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BlueCard[®] PPO Plan Benefits

USA Health Plan
BlueCard[®] PPO
USA Select Health Plan
Effective January 1, 2024



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

**USA Select Health Plan
Effective January 1, 2024**

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	\$8,000 individual; \$16,000 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.
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.

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.
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. Note: Bariatric Services in Alabama must be performed by Bariatric Surgery Network Provider	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 <i>Dependent maternity not covered</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.
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/SourceRxACAP reventiveDrugList for listing of immunizations and preventive services or call our Customer Service Department for a printed copy. <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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. 	100% of the allowed amount, no deductible or copay. In addition to the standard, the following exceptions apply: <ul style="list-style-type: none"> 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 <i>One routine eye examination (including refraction per member each benefit period)</i>	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.
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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: <ul style="list-style-type: none">• Evaluation and assessment services;• Habilitative and Rehabilitative outpatient services including speech, physical and occupational therapy;• 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 <ul style="list-style-type: none">• 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)		
Recertification is required for some drugs; if recertification is not obtained, no benefits are available.		
<p>Retail Prescription Prepaid Benefits</p> <p>The retail pharmacy network for the plan is Prime Participating Network</p> <ul style="list-style-type: none"> Locate a Prime Participating Retail Network pharmacy at AlabamaBlue.com/PrimeParticipatingPharmacyLocator <p>Maintenance drugs - up to 90-day supply with two copays</p> <ul style="list-style-type: none"> View the maintenance drug list that applies to the plan at AlabamaBlue.com/MaintenanceDrugList <p>Prescription drugs (other than maintenance drugs) - up to a 31-day supply with one copay</p> <ul style="list-style-type: none"> 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 <p>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)</p> <ul style="list-style-type: none"> Tier 5 and 6 (specialty) drugs can be dispensed for up to a 30-day supply View the Specialty Drug List at AlabamaBlue.com/SelfAdministeredSpecialtyDrugList 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 	<p>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:</p> <p>Tier 1 (preferred generic): \$10 copay per prescription</p> <p>Tier 2 (non-preferred generic): \$10 copay per prescription</p> <p>Tier 3 (preferred brand): \$50 copay per prescription</p> <p>Tier 4 (non-preferred brand): \$75 copay per prescription</p> <p>Tier 5 (preferred specialty): \$150 copay per prescription</p> <p>Tier 6 (non-preferred specialty): 50% coinsurance</p> <p>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.</p>	

BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
<p>Extended Supply Prescription Drug Card</p> <ul style="list-style-type: none"> The extended supply pharmacy network for the plan is the Prime Participating Network Locate a Prime Participating Retail Network pharmacy at AlabamaBlue.com/PrimeParticipatingPharmacyLocator 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 	<p>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:</p> <p>Tier 1 (preferred generic): \$10 copay per prescription</p> <p>Tier 2 (non-preferred generic): \$10 copay per prescription</p> <p>Tier 3 (preferred brand): \$50 copay per prescription</p> <p>Tier 4 (non-preferred brand): \$75 copay per prescription</p>	
<p>Select Generic Specialty and Biosimilar drugs</p> <p>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.</p> <ul style="list-style-type: none"> View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at AlabamaBlue.com/SelectGenericSpecialtyandBiosimilarDrugList. <p>Generic specialty and biosimilar drugs are not available through the Home Delivery Network.</p>	<p>Covered at 100% of the allowed amount.</p>	
<p>Mail Order Pharmacy Benefits (Voluntary program)</p> <ul style="list-style-type: none"> Up to a 90-day supply with two copays Mail Order Drugs are available through Home Delivery Network (Enroll online at AlabamaBlue.com/HomeDeliveryNetwork) <p>Only maintenance drugs can be purchased through this mail order pharmacy service</p> <ul style="list-style-type: none"> 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 <p>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</p>	<p>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:</p> <p>Tier 1 (preferred generic): \$10 copay per prescription</p> <p>Tier 2 (non-preferred generic): \$10 copay per prescription</p> <p>Tier 3 (preferred brand): \$50 copay per prescription</p> <p>Tier 4 (non-preferred brand): \$75 copay per prescription</p>	

BENEFIT	IN-NETWORK USA HEALTH (Affiliated with the University of South Alabama)	IN-NETWORK OTHER PPO (BCBS & BlueCard PPO)
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**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.
Quit for Life Tobacco Cessation Program	A tobacco cessation program for employees and spouses that provides support to participants through telephone-based counseling and nicotine replacement therapy. Call 1-888-768-7848 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 Emergency 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.

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

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. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free 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 services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these 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@bcsal.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>.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144 (TTY: 711) まで、お電話にてご連絡ください。