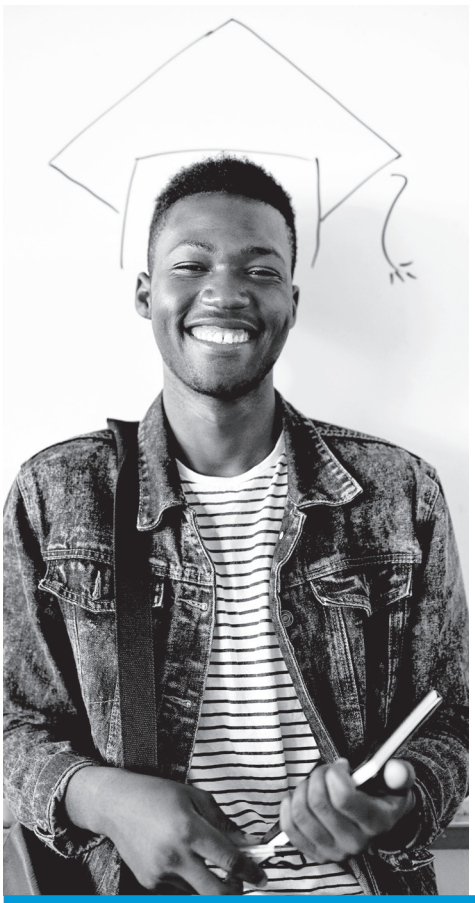
BlueCross BlueShield of Alabama



BlueCard PPO

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Student Health Plan Benefits

The University of Alabama Student Health Plan

BlueCard® PPO

Effective August 1, 2025

MKT348-23112

The University of Alabama
Student Health Plan
BlueCard® PPO
Effective August 1, 2025

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.		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Policy year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Policy Year Deductible August 1, 2025 – July 31, 2026 The in-network and out-of-network Plan Year deductibles are separate and do not apply to each other	$250 individual; $750 family	$1,000 individual; $3,000 family
Policy Year Out-of-Pocket Maximum August 1, 2025 – July 31, 2026	$8,700 individual; $17,400 family All deductibles, copays and coinsurance for in-network services and all deductibles, copay and coinsurance for out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum The dollar amount of any specialty drug financial assistance provided by providers or manufacturers will not apply to the in-network out-of-pocket maximum. After you reach your Plan Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of policy year	There is no out-of-network out-of-pocket maximum.
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (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 (toll-free) for precertification.		
Inpatient Hospital	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **Note:** In Alabama, available only for medical emergency services and accidental injury.
Inpatient Physician Visits and Consultations	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits; please see benefit booklet. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
Emergency Room (Medical Emergency)	Covered at 80% of the allowed amount, after $200.00 hospital copay; copay waived if admitted	Covered at 80% of the allowed amount, after $200.00 hospital copay; copay waived if admitted

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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, after $200.00 hospital copay; copay waived if admitted	Covered at 80% of the allowed amount, after $200.00 hospital copay for services rendered within 72 hours; copay waived if admitted; covered at 60% of the allowed amount, subject to the policy year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Emergency Room (Physician)	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 80% of the allowed amount, subject to policy year deductible
Chemotherapy, Dialysis, IV Therapy, Radiation Therapy and X-ray	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
CAT Scan, MRI, PET/SPECT, ERCP, angiography/arteriography, cardiac cath/arteriography, UGI endoscopy, muga-gated cardiac scan & colonoscopy	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
Outpatient Diagnostic Lab & Pathology	Covered at 80% of the allowed amount, subject to $30.00 copay per visit	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
Outpatient Injections	Covered at 80% of the allowed amount, subject to $20.00 copay per visit	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
PHYSICIAN BENEFITS **(Includes Mental Health Disorders and Substance Abuse)** **Precertification is required for some physician benefits; please see benefit booklet. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList.** **If precertification is not obtained, no benefits are available.**		
Office Visits and Consultations	Covered at 100% of the allowed amount, after $30.00 physician copay, not subject to policy year deductible.	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Student Health Center (SHC) Services - For Students, outpatient services received from a provider other than the Student Health Center without a referral from the SHC will be paid at the out of network benefit level. No referral is required from the Student Health Center for the following: • Medical Emergency/Accident. The student must return to SHC for necessary follow-up care • Student Health Center is closed • Service is rendered at another facility during break or vacation periods • Medical care obtained when student is no longer able to use Student health Center due to a change in the student status • Maternity, obstetrical and gynecological care • Medical care received when the student is more than 50 miles from campus • Mental Illness treatment and Substance Use Disorder treatment Dependents are not eligible to use the SHC and therefore are exempt from the above limitations and requirements.	Covered at 100% of the allowed amount, after $20.00 office visit copay, not subject to policy year deductible; any other medical service available and rendered at SHC will be covered at 100% of the allowed amount, not subject to the policy year deductible. See separate **Prescription Drug Benefits** below. Services for TB testing will be covered at 100% of the allowed amount, after $20.00 copay and not subject to policy year deductible.	Not Applicable

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Second Surgical Opinions	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Urgent Care	Covered at 80% of the allowed amount, subject to $50.00 copay per visit	Covered at 60% of the allowed amount, subject to $50.00 copay per visit **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Surgery & Anesthesia	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Maternity Care	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
CAT Scan, MRI, PET/SPECT, ERCP, angiography/arteriography, cardiac cath/arteriography, UGI endoscopy, muga-gated cardiac scan & colonoscopy	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/ PreventiveServices** and **AlabamaBlue.com/ StandardACAPreventiveDrugList** for listing of specific drugs, 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/ VaccineNetworkDrugList** 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. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PEDIATRIC VISION BENEFITS		
Benefits are available up to the end of the month in which the member turns 19. See your benefit booklet for visit and treatment limits.		
Pediatric Eye Exam Limited to one exam (including refraction) per member per policy year up to the end of the month in which the member turns 19.	Covered at 100% of the allowed amount, after $20.00 copay per visit	Covered at 50% of the allowed amount, subject to policy year deductible
Pediatric Eyeglass Lenses Limited to one per member per policy year	Covered at 100% of the allowed amount, after $40.00 copay per visit	Covered at 50% of the allowed amount, subject to policy year deductible
Additional Lens Limited to one per member per policy year. Includes polycarbonate lenses and lenses with standard scratch resistant coating	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost up to $130.	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to policy year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost of $130-$160.	Covered at 100% of the allowed amount, after $15.00 copay	Covered at 50% of the allowed amount, subject to policy year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost of $160-$200.	Covered at 100% of the allowed amount, after $30.00 copay	Covered at 50% of the allowed amount, subject to policy year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost of $200-$250.	Covered at 100% of the allowed amount, after $50.00 copay	Covered at 50% of the allowed amount, subject to policy year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per policy year with a retail cost greater than $250.	Covered at 60% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to policy year deductible
Pediatric Contact Lenses Fittings & Evaluation Limited to one per policy year	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Pediatric Contact Lenses Limited to one 12-month supply per policy year	Covered at 100% of the allowed amount, after $40.00 copay	Covered at 50% of the allowed amount, subject to policy year deductible
PRESCRIPTION DRUG BENEFITS **(Includes Mental Health Disorders and Substance Abuse)**		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.		
Student Health Center Prescription Drug Benefits.	Covered at 100% of the allowed amount, subject to the following copays for each prescription: **Tier 1 Drugs:** $10 copay per prescription **Tier 2 Drugs:** $10 copay per prescription **Tier 3 Drugs:** $40 copay per prescription **Tier 4 Drugs:** $50 copay per prescription **Tier 5 Drugs:** $40 copay per prescription **Tier 6 Drugs:** $50 copay per prescription	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Retail Prescription Prepaid Benefits The retail pharmacy network for the plan is **Prime Participating Retail Network** • Locate a **Prime Participating** Retail Network pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocator** Maintenance drugs - up to 90-day supply may be purchased but copay applies for each 30-day supply • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** Prescription drugs (other than maintenance drugs) - up to a 30-day supply • Some copays combined for diabetic supplies • View the **Source+Rx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ 2025SourcePlusRx1DrugList** The only in-network pharmacy for some specialty drugs is the **Pharmacy Select Network** • Specialty drugs can be dispensed for up to a 30-day supply • View the Specialty Drug List at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList** 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**.	Covered at 100% of the allowed amount, subject to the following copays for a 30-day supply for each prescription: **Prime Participating Retail Pharmacy Network:** **Tier 1 Drugs:** $25 copay per prescription **Tier 2 Drugs:** $25 copay per prescription **Tier 3 Drugs:** $50 copay per prescription **Tier 4 Drugs:** $60 copay per prescription **Tier 5 Drugs:** $50 copay per prescription **Tier 6 Drugs:** $60 copay per prescription Covered Insulin Products: $99.00 maximum cost share per 30-day supply.	Not covered
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/SelectGenericSpecialty andBiosimilarDrugList. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	100% of the allowed amount, no copay or deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Mail Order Pharmacy Benefits • Up to a 90-day supply with one copay • 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 **Source+Rx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ 2025SourcePlusRx1DrugList** **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 following copays: **Tier 1 Drugs:** $62.50 copay per prescription **Tier 2 Drugs:** $62.50 copay per prescription **Tier 3 Drugs:** $125 copay per prescription **Tier 4 Drugs:** $150 copay per prescription **Tier 5 Drugs:** Not applicable **Tier 6 Drugs:** Not applicable Covered Insulin Products: $99.00 maximum cost share per 30-day supply.	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	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible
Ambulance Service	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 80% of the allowed amount, subject to policy year deductible
Participating Chiropractic Services	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per policy year	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per policy year	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** covered at 50% of the allowed amount, subject to policy year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Home Health and Hospice	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
Home Infusion	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible **In Alabama,** not covered
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per policy year	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible
Physiotherapy Services When referred by SHC, review of medical necessary after 12 visits per sickness or injury	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 60% of the allowed amount, subject to policy year deductible
Impacted Wisdom Teeth Removal	Covered at 80% of the allowed amount, subject to policy year deductible	Covered at 80% of the allowed amount, subject to policy year deductible
PEDIATRIC DENTAL BENEFITS		
Policy Year Deductible: $250 per individual for in and out-of-network service combined **Benefits are available up to the end of the month in which the member turns 19. See your benefit booklet for visit and treatment limits.**		
Diagnostic and preventive services Limited to members up to the end of the month in which the member turns 19	Covered at 50% of the allowed amount, subject to policy year deductible	Covered at 50% of the allowed amount, subject to policy year deductible
Basic services Limited to members up to the end of the month in which the member turns 19	Covered at 50% of the allowed amount, subject to policy year deductible	Covered at 50% of the allowed amount, subject to policy year deductible
Major services Limited to members up to the end of the month in which the member turns 19	Covered at 50% of the allowed amount, subject to policy year deductible	Covered at 50% of the allowed amount, subject to policy year deductible
Medically Necessary Orthodontic Services for congenital or hereditary conditions requiring medical treatment and/or corrective surgery Limited to members up to the end of the month in which the member turns 19	Covered at 50% of the allowed amount, subject to policy year deductible	Covered at 50% of the allowed amount, subject to policy year deductible
HEALTH MANAGEMENT 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.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.	
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.	
Air Medical Transport	Air medical transportation 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.	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK

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 a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). 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/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area, the average charge for care in the area or in accordance with applicable Federal law.*
- *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.*
- *As a participant in the student health insurance plan, you enjoy a range of valuable services and benefits: Academic Emergency Services: Accessible from anywhere, this service provides Emergency Medical Evacuation, Repatriation, Emergency Family Reunion, and comprehensive assistance in Medical, Travel, Safety, and Legal matters. Please visit* ***aes.myahpcare.com*** *for more information.*
- *AcademicLiveCare (ALC): Through ALC, you will benefit from virtual visits with board-certified professionals for both behavioral and physical health concerns. This program offers 24/7 urgent care or scheduled appointments with a medical doctor, therapist, nutritionist or psychiatrist. Use your school's unique coupon code, sent to you upon enrolling in the student health insurance plan, to receive no-cost care. ALC is an independent company from Blue Cross and Blue Shield of Alabama. To access these services, please visit* ***ahplivecare.com*** *and use the service key and coupon code* ***AHPFREE****.*
- *Academic Student Assistance Program (ASAP): For immediate access to a counselor or life and wellbeing resources, utilize our ASAP service. To explore life and wellbeing resources, simply visit* ***myahpcare.personaladvantage.com*** *and enter AHP1 as the Company Code. Ready to speak to a counselor? Call 1 (866) 349-5575.*
- *Please refer to your benefit book or contact Blue Cross directly about coverage for your hospital charges and other related medical services. Approval for air medical transportation does not mean that hospitalization and other medical expenses will be covered. All coverage determinations for medical benefits are subject to the terms, conditions, limitations and exclusions of the health plan. Air medical transportation services are provided through a contract with AirMed International, LLC, an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical transportation services terminate if coverage by your health plan ends.*

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

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 بسهل 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 બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

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