Alabama State Bar

ASSOCIATION HEALTH PLAN

2023-2024

Benefits and Financials

Alabama State Bar

Group Number(s): 59617

Rating Period: 8/1/2023- 7/31/2024

Rate Summary for GOLD+	BCBS +MedPlus
	Renewal Rates
Employee	$738.00
Employee + Spouse	$1,482.00
Employee + Children	$1,345.00
Family	$2,089.00

Rate Summary for Gold Plan	BCBS + Medplus
	Renewal Rates
Employee	$681.00
Employee + Spouse	$1,356.00
Employee + Children	$1,239.00
Family	$1,912 .00

Rate Summary for Silver Plan	BCBS + Medplus
	Renewal Rates
Employee	$653.00
Employee + Spouse	$1,295.00
Employee + Children	$1,188.00
Family	$1,829.00

Rate Summary for Bronze Plan	BCBS-NO Secondary Insurance
	Renewal Rates
Employee	$579.00
Employee + Spouse	$1,138.00
Employee + Children	$1,056.00
Family	$1,613.00

Alabama State Bar

Group Number(s): 59617
Rating Period: 8/1/2023- 7/31/2024

Rate Summary for HSA Qualified Plan _NO SECONDARY

Employee	$ 630
Employee + Spouse	$1,219
Employee + Children	$1,132
Family	$1,720

Rate Summary for Dental Value

	Renewal Rates
Employee	$24
Employee + Spouse	$45
Employee + Children	$51
Family	$76

Rate Summary for Dental Complete

	Renewal Rates
Employee	$34
Employee + Spouse	$64
Employee + Children	$74
Family	$110

Rate Summary for VSP Vision

	Renewal Rates
Employee	$8
Employee + Spouse	$12
Employee + Children	$12
Family	$19

MedPlus

Part of your health insurance package includes MedPlus, which is your secondary insurance carrier. The secondary coverage allows you to pay a lessor deductible (than your primary insurance) while still receiving credit toward your primary insurance deductible. It is extremely important to remember the facts below when visiting your providers, as they may overlook this information and expect payment from you!

- When visiting ANY doctor, hospital, or facility where medical treatment is rendered, point out to the billing, insurance, or front desk coordinators that you have **two insurance companies** to file claims against.
- Information about how to file claims with your MedPlus plan can be found on your MedPlus insurance card, or on the right side of your combined insurance card under MedPlus.
- The Customer Service number is located on your card for benefit verification, claim status and other billing and benefit related matters. You can also call 800-890-7337 for questions about your plan.
- *REMEMBER – THE SECONDARY INSURANCE IS TO BE USED IN CONJUNCTION WITH YOUR PRIMARY COVERAGE.(PLEASE REFER TO YOUR HEALTH BOOKLET FOR ALL APPROVED AND ALLOWED SERVICES AS WELL AS DEDUCTIBLE AND COPAYS THAT MAY APPLY).*

Gulf Guaranty
Employee Benefit Services, Inc.

MedPlus supplemental plans are provided by Gulf Guaranty Employee Benefit Services and underwritten by Gulf Guaranty Life Insurance Company.

Gulf Guaranty Employee Benefit Services • P.O. Box 14977, Jackson, MS 39236-4977 • P: 800-890-7337 • F: 601-981-6805

Two cards, ONE benefit!
Make sure you present *both* your BlueCross card and your MedPlus card when using your benefits.

Sample BCBS AL Card

BlueCross BlueShield of Alabama

BLUE CROSS PREFERRED CARE

Subscriber Name

Contract Number

Group Number 59617
Effective Date 01-01-2021
Rx BIN Number 004915

HEALTH PAC

PPO

Rx

Sample Medplus Card

Primary Health Plan Logo Here

MedPlus

EMPLOYEE NAME HERE

Primary Health Plan
ID: **XYZ123456789**
Plan Codes: 111 111

Primary Health Plan
PO Box 123
Nowhere, USA 12345
CUST SRVC NBR HERE

Supplemental Health Plan
ID: **123456789**
Group Plan #: 00123

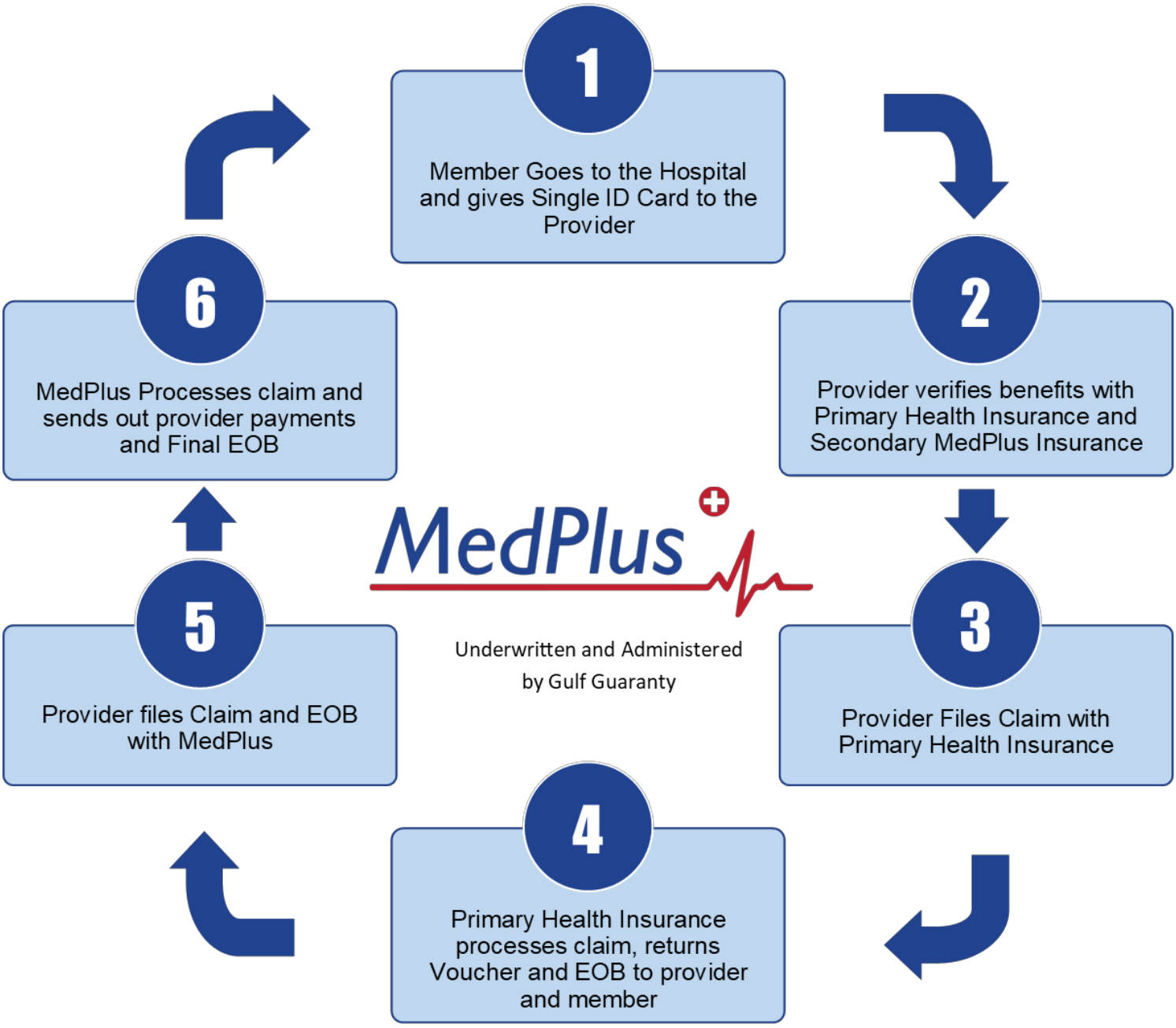
XYZ Company

Gulf Guaranty Health
P.O. Box 14977
Jackson, MS 39236-4977
1-800-890-7337

***The sample ID card shown is for illustrative purposes only and does not include valid plan information*

Alabama State Bar

MedPlus Claim Process



Definition of Terms:
EOB = Explanation of Benefits
Primary Insurance = *Other*
Secondary Insurance = Gulf Guaranty MedPlus

MedPlus

www.medplusplan.com

Alabama State Bar Association

GOLD+

Group Supplemental Health Insurance Proposal

Effective Date:
8/1/2023

Lower Employee Deductibles * Reduce Out of Pocket Exposure * Save Premium Cost

MedPlus
www.medplusplan.com

Alabama State Bar Association

August 1, 2023

COMPOSITE SUMMARY	BCBSAL	MEDPLUS GOLD +
DEDUCTIBLES & OUT OF POCKET MAXIMUM		
Calendar Year Deductible (CYD)	Single $9,100 / Family $18,200	Single $500 / Family $1,000
Coinsurance after Deductible	BCBSAL 60% / Member 40%	Medplus 100% / Member 0%
Out of Pocket Maximum (OPM)	Single $9,100 / Family $18,200	Single $500 / Family $1,000 *
Cost after Deductible and OPM have been met	BCBSAL covers 100%	BCBSAL covers 100%
INPATIENT HOSPITAL FACILITY		
Inpatient Hospital	$9,100 CYD then 60%	MedPlus pays up to $8,600
Inpatient Hospital Physician Services	$9,100 CYD then 60%	MedPlus pays up to $8,600
OUTPATIENT FACILITY AND PHYSICIAN CHARGES		
Emergency Room + Physician	$9,100 CYD then 60%	MedPlus pays up to $8,600
Outpatient Facility & Ambulatory Centers	$9,100 CYD then 60%	MedPlus pays up to $8,600
Outpatient Physician (surgery and anesthesia)	$9,100 CYD then 60%	MedPlus pays up to $8,600
Outpatient Diagnostic	$9,100 CYD then 60%	MedPlus pays up to $8,600
Ambulance	$9,100 CYD then 60%	MedPlus pays up to $8,600
Other Covered Services - PT, Chiro, DME	$9,100 CYD then 60%	MedPlus pays up to $8,600
PHYSICIAN AND RX CO-PAYS		
Preventative/Wellness	BCBSAL covers at 100%	Covered under BCBSAL
Primary/Specialist Physician Copay	$45 PCP / $65 Spec	Covered under BCBSAL
Telemedicine: (24 hour Physician Access)	BCBSAL excludes	No Copay - 24/7 Access
Prescription Drug Benefits: Tier 1,2,3,4	$0 ded $15/$60/$100/50%	Covered under BCBSAL

** The Out of Pocket with Medplus does NOT include Doctor Copays or Pharmacy deductibles or Copays.*

MedPlus

www.medplusplan.com

Alabama State Bar Association

Gold Plan

Group Supplemental Health Insurance Proposal

Effective Date:
8/1/2023

Lower Employee Deductibles * Reduce Out of Pocket Exposure * Save Premium Cost

MedPlus
www.medplusplan.com

Alabama State Bar Association

August 1, 2023

COMPOSITE SUMMARY	BCBSAL	MEDPLUS GOLD
DEDUCTIBLES & OUT OF POCKET MAXIMUM		
Calendar Year Deductible (CYD)	Single $9,100 / Family $18,200	Single $2,000 / Family $4,000
Coinsurance after Deductible	BCBSAL 60% / Member 40%	Medplus 100% / Member 0%
Out of Pocket Maximum (OPM)	Single $9,100 / Family $18,200	Single $2,000 / Family $4,000 *
Cost after Deductible and OPM have been met	BCBSAL covers 100%	BCBSAL covers 100%
INPATIENT HOSPITAL FACILITY		
Inpatient Hospital	$9,100 CYD then 60%	MedPlus pays up to $7,100
Inpatient Hospital Physician Services	$9,100 CYD then 60%	MedPlus pays up to $7,100
OUTPATIENT FACILITY AND PHYSICIAN CHARGES		
Emergency Room + Physician	$9,100 CYD then 60%	MedPlus pays up to $7,100
Outpatient Facility & Ambulatory Centers	$9,100 CYD then 60%	MedPlus pays up to $7,100
Outpatient Physician (surgery and anesthesia)	$9,100 CYD then 60%	MedPlus pays up to $7,100
Outpatient Diagnostic	$9,100 CYD then 60%	MedPlus pays up to $7,100
Ambulance	$9,100 CYD then 60%	MedPlus pays up to $7,100
Other Covered Services - PT, Chiro, DME	$9,100 CYD then 60%	MedPlus pays up to $7,100
PHYSICIAN AND RX CO-PAYS		
Preventative/Wellness	BCBSAL covers at 100%	Covered under BCBSAL
Primary/Specialist Physician Copay	$45 PCP / $65 Spec	Covered under BCBSAL
Telemedicine: (24 hour Physician Access)	BCBSAL excludes	No Copay - 24/7 Access
Prescription Drug Benefits: Tier 1,2,3,4	$0 ded $15/$60/$100/50%	Covered under BCBSAL

** The Out of Pocket with Medplus does NOT include Doctor Copays or Pharmacy deductibles or Copays.*

MedPlus

www.medplusplan.com

Alabama State Bar Association

Silver Plan

Group Supplemental Health Insurance Proposal

Effective Date:
8/1/2023

Lower Employee Deductibles * Reduce Out of Pocket Exposure * Save Premium Cost

MedPlus
www.medplusplan.com

Alabama State Bar Association

August 1, 2023

COMPOSITE SUMMARY	BCBSAL	MEDPLUS SILVER
DEDUCTIBLES & OUT OF POCKET MAXIMUM		
Calendar Year Deductible (CYD)	Single $9,100 / Family $18,200	Single $4,000 / Family $8,000
Coinsurance after Deductible	BCBSAL 60% / Member 40%	Medplus 100% / Member 0%
Out of Pocket Maximum (OPM)	Single $9,100 / Family $18,200	Single $4,000 / Family $8,000 *
Cost after Deductible and OPM have been met	BCBSAL covers 100%	BCBSAL covers 100%
INPATIENT HOSPITAL FACILITY		
Inpatient Hospital	$9,100 CYD then 60%	MedPlus pays up to $5,100
Inpatient Hospital Physician Services	$9,100 CYD then 60%	MedPlus pays up to $5,100
OUTPATIENT FACILITY AND PHYSICIAN CHARGES		
Emergency Room + Physician	$9,100 CYD then 60%	MedPlus pays up to $5,100
Outpatient Facility & Ambulatory Centers	$9,100 CYD then 60%	MedPlus pays up to $5,100
Outpatient Physician (surgery and anesthesia)	$9,100 CYD then 60%	MedPlus pays up to $5,100
Outpatient Diagnostic	$9,100 CYD then 60%	MedPlus pays up to $5,100
Ambulance	$9,100 CYD then 60%	MedPlus pays up to $5,100
Other Covered Services - PT, Chiro, DME	$9,100 CYD then 60%	MedPlus pays up to $5,100
PHYSICIAN AND RX CO-PAYS		
Preventative/Wellness	BCBSAL covers at 100%	Covered under BCBSAL
Primary/Specialist Physician Copay	$45 PCP / $65 Spec	Covered under BCBSAL
Telemedicine: (24 hour Physician Access)	BCBSAL excludes	No Copay - 24/7 Access
Prescription Drug Benefits: Tier 1,2,3,4	$0 ded $15/$60/$100/50%	Covered under BCBSAL

** The Out of Pocket with Medplus does NOT include Doctor Copays or Pharmacy deductibles or Copays.*

We cover what matters.

Visit our website at
AlabamaBlue.com

BlueCard® PPO
Plan Benefits

Alabama State Bar Association and Trust

Bronze Plan
BlueCard® PPO

Effective August 01, 2023

BlueCross BlueShield of Alabama

Prescription Drugs: ValueONE Network

ValueONE Network Facts:

- 51,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Retail Network. This includes many national pharmacies you may already be using.
- 50,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Extended Supply Network (ESN). This includes many national pharmacies you may already be using.
- Generally, ValueONE Retail Network pharmacies can fill up to a 30-day supply of retail drugs while ValueONE ESN Network pharmacies can fill up to a 90-day supply of certain medications (prescription must be written for up to a 90-day supply). Refer to your benefit booklet for the specific day supply permitted by your benefit plan. Since the type of pharmacy differs within the ValueONE Network, be sure to check your specific pharmacy.
- If you do not use a ValueONE Network pharmacy, you may be responsible for the full cost of your prescription medication. Benefits may not be provided for out-of-network pharmacies.
- To maximize your pharmacy benefits, you will need to transfer all your prescriptions to a ValueONE Network pharmacy.

Find a ValueONE Network Pharmacy

You can locate all of the participating pharmacies in your area at **AlabamaBlue.com/ValueONERetailPharmacyLocator**. Click on “Find a Pharmacy by Name or Location” located under Find a Pharmacy. When searching for a participating pharmacy, make sure either “ValueONE Retail Network” or “ValueONE ESN Network” is listed under “Network Participation” located to the right of the pharmacy address.

Alabama State Bar Association and Trust
BlueCard® PPO
Effective August 01, 2023

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)		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible The in-network and out-of-network calendar year deductibles are separate and do not apply to each other	$9,100 individual; $18,200 family	$10,000 individual; $20,000 family
Calendar Year Out-of-Pocket Maximum All deductibles, copays and coinsurance for in-network services and all deductibles, copays and coinsurance for out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum.	$9,100 individual; $18,200 family Available manufacturer or provider cost share assistance program payments made with respect to the specialty drugs on the Specialty Drug Coupon Program List do not apply to the in-network out-of-pocket maximum 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, 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 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **Note:** In Alabama, available only for medical emergency services and accidental injury
Inpatient Physician Visits and Consultations	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 50% of the allowed amount, no copay or 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 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Medical Emergency)	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 60% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 60% of the allowed amount, subject to in-network 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 60% of the allowed amount, subject to calendar year deductible	Covered at 60% of the allowed amount, subject to calendar year deductible for services rendered within 72 hours; covered at 50% of the allowed amount subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Emergency Room (Physician)	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 60% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 60% of the allowed amount, subject to in-network calendar year deductible
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits; 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 $45.00 primary care physician copay or $65.00 specialist physician copay	Covered at 50% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount, after $65.00 copay	Covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Surgery & Anesthesia	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Maternity Care	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/ PreventiveServices** and **AlabamaBlue.com/ SourceRxACAPreventiveDrugList** 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
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.		
Retail Prescription Prepaid Benefits The retail pharmacy network for the plan is **ValueONE Retail Network** • Locate a **ValueONE Retail Network** pharmacy at **AlabamaBlue.com/ ValueONEPharmacyLocator** Maintenance drugs – up to a 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 **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Pharmacy Select Network** • Tier 4 (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: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $60 copay per prescription **Tier 3 Drugs:** $100 copay per prescription **Tier 4 (specialty) Drugs:** 50% of the allowed amount up to $500 maximum Covered Insulin Products: $99.00 maximum cost share per 30-day supply.	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Extended Supply Prescription Prepaid Benefits The extended supply pharmacy network for the plan is the **ValueONE ESN Network** • Locate a **ValueONE** Pharmacy at **AlabamaBlue.com/ ValueONEESNPharmacyLocator** 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 **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** • **Tier 4 (specialty)** drugs are not available through extended supply pharmacy service	Covered at 100% of the allowed amount, subject to the following copays for a 30-day supply for each prescription: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $60 copay per prescription **Tier 3 Drugs:** $100 copay per prescription **Tier 4 (specialty) Drugs:** Not covered 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/ SelectGenericSpecialtyandBiosimilarDrugList**. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	100% of the allowed amount, no deductible or copayment	Not Covered
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 **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** **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 for a 30-day supply for each prescription: **Tier 1 Drugs:** $37.50 copay per prescription **Tier 2 Drugs:** $150 copay per prescription **Tier 3 Drugs:** $250 copay per prescription **Tier 4 (specialty) Drugs:** Not Covered Covered Insulin Products: $99.00 maximum cost share per 30-day supply.	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Ambulance Service	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 60% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services Limited to 15 visits per member per calendar year	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Durable Medical Equipment (DME)	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Home Health and Hospice	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Home Infusion	Covered at 60% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per calendar year	Covered at 100% of the allowed amount, after $45.00 copay	Covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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.	

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 or 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.*
- *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.

We cover what matters.

BlueCard® PPO Plan Benefits

Preferred Blue® HDHP 4000

BlueCard® PPO - HSA Qualified HDHP

Effective August 1, 2023

Visit our website at
AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescription Drugs: ValueONE Network

ValueONE Network Facts:

- 51,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Retail Network. This includes many national pharmacies you may already be using.
- 50,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Extended Supply Network (ESN). This includes many national pharmacies you may already be using.
- Generally, ValueONE Retail Network pharmacies can fill up to a 30-day supply of retail drugs while ValueONE ESN Network pharmacies can fill up to a 90-day supply of certain medications (prescription must be written for up to a 90-day supply). Refer to your benefit booklet for the specific day supply permitted by your benefit plan. Since the type of pharmacy differs within the ValueONE Network, be sure to check your specific pharmacy.
- If you do not use a ValueONE Network pharmacy, you may be responsible for the full cost of your prescription medication. Benefits may not be provided for out-of-network pharmacies.
- To maximize your pharmacy benefits, you will need to transfer all your prescriptions to a ValueONE Network pharmacy.

Find a ValueONE Network Pharmacy

You can locate all of the participating pharmacies in your area at **AlabamaBlue.com/ValueONERetailPharmacyLocator.** Click on “Find a Pharmacy by Name or Location” located under Find a Pharmacy. When searching for a participating pharmacy, make sure either “ValueONE Retail Network” or “ValueONE ESN Network” is listed under “Network Participation” located to the right of the pharmacy address.

Preferred Blue® HDHP 4000
BlueCard® PPO - HSA Qualified HDHP
Effective January 01, 2023

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.		
HEALTH SAVINGS ACCOUNT (HSA)		
A Health Savings Account (HSA) is an account established with pre-taxed money in order to save for future medical expenses. In order to establish an HSA you must first be enrolled in an HSA-Qualified High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain government requirements for use in conjunction with a HSA. This plan is designed to meet those government requirements. Enrolling in an HDHP allows you the opportunity to make contributions to an HSA on a pre-tax basis.		
Maximum Contribution: The maximum contribution amount is indexed each year by the U.S. Treasury. The 2023 maximum contribution is **$3,850** for single coverage and **$7,750** for family coverage. If you have any questions about the benefits of an HSA, please consult your tax accountant.		
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.		
Calendar Year Deductible The in-network and out-of-network calendar year deductibles are separate and do not apply to each other For family coverage, no benefits, except preventive care, are paid by the plan to any family member until the total medical expenses paid by the family equal the family deductible amount.	$4,000 self-only coverage; $8,000 family coverage	$8,000 self-only coverage; $16,000 family coverage
Calendar Year Out-of-Pocket Maximum All deductibles 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 self-only coverage; $12,000 family coverage Available manufacturer or provider cost share assistance program payments made with respect to the specialty drugs on the Specialty Drug Coupon Program List do not apply to the in-network out-of-pocket maximum After you reach your self-only Calendar Year Out-of-Pocket Maximum (even if you are covered under family coverage), applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year	There is no out-of-pocket maximum for out-of-network services.
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services and 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 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **Note:** In Alabama, available only for medical emergency services and accidental injury
Inpatient Physician Visits and Consultations	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Emergency Room (Medical Emergency)	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 60% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 60% of the allowed amount, subject to in-network 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 60% of the allowed amount, subject to calendar year deductible	Covered at 60% of the allowed amount, and subject to calendar year deductible for services rendered within 72 hours; covered at 50% of the allowed amount, subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Emergency Room (Physician)	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 60% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 60% of the allowed amount, subject to in-network calendar year deductible
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program To enroll in the telephone and online video consultations program, go to AlabamaBlue.com/Teleconsultation or call 1-855-477-4549. Telephone and online video consultations are available to diagnose, treat and prescribe medication (when necessary) for certain medical issues.	Covered at 0% of the allowed amount, subject to a $55.00 payment per consultation	Not Covered
Second Surgical Opinions	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Surgery & Anesthesia	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Maternity Care	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/ PreventiveServices** and **AlabamaBlue.com/ SourceRxACAPreventiveDrugList** 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

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Additional HSA Preventive Medical Services Blood Pressure Monitor • One every 5 years for member diagnosed with hypertension Peak Flow Meter • One annually for member diagnosed with asthma International Normalized Ratio (INR) Testing • Maximum of 15 per year for member diagnosed with liver disorder and/or bleeding disorder Lipoprotein (LDL) Testing • Maximum of 5 per year for member diagnosed with heart disease Hemoglobin A1C Testing • Maximum of 4 per year for member diagnosed with diabetes Retinopathy Screening • Maximum of 3 per year for member diagnosed with diabetes	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.		
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.		
Retail Prescription Prepaid Benefits The retail pharmacy network for the plan is **ValueONE Retail Network** • Locate a **ValueONE** Retail Network pharmacy at **AlabamaBlue.com/ ValueONERetailPharmacyLocator** Maintenance drugs – up to a 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 • View the **SourceRx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourceRx1DrugList4T** The only in-network pharmacy for some Tier 4 (specialty) drugs is the **Pharmacy Select Network** • Tier 4 (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 deductible and following copays: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $50 copay per prescription **Tier 3 Drugs:** $75 copay per prescription **Tier 4 (specialty) Drugs:** $395 copay per prescription Covered Insulin Products: $99.00 maximum cost share per 30-day supply. When a Covered Insulin Product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a Covered Insulin Product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met.	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Extended Supply Prescription Prepaid Benefits The extended supply pharmacy network for the plan is the **ValueONE ESN Network** • Locate a **ValueONE** Pharmacy at **AlabamaBlue.com/ ExtendedSupplyNetwork PharmacyLocator** Prescription drugs can be purchased through this extended supply pharmacy service - Maintenance prescription drugs can be dispensed for up to a 90-day supply but the copayment is applicable for each 30-day supply Prescription drugs (other than maintenance prescription drugs) can be dispensed for up to a 30-day supply • 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/ SourceRx1DrugList4T** • **Tier 4 (specialty)** drugs are not available through extended supply pharmacy service	Covered at 100% of the allowed amount, subject to the deductible and following copays: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $50 copay per prescription **Tier 3 Drugs:** $75 copay per prescription **Tier 4 (specialty) Drugs:** Not covered Covered Insulin Products: $99.00 maximum cost share per 30-day supply. When a Covered Insulin Product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a Covered Insulin Product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met.	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/SelectGenericSpecialtyandBiosimilarDrugList. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	Covered at 100% of the allowed amount, subject to the calendar year deductible	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 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Ambulance Service	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 60% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered

Durable Medical Equipment (DME)	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Home Health and Hospice	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Home Infusion	Covered at 100% of the allowed amount, after $395.00 copay subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per calendar year	Covered at 60% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar 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.	

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 or 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.*

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.

We cover what matters.

Visit our website at
AlabamaBlue.com

Dental
Plan Benefits

Alabama State Bar

Effective August 1,2023

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Dental Blue® 1500B Complete
Dental Benefits

GENERAL PROVISIONS	
Calendar Year Deductible	$25 deductible per member per calendar year; $75 family maximum.
Annual Maximum Benefits each Calendar Year	$1,500 per member per calendar year.
Annual Maximum Benefits Rollover each Calendar Year	Plan will allow up to $500 of unused annual maximum dollars to carry over when a member completes their diagnostic and preventive service(s) within a calendar year.
Rollover Account Maximum Limit	The rollover amount is $1,000.

DIAGNOSTIC AND PREVENTIVE SERVICES

Covered at 100%, with no deductible.
Includes:

- Dental exams up to twice per calendar year.
- Full mouth x-rays, one set during any 36 consecutive months.
- Bitewing x-rays, up to twice per calendar year.
- Other dental x-rays, used to diagnose a specific condition.
- Routine cleanings, twice per calendar year.
- Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20 per tooth. Limited to the first permanent molars of children through age 13.
- Fluoride treatment for children through age 18 twice per calendar year.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

BASIC RESTORATIVE SERVICES

Covered at 100%, subject to deductible.
Includes:

- Fillings made of silver amalgam and synthetic tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings).
- Simple tooth extractions.
- Direct pulp capping, removal of pulp and root canal treatment.
- Repairs to crowns, inlays, onlays, veneers, fixed partial dentures and removable dentures.
- Emergency treatment for pain.

BASIC SUPPLEMENTAL SERVICES

Covered at 100%, subject to deductible.
Includes:

- Oral surgery for tooth extractions and impacted teeth and to treat mouth cysts and abscesses of the intra-oral and extra-oral soft tissue.
- General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.
- Treatment of the root tip of the tooth including its removal.

MAJOR PROSTHETIC SERVICES

Covered at 50%, subject to deductible.
Includes:

- Full or partial dentures.
- Fixed or removable bridges.
- Inlays, onlays, veneers or crowns to restore diseased or accidentally broken teeth, if less expensive fillings will not restore the teeth.

Note: No benefits for late enrollee until the member has been covered for a continuous 365-days

MAJOR PERIODONTIC SERVICES

Covered at 80%, subject to deductible.
Includes:

- Periodontic exams twice each 12 months.
- Removal of diseased gum tissue and reconstructing gums.
- Removal of diseased bone.
- Reconstruction of gums and mucous membranes by surgery.
- Removing plaque and calculus below the gum line for periodontal disease.

Note: No benefits for late enrollee until the member has been covered for a continuous 365-days

Dental Blue® 1000B
Value Dental Benefits

GENERAL PROVISIONS	
Calendar Year Deductible	$50 deductible per member per calendar year; $150 family maximum.
Annual Maximum Benefits each Calendar Year	$1,000 per member per calendar year.
Annual Maximum Benefits Rollover each Calendar Year	Plan will allow up to $500 of unused annual maximum dollars to carry over when a member completes their diagnostic and preventive service(s) within a calendar year.
Rollover Account Maximum Limit	The rollover amount is $1,000.

DIAGNOSTIC AND PREVENTIVE SERVICES

Covered at 100%, with no deductible.
Includes:

- Dental exams up to twice per calendar year.
- Full mouth x-rays, one set during any 36 consecutive months.
- Bitewing x-rays, up to twice per calendar year.
- Other dental x-rays, used to diagnose a specific condition.
- Routine cleanings, twice per calendar year.
- Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20 per tooth. Limited to the first permanent molars of children through age 13.
- Fluoride treatment for children through age 18 twice per calendar year.
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.

BASIC RESTORATIVE SERVICES

Covered at 100%, subject to deductible.
Includes:

- Fillings made of silver amalgam and synthetic tooth color materials (tooth color materials include composite fillings on the front upper and lower teeth numbers 5-12 and 21-28; payment allowance for composite fillings used on posterior teeth is reduced to the allowance given on amalgam fillings).
- Simple tooth extractions.
- Direct pulp capping, removal of pulp and root canal treatment.
- Repairs to crowns, inlays, onlays, veneers, fixed partial dentures and removable dentures.
- Emergency treatment for pain.

BASIC SUPPLEMENTAL SERVICES

Covered at 80%, subject to deductible.
Includes:

- Oral surgery for tooth extractions and impacted teeth and to treat mouth cysts and abscesses of the intra-oral and extra-oral soft tissue.
- General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.
- Treatment of the root tip of the tooth including its removal.

MAJOR PERIODONTIC SERVICES

Covered at 80%, subject to deductible.
Includes:

- Periodontic exams twice each 12 months.
- Removal of diseased gum tissue and reconstructing gums.
- Removal of diseased bone.
- Reconstruction of gums and mucous membranes by surgery.
- Removing plaque and calculus below the gum line for periodontal disease.

Note: No benefits for late enrollee until the member has been covered for a continuous 365-days

VSP® Vision Care

Look what's included with VSP:

- WellVision Exam®
- Coverage for glasses and contact lenses
- Lens enhancements
- Diabetic Eyecare Plus Program[5M]

PLUS, extra discounts on:

- Additional pairs of glasses, lenses and sunglasses
- Laser vision correction
- Featured Frame Brands

Extra savings with access to Exclusive Member Offers.

Why Everyone Needs Vision Care

Vision is more critical to a benefits package than you might think. Employees who have a vision benefit are nearly twice as satisfied with their benefits - and are more than twice as likely to say benefits are a reason they stay with their employer.[1]

Employees Need Vision Care

3 in 4 adults need vision correction.[2]

1 in 4 children need vision correction.[2]

9 in 10 employees say visual disturbances affect their quality of work.[3]

Powerful Preventive Healthcare

Only **1 in 5** Americans get an annual medical exam – only half get the preventive screenings you'd expect.[4]

6 in 10 VSP members get an annual WellVision Exam®.[5]

VSP doctors are often first to detect signs of diabetes **34% OF THE TIME.**[6]

$2,787 SAVINGS over 2 years for every employee who seeks care for diabetes after early identification.[6]

Increased Employee Satisfaction

VSP MEMBER PROMISE SATISFACTION GUARANTEE

Your employees will be happy or we'll make it right.

VSP members report **99%** satisfaction.[5]

Employees satisfied with their benefits are **2X MORE LOYAL.**[7]

The right vision benefit can improve employee health and productivity, while lowering healthcare costs. Add value to your benefits package with a VSP plan.

Sources: 1. MetLife Seeing Eye to Eye on Vision Benefits, 2013; 2. Vision Council, VisionWatch December 2014; 3. Transitions 2015 Employee Perceptions of Vision Benefits survey; 4. American Journal of Preventive Medicine 2012, 42, Issue 2:164-73. 5. VSP data. 6. Human Capital Management Services, Inc. (HCMS) on behalf of VSP, 2013. 7. MetLife 11th Annual study of Employee Benefits Trends, 2013.

VSP Choice Plan® Proposal

Prepared for Alabama Bar Association

The VSP Choice Plan is a full-service plan that offers low costs, a focus on health, and real provider choices.

Guaranteed Lowest Out-of-Pocket Costs

Our Member Promise guarantees that employees are completely satisfied with their eye care and eyewear from VSP network providers, or we'll make it right. This includes satisfaction with out-of-pocket costs, consumer's #1 priority in a vision plan. We guarantee your employees will have the lowest out-of-pocket costs for equivalent glasses with VSP network providers, compared to your current vision plan, if applicable. One of the ways we reduce patient out-of-pocket costs is by applying fixed copays toward popular lens enhancements. We're also covering standard progressives with no additional copay. Unlike most competing vision plans, we also offer a wholesale frame pricing guarantee allowing us to cover more frames.

A Focus on Health - VSP Healthy Innovations

Your benefit includes VSP Healthy Innovations, a total wellness solution that leverages the power of a VSP WellVision® exam to see beyond eye health issues. Taking this wholistic approach helps identify signs of chronic conditions before they become serious, saving you money and helping your employees manage their health. This year we're even more focused on helping our members with diabetes and pre-diabetes. VSP doctors are often the first to detect chronic conditions—before other healthcare providers—including diabetes 34% of the time. Members identified in our system as having diabetes receive a complimentary reminder letter from us 14 months after their last eye exam. Every year, we see an average of 22% of these members then scheduling and receiving an exam

Real Provider Choices

Your employees can choose their provider from **98,000 access points**, including the largest national network of independent doctors and nearly 22,000 participating retail chain access points.

VSP Doctors - 91% offer early morning, evening and weekend appointments. 24-hour access to emergency care.

Participating Retail Chains[1] - Your employees get the convenience of popular retail chains like these and more.

VSP Benefits subject to applicable copays[2]

Exam Services	Comprehensive WellVision Exam® covered-in-full after copay Contact lens exam - fitting and evaluation (when choosing contacts): **Standard** and **Premium fit**: Covered in full with a copay. Member receives 15% off[3] of contact lens exam services;[4] member's copay will never exceed $60 Routine retinal screening covered after an up to $39 copay[3]		
Lenses	Glass or plastic:	Single vision Lined bifocal Lined trifocal Lenticular	Covered-in-full after copay Covered-in-full after copay Covered-in-full after copay Covered-in-full after copay
Frame	• Frames covered-in-full after copay up to the retail allowance of $130[5] • Frame allowance is guaranteed by a $50 wholesale allowance at VSP doctors, ensuring nearly 12,000 frames are covered-in-full • Members who select a featured frame brand including bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more will receive an extra $20 toward their frame allowance.[6] • 20% off[3] any amount above the retail frame allowance[4] • Members can choose from virtually any frame on the market		

Our proposal is based on the scope of the obligations that VSP agrees to undertake. VSP will comply with state and/or federal rules and regulations as they pertain to pre-paid vision plans with a defined benefit

Lens Enhancements	The most popular lens enhancements are covered after a copay, saving members an average of 20-25%[4]; members should see their VSP network provider for special pricing on additional lens enhancements. Maximum copay on standard lens enhancements:

Lens Enhancement	*Single Vision*	*Multifocal*
Standard progressives plastic	N/A	No copay
Premium progressives plastic	N/A	$95-105
Custom progressives plastic	N/A	$150-175
Standard anti-reflective coating	$41	$41
Solid tints & dyes (pink I&II)	No copay	No copay
Solid plastic dye (except pink I&II)	$15	$15
Plastic gradient dye	$17	$17
UV protection	$16	$16
Factory applied scratch-resistant coating	$17	$17
Polycarbonate for children	No copay	No copay
Polycarbonate	$31	$35
Photochromic plastic	$75	$75

Elective Contact Lenses (instead of lenses & frame)	• Prescription contact lens materials covered-in-full up to $130 retail allowance • VSP members get exclusive mail-in savings[7] on eligible contacts at VSP doctors • Members can choose from any available prescription contact lens materials
Necessary Contact Lenses (instead of lenses & frame)	• Covered-in-full after copay for members who have specific conditions at VSP doctors • Covered up to $210 after copay for members who have specific conditions at participating retail chains
Additional Pairs of Glasses[8]	20% off[3] unlimited additional pairs of prescription glasses and/or non-prescription sunglasses[4]
Primary EyeCare Program℠	Supplemental coverage for non-surgical medical eye conditions, such as pink eye and other urgent eye care - $20 copay[9] per visit at VSP doctors
Laser VisionCare Program℠	Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, and Custom LASIK[10] through VSP doctors
Low Vision	Supplemental testing covered every two years. 75% coverage for approved low vision aids, up to $1,000 (less any amount paid for supplemental testing) every two years at VSP doctors
Eye Health Management Program®	Exam reminder letters sent to VSP members with diabetes who have not had an eye exam in 14 months

Out-of-Network Benefits subject to applicable copays[2]

Exam	Reimbursed up to $45	Frame	Reimbursed up to $70
Lenses:			
Single vision	Reimbursed up to $30	Contact lens exam & materials	
Lined bifocal	Reimbursed up to $50	(in lieu of lenses & frame):	
Lined trifocal	Reimbursed up to $65	Elective	Reimbursed up to $105[11]
Lenticular	Reimbursed up to $100	Necessary	Reimbursed up to $210

Exclusions[12] There may be some materials and services with either limited or no coverage under this plan. Please contact your VSP representative for more information.

[1] Participating retail chains upon request. Benefits may vary at participating retail chain locations.
[2] When covered-in-full services are obtained from a VSP network provider, the patient will have no out-of-pocket expense other than any applicable copays. Services and eyewear obtained through out-of-network providers are subject to product availability and the same copays and limitations. Please refer to rate page.
[3] Based on applicable laws, benefits may vary by location.
[4] Walmart and Costco published prices already include discounts instead of those noted.
[5] Walmart and Costco allowance of $70 is equivalent to the frame allowance at other VSP network providers.
[6] Reflects current promotion, evaluated annually. Promotion/featured frame brands are subject to change and the promotional allowance does not apply at Walmart and Costco. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.
[7] Rebates subject to change.
[8] 20% off applies to unlimited additional pairs of glasses valid through any VSP network provider within 12 months of the last covered eye exam.
[9] The VSP Primary EyeCare Plan pays secondary to other medical eye insurance coverage.
[10] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Laser VisionCare discounts are only available from VSP-contracted facilities.
[11] If $100 allowance is purchased, out-of-network providers will reimburse up to $85.
[12] Coverage shall be governed solely by the terms of your VSP contract

Alabama State Bar

Application for Enrollment or Changes for: Health, Dental and Vision

Employer Company Name	Group # 374/ 5	Employer's Phone Number
Employee Name (Last) (First) (Initial)		Employee's Date of Birth
Street Address City State Zip		Employee's Phone Number

CHECK ONE:	CHECK ONE:	Employee's Social Security Number	Date of Hire
□ Male □ Female	□ Single □ Divorced □ Married □ Widowed		

LIST ALL ELIGIBLE DEPENDENTS TO ENROLL LAST NAME FIRST NAME INITIAL	SOCIAL SECURITY NUMBER	RELATIONSHIP	DATE OF BIRTH M	D	Y
1.		□ Husband □ Wife			
2.		□ Son □ Daughter			
3.		□ Son □ Daughter			
4.		□ Son □ Daughter			
5.		□ Son □ Daughter			

NATURE OF APPLICATION – CHOOSE ONE

NEW CONTRACT APPLICATION	CHANGE OF CONTRACT	ADD DEPENDENT	REMOVE DEPENDENT
☐ New Individual Health ☐ New Family Health ☐ New Individual Dental ☐ New Family Dental ☐ New Individual Vision ☐ New Family Vision	☐ Name Change ☐ Address Change ☐ Type of Coverage Change Single to family Family to Single	☐ Add Spouse ☐ Add Dependent Child	☐ Divorce ☐ Remove all dependents ☐ Remove spouse only ☐ Loss of Eligibility

Date:_____

EVENT AND DATE OCCURRED: (Examples: Marriage, Birth, Divorce, Death) _____

Do you or your dependents currently have coverage with BC/BS of AL? YES NO If yes, list your contract number. _____	Do you or your dependents have coverage with another group health plan? YES NO Ins. Co. Name _____ Contract # _____

I apply for the Group Health Benefit Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay you direct and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by the law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for service to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I understand that if I did not enroll within 30 days of my initial eligibility or as a special enrollee, my next opportunity to enroll would be at open enrollment.

SIGNATURE OF EMPLOYER DATE	SIGNATURE OF EMPLOYEE DATE
☐ Health ***Cancel Coverage*** ☐ Dental ☐ Vision	REQUESTED START DATE

Medical Plan Elected	Dental Plan Elected	Vision Plan Elected
☐ Gold ☐ Silver ☐ Bronze	☐ Complete ☐ Value	☐ VSP

Building a good customer experience does not happen by accident.
It happens by design.
Our goal is to exceed our members expectations and deliver value to each organization. Should you ever need us, we are here for you.

Contact Information:

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Montgomery, AL 36104

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Alliance Insurance Group

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