsurance	Subject to overall deductible
	Urgent care	0% coinsurance & $30 copay	Not Covered	The first three illness related visits are subject to $30 copay; thereafter, subject to 20% coinsurance and overall deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Subject to overall deductible
	Physician/surgeon fee	20% coinsurance	Not Covered	Subject to overall deductible

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance & $30 copay	Not Covered	Benefits listed are outpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; the first three illness related visits are subject to $30 copay; thereafter, subject to 20% coinsurance and overall deductible; additional benefits are also available; some services require precertification
	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	Benefits listed are inpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician;additional benefits are also available; subject to overall deductible; precertification is required
	Substance use disorder outpatient services	0% coinsurance & $30 copay	Not Covered	Benefits listed are outpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; the first three illness related visits are subject to $30 copay; thereafter, subject to 20% coinsurance and overall deductible; additional benefits are also available; some services require precertification
	Substance use disorder inpatient services	20% coinsurance	Not Covered	Benefits listed are inpatient physician services and are available through the Blue Choice Behavioral Health Network or PPO physician; additional benefits are also available; subject to overall deductible; precertification is required
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not Covered	Benefits listed are outpatient physician services; subject to overall deductible

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out of Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% coinsurance	Not Covered	Benefits listed are inpatient physician services; subject to overall deductible
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Subject to overall deductible; precertification may be required for coverage
	Rehabilitation services	20% coinsurance	Not Covered	Subject to overall deductible; limited to combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year
	Habilitation services	20% coinsurance	Not Covered	Subject to overall deductible; limited to combined maximum of 30 visits for occupational, physical and speech therapy per member per calendar year
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	Not Covered	Subject to overall deductible
	Hospice service	20% coinsurance	40% coinsurance	Subject to overall deductible; precertification may be required for coverage
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Please see AlabamaBlue.com/preventiveservices
	Glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Dental check-up	No Charge	Not Covered	Please see AlabamaBlue.com/preventiveservices

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Glasses, child	• Routine eye care (Adult)
• Bariatric surgery	• Hearing aids	• Routine foot care
• Cosmetic surgery	• Long-term care	• Skilled nursing care
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care (limited to 15 visits per member per calendar year)	• Infertility treatment (Assisted Reproductive Technology not covered)	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan administrator at the phone number listed in your benefit booklet. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan administrator at 1-800-292-8868. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have healthcare coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% health coverage. **This plan does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-292-8868.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,490
- **Patient pays** $4,050

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3000
Copays	$50
Coinsurance	$850
Limits or exclusions	$150
Total	**$4,050**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: AlabamaBlue.com.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,570
- **Patient pays** $3,830

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3000
Copays	$430
Coinsurance	$30
Limits or exclusions	$370
Total	**$3,830**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: AlabamaBlue.com.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-292-8868 or visit us at AlabamaBlue.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-292-8868 to request a copy.

PRemployer
Blue Saver Merit
BlueCard® PPO

Effective January 1, 2016

PRemployer
Blue Saver Merit
BlueCard® PPO
Effective January 1, 2016

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received. Some services require a copay, coinsurance, calendar year deductible or deductible for each admission, visit or service.		
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	$3,000 individual; $6,000 family	$3,000 individual; $6,000 family
Calendar Year Out-of-Pocket Maximum (includes calendar year deductible) All deductibles, copays and coinsurance for in-network services and out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum	$6,000 individual; $12,000 family After you reach your 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
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	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Inpatient Physician Visits and Consultations	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Emergency Room (Medical Emergency)	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
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)** above.	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible for services within 72 hours; not covered, when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Emergency Room Physician	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits, Consultations & Second Surgical Opinions	Covered at 100% of the allowed amount after $30 physician copay for first three illness related office visits; thereafter, covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Surgery & Anesthesia	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Maternity Care	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/preventiveservices** for a listing of the specific 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/pharmacy** for more information.	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Note: In some cases, office visit copays or facility copays may apply		
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Prescription Drug Card • The pharmacy network for the plan is the **Prime Participating Pharmacy Network** • Prescription drugs (other than Tier 4 (specialty) drugs) can be dispensed for up to a 90-day supply but the copay is applicable for each 30-day supply • Some drugs require precertification • Some copays combined for diabetic supplies • Tier 4 (specialty) drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Prime Therapeutics Specialty Pharmacy™** network. Go to **AlabamaBlue.com/web/pharmacy/druggguide.html** for a list of these Tier 4 (specialty) drugs. • View the **Standard Prescription Drug** list that applies to the plan at **AlabamaBlue.com/web/pharmacy/druggguide.html**	Covered at 100% of the allowed amount after the following copays for a 30-day supply for each prescription: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $50 copay per prescription **Tier 3 Drugs:** $70 copay per prescription **Tier 4 (specialty) Drugs:** $395 copay per prescription **Generic drugs are mandatory when available and may be classified at any Tier.**	Not covered
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 Limited to 6 visits per calendar year for allergy treatment	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Ambulance Service	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Participating Chiropractic Services Limited to 15 visits per calendar year	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Occupational, Physical and Speech Therapy • Occupational, physical and speech therapy limited to a combined maximum of 30 visits per calendar year • Children ages 0-9 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Home Health and Hospice	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HEALTH MANAGEMENT AND ADDITIONAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **BeHealthy.com**.	
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.	
Air Medical Services	Air ambulance service to a network hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624.	

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website (**AlabamaBlue.com**) or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *Out-of-network providers generally do not contract with Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan. 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.*
- *Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.*

This is not a contract or benefit booklet.
Benefits are subject to the terms, limitations and conditions of your contract with us (including your benefit booklet).
Check your benefit booklet for more detailed coverage information.
Please visit our website, AlabamaBlue.com.