Form 1
PR Companies Benefit Information

To: Field Staff Employees
Re: Benefit Enrollment package 2021

BENEFITS INFORMATION

Enclosed is your benefit enrollment information. It is your responsibility to complete and return the forms. The information may also be found on our website. Please visit www.partnerwithexperts.com and click on Job Seekers. At the bottom of the page you can view the Summary of Benefits and Coverage for each plan and the enrollment forms. Below are the two plans currently available and the employee's portion of the monthly premium. Benefit plan designs and premium costs are subject to change.

BCBS High Option Plan (PPO)			BCBS Value Plan (PPO)		
Single:	$220.84	month	Single:	$104.53	month
Employee/Children:	$554.70	month	Employee/Children:	$375.29	month
Employee/Spouse:	$843.58	month	Employee/Spouse:	$588.21	month
Employee/Family:	$1,208.32	month	Employee/Family:	$1,035.26	month

ELIGIBILTY INFORMATION

Full-time active field staff employees who work at least 120 hours in a calendar month will be eligible for coverage. Coverage will be effective on the 1st day of the month following sixty (60) day waiting period. The waiting period begins on the first day of the employee's first full-time month (the first full month in which the employee works a minimum of 120 hours.

It is your responsibility to inform us if your address changes. If you fail to complete and return the required election and enrollment forms within 60 days of hire, this will be considered a decline/waiver of coverage.

If you decline coverage, you will not be eligible to enroll in the plan until the next open enrollment period (if you are determined to be eligible at that time), unless you have a special enrollment event. Open enrollment is normally held in the month of November to be effective January 1 of the following year. Employees who elect coverage will have their share of the premium charged the month coverage is effective, and each month thereafter.

THE FULL MONTH'S PREMIUM WILL BE DUE BY THE FIRST FRIDAY OF EACH CALANDER MONTH AND MUST BE PAID BY VALID AND UNEXPIRED CREDIT CARD. IF YOU DO NOT HAVE A CREDIT CARD PLEASE CALL THE BENEFITS DEPARTMENT TO DISCUSS OTHER PAYMENT OPTIONS. CREDIT CARDS WILL AUTOMATICALLY BE CHARGED ON THE FIRST FRIDAY OF EVERY CALENDAR MONTH IN WHICH COVERAGE IS EFFECTIVE. IF ANY PAYMENT IS REJECTED OR DECLINED, FOR ANY REASON, COVERAGE WILL CEASE.
Employees will be provided up to a 30-day grace period to submit all required unpaid premium, but all unpaid balances must be zero by the last day of the calendar month for coverage to be reinstated. If coverage is canceled for non-payment of premium, that employee cannot re-enroll for health coverage until the next open-enrollment period, which will take place in November.

Employees who are enrolled in coverage must maintain a working schedule that results in a minimum of 120 hours worked in any month. Failure to maintain the requisite work hours may result in coverage being canceled unless the reduction in hours is due to a qualifying leave under FMLA, Military Leave, Worker's Compensation Leave, or a scheduled break during an ongoing assignment.

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NOTICE OF GROUP HEALTH PLAN SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards other coverage for you or your dependents).

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage, you may be able to enroll yourself and your dependent in this plan. You may also be able to enroll in this plan if you or your dependent becomes eligible for premium assistance under Medicaid or SCHIP for coverage under this plan. However, you must request enrollment within 60 days of any such event.

Please return the completed packet to:

Mail: Personnel Resources
Benefits Department
113 Adris Place
Dothan, Al 36303
Email: benefits@prdothan.com

If you do not receive a confirmation we received the packet please contact us. If you have any questions or lose your benefit information, please contact the Benefits Department at 334-794-8722.

Megan Lane
mlane@prdothan.com
334-794-8722 EXT 220

LeAnn Fassett
lfassett@prdothan.com
334-794-8722 EXT 110

BlueCross BlueShield of Alabama

: PR Employer - High Option

For: Individual + Family **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-292-8868 or visit us at AlabamaBlue.com**.** For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbsal.org/sbcglossary/ or call 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 individual/$1,500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services in-network are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $750 per admission for out-of-network. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit for this plan?	$5,000 individual/$10,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits and pre-certification penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See AlabamaBlue.com or call 1-800-810-BLUE for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit No overall deductible	50% coinsurance	None
	Specialist visit	$50 copay/visit No overall deductible	50% coinsurance	
	Preventive care/screening/ immunization	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge No overall deductible	50% coinsurance	Benefits listed are physician services; facility benefits are also available; precertification may be required
	Imaging (CT/PET scans, MRIs)	$200 copay/test No overall deductible	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$400 copay No overall deductible	20% coinsurance	In Alabama, out-of-network not covered
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Accident: $400 copay/visit No overall deductible Medical Emergency: $400 copay/visit No overall deductible	Accident: $400 copay/visit Medical Emergency: $400 copay/visit	Physician charges will apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay/visit No overall deductible	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/day days 1-5 No overall deductible	$750 per admission deductible & 20% coinsurance No overall deductible	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge EPS $50 copay/visit No overall deductible	50% coinsurance	Benefits listed are physician services; additional benefits are available; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization
	Inpatient services	No Charge EPS No Charge No overall deductible	20% coinsurance No overall deductible	
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$200 copay/day days 1-5 No overall deductible	$750 per admission deductible & 20% coinsurance No overall deductible	

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	In Alabama, out-of-network not covered; precertification may be required
	Rehabilitation services	20% coinsurance	20% coinsurance	Benefits listed are for Rehabilitation & Habilitation services; each service has a combined maximum of 30 visits for occupational, physical and speech therapy per year; in Alabama, out-of-network coinsurance is 50%; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	20% coinsurance	In Alabama, out-of-network coinsurance is 50%
	Hospice services	0% coinsurance	20% coinsurance	In Alabama, out-of-network not covered; precertification may be required
If your child needs dental or eye care	Children's eye exam	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Glasses, child
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing care
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Infertility treatment (Assisted Reproductive Technology not covered)	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or your state insurance department.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$500**
- **Specialist copay/coinsurance** **$50/0%**
- **Hospital (facility) copay/coinsurance** **$200/0%**
- **Other copay/coinsurance** **$50/20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,000

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist copay/coinsurance** **$50/0%**
- **Hospital (facility) copay/coinsurance** **$200/0%**
- **Other copay/coinsurance** **$50/20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$20
Copayments	$1080
Coinsurance	$0
What isn't covered	
Limits or exclusions	$420
The total Joe would pay is	$1,520

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist copay/coinsurance** **$50/0%**
- **Hospital (facility) copay/coinsurance** **$200/0%**
- **Other copay/coinsurance** **$50/20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$150
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$710

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: AlabamaBlue.com.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

Language Access Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

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

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

Foreign Language Assistance

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

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

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

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

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل ب1-855-216-3144 (الهاتف النصي: 711).

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

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

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

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

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

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

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

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

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

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

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

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

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

PREmployer

Member Brochure

Prescription Health Plan

1590 University Ave | Dubuque, IA 52001

888-884-6331 | www.medone-rx.com

PREmployer Prescription Drug Benefit – PPO Plan

Effective Date: January 1, 2021

Embedded RX Deductibles (specialty medication only):
Individual: $500
Family: $1,500

Embedded Rx/Medical Out-of-Pocket Maximums:
Individual: $5,000
Family: $10,000

Please note this is an embedded out-of-pocket maximum. This means when an individual in the family plan meets the individual out-of-pocket maximum, that individual will have the remainder of their prescription drug expenses covered at 100% for the rest of the benefit year. The entire family out-of-pocket maximum must be met for the entire family to receive their prescriptions covered at 100%.

Payment Structure – 30-Day Retail and MedOne Mail-Order
Up to a 30-day supply of maintenance medication is available at any retail network pharmacy (excluding all CVS locations) or by mail-order with MedOne Mail-Order Pharmacy.
Generic: $15
Preferred Brand: $40
Non-Preferred Brand: $60

Payment Structure – 31-60 Day Retail and MedOne Mail-Order
Up to a 60-day supply of maintenance medication is available at any retail network pharmacy (excluding all CVS locations) or by mail-order with MedOne Mail-Order Pharmacy.
Generic: $30
Preferred Brand: $80
Non-Preferred Brand: $120

Payment Structure - 61-90 Day and MedOne Mail-Order
Up to a 90-day supply of maintenance medication is available at any retail network pharmacy (excluding all CVS locations) or by mail-order with MedOne Mail-Order Pharmacy.
Generic: $45
Preferred Brand: $100
Non-Preferred Brand: $180

Specialty Drugs Co-pay: $295 (after deductible has been met). Limited to a 30-day supply or less per fill. Special distribution applies.

Specialty Drugs Included in the MedOne Copay Assist Program
30% coinsurance per drug per 30-day fill (after deductible has been met.) Manufacturer assistance program covers most if not all of the coinsurance amount. Claim cost incurred by drugs included in the MedOne Copay Assist Program will NOT apply toward the annual deductible and out-of-pocket maximum, as most or all of the payment will be paid by the manufacturer copay assistance program. If you have actual out-of-pocket costs after the manufacturer copay assistance program has paid, you will pay no more than your copay or coinsurance when utilizing the manufacturers copay assistance.

Site of care services: Nursing and supply fees included at a $0 copay.

Bowel preparation medications: $0 co-pay. Limited to 1 per year.

Breast cancer chemo-prevention: $0 co-pay.
Prior authorization required.

Contraceptives: Up to a 91-day supply of contraceptives (depending on package size) is available at a $0 co-pay.

Smoking cessation: Prescription and over-the-counter smoking cessation products (with an Rx) are available at a $0 co-pay.

Statins for primary prevention of CVD: Select low- to moderate-dose statins are free for members when used for primary prevention of CVD in high risk patients between ages 40-75.

Vaccinations
The following vaccinations are available at a $0 co-pay:
- Flu
- Pneumonia
- Shingles (Zostavax—Age 60+ or Shingrix—Age 50+)
- Whooping Cough

Check with retail network pharmacies for availability.

Excluded Drugs / Categories
- Anti-obesity drugs
- Diabetic glucose meters

Excluded Drugs / Categories (con't)
- Fertility drugs
- Hair growth stimulants
- Lancet devices
- Non-prescription / non-prenatal vitamins and supplements
- Nutritional diet supplement
- Ostomy supplies
- Over-the-counter (OTC) drugs except those listed as covered*
- Products for cosmetic indications

***Over-the-Counter (OTC) drugs:** OTC smoking cessation treatments are covered by the plan. The physician must write a prescription specifically for an OTC item.

Drugs Requiring Prior Authorization
- Compounded drugs more than $100
- Standard drug more than $1,000
- Specialty drugs
- ADHD / narcolepsy drugs
- Androgens
- Breast cancer chemo-prevention drugs
- Growth hormones
- Hepatitis C medications
- Inhalation / nasal smoking cessation products
- Isotretinoin
- Sexual dysfunction drugs
- Smoking cessation drugs (for treatment more than 6 months)

This list is subject to change. The physician's office may obtain a prior authorization form by calling MedOne at 1-888-884-6331.

Drug Limitations
- Brand Proton Pump Inhibitors for ulcers/GERD limited to 1 capsule or tablet per day
- Cholesterol medications limited to 1 dose per day
- Migraine medications limited to 6 injections, 6-12 nasal spray doses, or 6-12 tablets (depending on package size) per 30 days
- Opioids limited to 200 MME per day
- Sexual dysfunction drugs limited to 6 pills/inserts/injections per 30 days for occasional use. Daily use is limited to 1 per day.
- Sleep agents limited to 1 dose per day

Dispense As Written Penalty
If a member requests a brand drug when a generic drug is available, the member is responsible for the applicable co-pay plus the difference in cost between the generic and brand drug.

Dependents
Dependents are covered until age 26.

Refill Too Soon Limitation
A prescription may not be refilled until at least 75% of the supply has been utilized. For example, if the member has a 30-day supply, 23 days must be utilized before the prescription could be refilled.

Benefit Plan Network
Your plan includes a network of pharmacies locally and nationwide, ***excluding*** all CVS locations. You may also call MedOne at 1-888-884-6331 for assistance in locating a network pharmacy.

Step Therapy Program
This program ensures that members receive the most cost-effective medications prior to the plan approving brand medications. For the most current information, check www.MedOne-rx.com.

Mail-Order
For assistance in setting up a mail-order account, see the mail-order section in this brochure or contact MedOne at 1-888-884-6331.

To download a mail-order form, go to www.MedOne-rx.com. Upon request, a copy of the mail-order brochure and order form can be sent by email, fax, or mail. Allow 10-14 days from the time the mail-order request is submitted until the prescription is delivered.

MedOne Mail-Order

How to Enroll Online for MedOne

Mail-Order Service

1. Go to www.medone-rx.com
2. On the right-hand side, click on the **Menu** tab and select the section titled **Resources**
3. Select the **Mail-Order Online Enrollment** option
4. Read through terms and conditions, then click "I Agree" and submit
5. Read through the notice of privacy practices, then click "I Agree" and submit
6. Enter your personal information in the Patient Information section (name, address, phone number). The information on your pharmacy ID card will also be needed to complete this section (See Sample Company ID Card)
7. **Prescriptions**: List the medication, last filled date (if available), day supply, prescriber name and phone number
8. Select whether you would like automatic refills, or to call in when medication is needed
9. Please note any known allergies or medical conditions
10. **Release of Medical Information**: Only complete if you authorize MedOne to speak to anyone regarding your medical information
11. **Electronic Signature**: Type your name at the bottom of the screen to acknowledge the information submitted to be correct
12. Enter payment information—you will need to use either a debit card or credit card

Once this has all been completed, **please contact your prescriber** and inform them to send your prescriptions to MedOne Pharmacy Services. Thank you for choosing MedOne Mail-Order Service!

MedOne Member Portal

Easy Online Access to Your Prescription Profile

- Convenient
- Reliable
- Easy-to-Use

How to register for the MedOne Member Portal

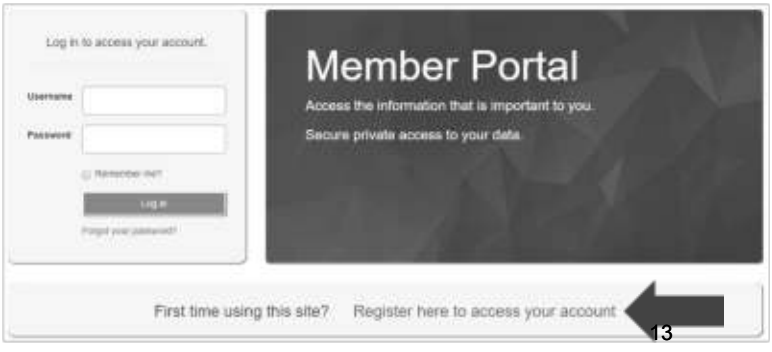
1. Go to medone-rx.com
2. On the right-hand side, click **Member Portal**
3. At the bottom of the page, click "Register here to access your account"
4. Enter the information requested (group number and member ID can be found on your pharmacy ID card) then click "Register"
5. You will then be prompted to open the confirmation email and follow the link provided
6. Enter your log-in credentials and proceed to your account

What can be accessed within the MedOne Member Portal?

1. View Claims Detail / Rx History
2. Look up **in-network pharmacies** in the area
3. Run **sample pricing** for potential medications
4. Gather ID card **processing information**
5. Review Out of Pocket Maximum
6. Access Drug Information Directory
7. Enroll in the **MedOne Mail-Order Program**

What can be accessed through the main MedOne Website?

1. Preferred Product Listing
2. Specialty Product Listing
3. MedOne Mail Order Enrollment
4. Frequently Asked Questions
5. Direct Member Reimbursement Form
6. MedOne Member Services and Pharmacy Contact Information



BlueCross BlueShield of Alabama

: PR Employer - Value Plan

For: Individual + Family **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-292-8868 or visit us at AlabamaBlue.com**.** For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bcbsal.org/sbcglossary/ or call 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000 individual/$6,000 family in-network. $3,000 individual/$6,000 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services in-network are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out–of–pocket limit for this plan?	For in-network $6,000 individual/$12,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, cost sharing for most out-of-network benefits and pre-certification penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See AlabamaBlue.com or call 1-800-810-BLUE for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not Covered	The first three illness-related visits are subject to $30 copay; thereafter, subject to overall deductible
	Specialist visit	20% coinsurance	Not Covered	
	Preventive care/screening/ immunization	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	Benefits listed are physician services; facility benefits are also available; precertification may be required
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	Accident: 20% coinsurance Medical Emergency: 20% coinsurance	Accident: 20% coinsurance Medical Emergency: 20% coinsurance	Physician charges will apply
	Emergency medical transportation	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	20% coinsurance	Not Covered	The first three illness-related visits are subject to $30 copay; thereafter, subject to overall deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Precertification is required
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not Covered	Benefits listed are physician services; additional benefits are available; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization
	Inpatient services	20% coinsurance	Not Covered	
If you are pregnant	Office visits	20% coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Precertification is required for out-of-state providers
	Rehabilitation services	20% coinsurance	Not Covered	Benefits listed are for Rehabilitation & Habilitation services; each service has a combined maximum of 30 visits for occupational, physical and speech therapy per year; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy
	Habilitation services	20% coinsurance	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	Not Covered	None
	Hospice services	20% coinsurance	Not Covered	Precertification is required for out-of-state providers
If your child needs dental or eye care	Children's eye exam	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.

Excluded Services & Other Covered Services:

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (limited to 15 visits per member per calendar year)	• Infertility treatment (Assisted Reproductive Technology not covered)	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or your state insurance department.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

* For more information about limitations and exceptions, see the plan or policy document at AlabamaBlue.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3000
Specialist copay/coinsurance	$0/20%
Hospital (facility) copay/coinsurance	$0/20%
Other copay/coinsurance	$50/20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3000
Copayments	$40
Coinsurance	$1920
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,020

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3000
Specialist copay/coinsurance	$0/20%
Hospital (facility) copay/coinsurance	$0/20%
Other copay/coinsurance	$50/20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$850
Copayments	$1080
Coinsurance	$0
What isn't covered	
Limits or exclusions	$420
The total Joe would pay is	$2,350

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3000
Specialist copay/coinsurance	$0/20%
Hospital (facility) copay/coinsurance	$0/20%
Other copay/coinsurance	$50/20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1930
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,930

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: AlabamaBlue.com.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

Language Access Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

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

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

Foreign Language Assistance

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

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

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

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

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل ب1-855-216-3144 (الهاتف النصي: 711).

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

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

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

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

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

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

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

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

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

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

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

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

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

PREmployer

Member Brochure

Prescription Health Plan

1590 University Ave | Dubuque, IA 52001

888-884-6331 | www.medone-rx.com

PREmployer Prescription Drug Benefit – Value Plan

Effective Date: January 1, 2021

Embedded RX Deductibles (specialty medication only):
Individual: $500
Family: $1,500

Embedded Rx/Medical Out-of-Pocket Maximums:
Individual: $6,000
Family: $12,000

Please note this is an embedded out-of-pocket maximum. This means when an individual in the family plan meets the individual out-of-pocket maximum, that individual will have the remainder of their prescription drug expenses covered at 100% for the rest of the benefit year. The entire family out-of-pocket maximum must be met for the entire family to receive their prescriptions covered at 100%.

Payment Structure – 30-Day Retail and MedOne Mail-Order
Up to a 30-day supply of maintenance medication is available at any retail network pharmacy (excluding all CVS locations) or by mail-order with MedOne Mail-Order Pharmacy.
Generic: $15
Preferred Brand: $50
Non-Preferred Brand: $70

Payment Structure – 31-60 Day Retail and MedOne Mail-Order
Up to a 60-day supply of maintenance medication is available at any retail network pharmacy (excluding all CVS locations) or by mail-order with MedOne Mail-Order Pharmacy.
Generic: $30
Preferred Brand: $100
Non-Preferred Brand: $140

Payment Structure - 61-90 Day Retail and MedOne Mail-Order
Up to a 90-day supply of maintenance medication is available at any retail network pharmacy (excluding all CVS locations) or by mail-order with MedOne Mail-Order Pharmacy.
Generic: $45
Preferred Brand: $150
Non-Preferred Brand: $210

Specialty Drugs Co-pay: $395 (after deductible has been met). Limited to a 30-day supply or less per fill. Special distribution applies.

Specialty Drugs Included in the MedOne Copay Assist Program
30% coinsurance per drug per 30-day fill (after deductible has been met.) Manufacturer assistance program covers most if not all of the coinsurance amount. Claim cost incurred by drugs included in the MedOne Copay Assist Program will NOT apply toward the annual deductible and out-of-pocket maximum, as most or all of the payment will be paid by the manufacturer copay assistance program. If you have actual out-of-pocket costs after the manufacturer copay assistance program has paid, you will pay no more than your copay or coinsurance when utilizing the manufacturers copay assistance.

Bowel preparation medications: $0 co-pay. Limited to 1 per year.

Breast cancer chemo-prevention: $0 co-pay.
Prior authorization required.

Contraceptives: Up to a 91-day supply of contraceptives (depending on package size) is available at a $0 co-pay.

Smoking cessation: Prescription and over-the-counter smoking cessation products (with an Rx) are available at a $0 co-pay.

Statins for primary prevention of CVD: Select low-to-moderate-dose statins are free for members when used for primary prevention of CVD in high risk patients between ages 40-75.

Vaccinations
The following vaccinations are available at a $0 co-pay:
- Flu
- Pneumonia
- Shingles (Zostavax—Age 60+ or Shingrix—Age 50+)
- Whooping Cough

Check with retail network pharmacies for availability.

Excluded Drugs / Categories
- Anti-obesity drugs
- Diabetic glucose meters
- Fertility drugs
- Hair growth stimulants
- Lancet devices
- Non-prescription / non-prenatal vitamins and supplements
- Nutritional diet supplement
- Ostomy supplies
- Over-the-counter (OTC) drugs except those listed as covered*
- Products for cosmetic indications

Over-the-Counter (OTC) drugs: OTC smoking cessation treatments are covered by the plan. The physician must write a prescription specifically for an OTC item.

Drugs Requiring Prior Authorization
- Compounded drugs more than $100
- Standard drug more than $1,000
- Specialty drugs
- ADHD / narcolepsy drugs
- Androgens
- Breast cancer chemo-prevention drugs
- Growth hormones
- Hepatitis C medications
- Inhalation / nasal smoking cessation products
- Isotretinoin
- Sexual dysfunction drugs
- Smoking cessation drugs (for treatment more than 6 months)

This list is subject to change. The physician's office may obtain a prior authorization form by calling MedOne at 1-888-884-6331.

Drug Limitations
- Brand Proton Pump Inhibitors for ulcers/GERD limited to 1 capsule or tablet per day
- Cholesterol medications limited to 1 dose per day
- Migraine medications limited to 6 injections, 8-12 nasal spray doses, or 6-12 tablets (depending on package size) per 30 days
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This program ensures that members receive the most cost-effective medications prior to the plan approving brand medications. For the most current information, check www.MedOne-rx.com.

Mail-Order
For assistance in setting up a mail-order account, see the mail-order section in this brochure or contact MedOne at 1-888-884-6331.

To download a mail-order form, go to www.MedOne-rx.com. Upon request, a copy of the mail-order brochure and order form can be sent by email, fax, or mail. Allow 10-14 days from the time the mail-order request is submitted until the prescription is delivered.

MedOne Mail-Order

How to Enroll Online for MedOne

Mail-Order Service

1. Go to www.medone-rx.com
2. On the right-hand side, click on the **Menu** tab and select the section titled **Resources**
3. Select the **Mail-Order Online Enrollment** option
4. Read through terms and conditions, then click "I Agree" and submit
5. Read through the notice of privacy practices, then click "I Agree" and submit
6. Enter your personal information in the Patient Information section (name, address, phone number). The information on your pharmacy ID card will also be needed to complete this section (See Sample Company ID Card)
7. **Prescriptions**: List the medication, last filled date (if available), day supply, prescriber name and phone number
8. Select whether you would like automatic refills, or to call in when medication is needed
9. Please note any known allergies or medical conditions
10. **Release of Medical Information**: Only complete if you authorize MedOne to speak to anyone regarding your medical information
11. **Electronic Signature**: Type your name at the bottom of the screen to acknowledge the information submitted to be correct
12. Enter payment information—you will need to use either a debit card or credit card

Once this has all been completed, **please contact your prescriber** and inform them to send your prescriptions to MedOne Pharmacy Services. Thank you for choosing MedOne Mail-Order Service!

MedOne Member Portal

Easy Online Access to Your Prescription Profile

- Convenient
- Reliable
- Easy-to-Use

How to register for the MedOne Member Portal

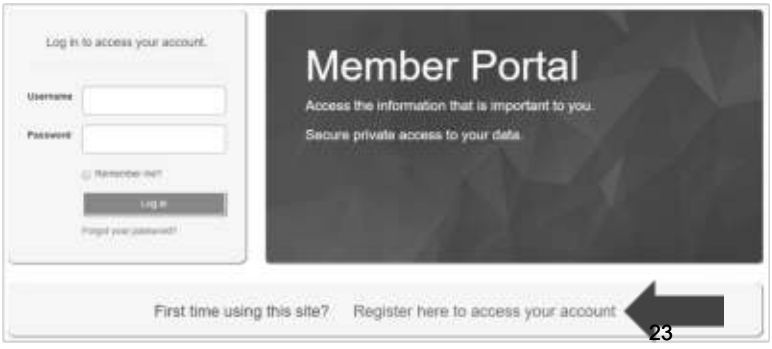
1. Go to medone-rx.com
2. On the right-hand side, click **Member Portal**
3. At the bottom of the page, click "Register here to access your account"
4. Enter the information requested (group number and member ID can be found on your pharmacy ID card) then click "Register"
5. You will then be prompted to open the confirmation email and follow the link provided
6. Enter your log-in credentials and proceed to your account

What can be accessed within the MedOne Member Portal?

1. View Claims Detail / Rx History
2. Look up **in-network pharmacies** in the area
3. Run **sample pricing** for potential medications
4. Gather ID card **processing information**
5. Review Out of Pocket Maximum
6. Access Drug Information Directory
7. Enroll in the **MedOne Mail-Order Program**

What can be accessed through the main MedOne Website?

1. Preferred Product Listing
2. Specialty Product Listing
3. MedOne Mail Order Enrollment
4. Frequently Asked Questions
5. Direct Member Reimbursement Form
6. MedOne Member Services and Pharmacy Contact Information



IMPORTANT DISCLOSURE NOTICE

Notice of Group Health Plan Special Enrollment Rights

If you are declining enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards other coverage for you or your dependents). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage, you may be able to enroll yourself and your dependent in this plan. You may also be able to enroll in this plan if you or your dependent become eligible for premium assistance under Medicaid or SCHIP for coverage under this plan. However, you must request enrollment within 60 days of any such event.

To request special enrollment or obtain more information, contact your employer at the telephone number or address listed for your employer in this enrollment application.

Notice of Group Health Plan Pre-existing Conditions Exclusion

Effective on the first day of this group health plan's plan year beginning in 2014, this plan does not impose any pre-existing condition exclusion.

Up until the first day of this group health plan's plan year beginning in 2014, this group health plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before enrolling in this plan, you might have to wait a certain period of time before this plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before the day coverage becomes effective. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. Effective for plan years beginning on and after October 1, 2010, the pre-existing condition exclusion will not apply to members under age 19.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this pre-existing condition exclusion period by the number of days of your prior "creditable coverage" so long as you have not had a break in coverage of at least 63 days. Most prior health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, U.S. Military, TRICARE, State Children's Health Insurance Program (SCHIP), Federal Employee Program, Peace Corps Service, a state high risk pool, or a public health plan established or maintained by a State, U.S. Government, foreign country or any political subdivision of a State, U.S. Government or foreign country. You may request a certificate of creditable coverage from a prior plan or issuer. There are also other ways that you can show you have creditable coverage.

To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should attach a copy of any certificates of creditable coverage or other documentation you have to this enrollment application. If you do not have a certificate of creditable coverage, but you do have prior health coverage, Blue Cross and Blue Shield of Alabama will help you obtain one from your prior plan or issuer, if necessary.

All questions about pre-existing condition exclusions and creditable coverage should be directed to your employer at the telephone number and address listed for your employer in this enrollment application.

Even if you have no pre-existing conditions, benefits may not be available under other provisions of the plan. For example, the services may be excluded or may require preapproval. Be sure to read your Benefit Booklet for details.

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Benefits for this will be subject to the same calendar year deductible and coinsurance provisions that apply to other medical and surgical benefits.

Benefit Election Agreement

☐ New Hire ☐ Open Enrollment ☐ Special Enrollment Event(Reason)_____

Name (Please Print)_____

Date of Hire_____ Last 4 SSN_____ DOB_____

BCBS MEDICAL INSURANCE

Check Plan Type:

- ◯ High Option PPO
- ◯ Value Plan PPO

Check Coverage Type:

- ◯ Employee Only
- ◯ Employee & Children
- ◯ Employee & Spouse
- ◯ Family

DECLINE Medical Coverage (Please check reason below.)

- ◯ Currently covered by spouse or family member's health plan
- ◯ Currently covered by Medicaid or Medicare
- ◯ Other, please explain _____

CERTIFICATION & SIGNATURE

I certify that I have read the benefits summaries, reviewed the rate information, and understand the benefits for which I am enrolling or declining. I want to enroll or decline benefits as I have indicated. If I enrolled in the benefit plans, I have completed, signed, and attached the enrollment forms.

I understand if I fail to return the election form and enrollment application by my effective date this will be treated as having declined coverage.

I understand that by declining some or all coverage I will not be eligible to enroll in the plan until next open enrollment, unless I have a special enrollment event.

I I understand this election will automatically rollover to the following election year if I do not complete new election forms.

Print: _____

Sign: _____

Date: _____

Recurring Insurance Premium Payment Authorization Form

Schedule your portion of the insurance premium payment to be automatically charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started.

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your credit card for your portion of insurance premiums only. You will be charged the amount indicated below each billing period for your portion of the insurance premium. The insurance premium charge will appear on your credit card statement. You agree that no prior-notification will be provided unless the date or your portion of the premium amount changes, in which case you will receive notice from us at least 10 days prior to the insurance premium payment being collected. If at any time your credit card is declined or fails to process payment, your benefits will be cancelled.

Please complete the information below:

I _____ authorize Personnel Resources to charge my credit card
(full name)

in the amount indicated below for my first employee insurance premium on

_____ for coverage period _____ .

Thereafter, I authorize Personnel Resources to charge my credit card for employee insurance premium on the first friday each month for insurance coverage in that month.

Monthly Premium Amount: $_____

Billing Address _____

City _____ ST Zip _____

Phone# _____ Email _____

Credit Card

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

(You must be an authorized user of the card.)

Credit Card Number _____

Exp. Date _____ CVV# _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Personnel Resources in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Revised 6/19/15

PLEASE PRINT USING UPPERCASE LETTERS: (USE BLACK BALL POINT PEN - PRESS FIRMLY)
* INDICATES REQUIRED FIELDS

Application For Enrollment

EMPLOYEE INFORMATION

○ DR. ○ MR. ○ MRS. ○ MS.

HEALTH GROUP NO.* 3 7 5 9 9
HEALTH DIV. NO.*
DENTAL GROUP NO.* X X X X X
DENTAL DIV. NO.*

LAST NAME*
FIRST NAME*
MAIDEN/MIDDLE NAME
SUFFIX (JUNIOR, SENIOR)
SOCIAL SECURITY NUMBER* - -
MAILING ADDRESS*
CITY
STATE
ZIP
PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL
( ) -
E-MAIL ADDRESS (Optional)
DATE OF BIRTH (MM/DD/YYYY)* / /
EMPLOYEE NUMBER
○ MALE ○ FEMALE

MARITAL STATUS (MARK ONE)
○ SINGLE ○ MARRIED
○ DIVORCED ○ WIDOWED

TYPE OF MEDICAL COVERAGE SELECTED*
○ EMPLOYEE ○ EMPLOYEE & CHILDREN
○ EMPLOYEE & SPOUSE ○ EMPLOYEE & ALL DEPENDENTS

~~TYPE OF DENTAL COVERAGE SELECTED*(Only applies if division number is different)~~
○ ~~EMPLOYEE~~ ○ ~~EMPLOYEE & CHILDREN~~
○ ~~EMPLOYEE & SPOUSE~~ ○ ~~EMPLOYEE & ALL DEPENDENTS~~

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.
By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

LAST NAME*
FIRST NAME*
MAIDEN/MIDDLE NAME
SUFFIX (JUNIOR, SENIOR)
SOCIAL SECURITY NUMBER* - -
TYPE OF COVERAGE APPLYING FOR: ○ **HEALTH** ○ **DENTAL**
DATE OF BIRTH (MM/DD/YYYY)* / /
RELATIONSHIP ○ SPOUSE ○ OTHER ____________________
GENDER ○ MALE ○ FEMALE

LAST NAME*
FIRST NAME*
MAIDEN/MIDDLE NAME
SUFFIX (JUNIOR, SENIOR)
SOCIAL SECURITY NUMBER* - -
TYPE OF COVERAGE APPLYING FOR: ○ **HEALTH** ○ **DENTAL**
DATE OF BIRTH (MM/DD/YYYY)* / /
RELATIONSHIP ○ CHILD ○ OTHER ____________________
GENDER ○ MALE ○ FEMALE

LAST NAME*
FIRST NAME*
MAIDEN/MIDDLE NAME
SUFFIX (JUNIOR, SENIOR)
SOCIAL SECURITY NUMBER* - -
TYPE OF COVERAGE APPLYING FOR: ○ **HEALTH** ○ **DENTAL**
DATE OF BIRTH (MM/DD/YYYY)* / /
RELATIONSHIP ○ CHILD ○ OTHER ____________________
GENDER ○ MALE ○ FEMALE

LAST NAME*
FIRST NAME*
MAIDEN/MIDDLE NAME
SUFFIX (JUNIOR, SENIOR)
SOCIAL SECURITY NUMBER* - -
TYPE OF COVERAGE APPLYING FOR: ○ **HEALTH** ○ **DENTAL**
DATE OF BIRTH (MM/DD/YYYY)* / /
RELATIONSHIP ○ CHILD ○ OTHER ____________________
GENDER ○ MALE ○ FEMALE

ENR-441 (Rev. 8-2013) BLUE CROSS AND BLUE SHIELD COPY EMPLOYER COPY EMPLOYEE COPY

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed. By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

LAST NAME*

FIRST NAME*

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER* ___ – ___ – ____

TYPE OF COVERAGE APPLYING FOR: ○ **HEALTH** ○ **DENTAL**

DATE OF BIRTH (MM/DD/YYYY)* __ / __ / ____

RELATIONSHIP ○ CHILD ○ OTHER _____

GENDER ○ MALE ○ FEMALE

If any dependent child above is over the applicable maximum age under your Group Plan and is incapacitated, please contact your Group Administrator to determine if coverage is available and/or obtain additional documents for completion.

STUDENT EXTENSION CERTIFICATION: If the Group Plan under which you are applying requires student certification, please list any dependent child applying for student extension.

NAME OF CHILD _____ **NAME OF SCHOOL** _____

NAME OF CHILD _____ **NAME OF SCHOOL** _____

NATURE OF APPLICATION

○ **NEW CONTRACT APPLICATION**

○ **CANCEL CONTRACT**
- ○ Medical Coverage
- ○ Dental Coverage
- ○ Medical and Dental Coverage

○ **CHANGE CONTRACT**
- ○ Name Change
- ○ Address Change
- ○ Type of Coverage Change

○ **ADD/REMOVE DEPENDENT**
- ○ Add Spouse
- ○ Add Dependent Child
- ○ Remove Spouse
- ○ Remove Dependent Child

○ **REMOVE DEPENDENT DUE TO**
- ○ Entered Military Service
- ○ Divorce
- ○ Death
- ○ Request

_____

QUALIFYING EVENT TYPE: ○ Marriage ○ Birth/Adoption

○ Loss of Coverage (Attach Certificate of Creditable Coverage)

__ / __ / ____

○ Other_____

COORDINATION OF BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by any other group health insurance, please provide the following information.

NAME OF CONTRACT HOLDER/DEPENDENT

POLICY, ID, CONTRACT OR CERTIFICATE NUMBER

NAME OF INSURANCE COMPANY

TYPE COVERAGE
○ INDIVIDUAL ○ FAMILY

EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY) __ / __ / ____

EMPLOYER'S NAME

GROUP NUMBER

~~TRANSFER COVERAGE~~

~~A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete.~~

~~CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER~~

MEDICARE BENEFITS INFORMATION

If you, your spouse, or your dependents are covered by Medicare, please provide the following information.

LAST NAME

FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

MEDICARE NUMBER

○ PART A (MM/DD/YYYY EFFECTIVE DATE) __ / __ / ____

○ PART B (MM/DD/YYYY EFFECTIVE DATE) __ / __ / ____

○ PART D (MM/DD/YYYY EFFECTIVE DATE) __ / __ / ____

TO BE COMPLETED BY EMPLOYEE

◯ **I waive my right to benefits and do not wish to enroll. Employer should maintain this record in employee's file.**

◯ I am requesting cancellation of my existing benefits as checked above.

◯ I apply for the Group Health Benefits 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 or other organization through which I am applying for coverage) 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 directly 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 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. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

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 services to me. I ask that my doctor, hospital or anyone else gives my or my family's medical records 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 acknowledge by my signature that I have read and understand the important information printed on the back of this application.

PLEASE PRINT USING UPPERCASE LETTERS

LAST NAME*

FIRST NAME*

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER* – –

SIGNATURE OF EMPLOYEE*

DATE SIGNED (MM/DD/YYYY) / /

FULL-TIME EMPLOYMENT (MM/DD/YYYY)* / /

TO BE COMPLETED BY EMPLOYER

PRINTED GROUP ADMINISTRATOR NAME

(334) 712 – 9939

EMPLOYER'S PHONE NUMBER

GROUP ADMINISTRATOR SIGNATURE*

DATE SIGNED (MM/DD/YYYY) / /

EMPLOYER'S EXTENSION

PRemployer	PO Box 8516 Dothan, AL 36304
EMPLOYER'S NAME	EMPLOYER'S ADDRESS