



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 1-855-350-7437 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$500 / individual or \$1,050 / 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.
Are there other deductibles for specific services?	Yes. \$450 per admission. \$600 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?	\$600 individual.	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 limits until the overall family out-of-pocket limits has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, copays , cost sharing for most out-of-network benefits, deductibles 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 Deductible does not apply	20% coinsurance	In Alabama, out-of-network coinsurance is 50%; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	\$50 copay /visit Deductible does not apply	20% coinsurance	
	Preventive care/screening/immunization	\$35 copay /visit Deductible does not apply	Not Covered	Age and visit limitations apply; facility charges may apply; you may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge Deductible does not apply	20% coinsurance	Benefits listed are physician services ; in Alabama, out-of-network coinsurance is 50%; facility benefits are also available; precertification may be required; if no precertification is obtained, no benefits are available
	Imaging (CT/PET scans, MRIs)	No Charge Deductible does not apply	20% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at AlabamaBlue.com/pharmacy	Tier 1 Drugs	No Charge Deductible does not apply	Not Covered	Precertification is required for some drugs; if no precertification is obtained, no benefits are available; select generic specialty and biosimilar drugs on the Select Generic Specialty and Biosimilar Drug List will have lower member cost share
	Tier 2 Drugs	20% coinsurance (retail)	Not Covered	
	Tier 3 Drugs	20% coinsurance (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 copay Deductible does not apply	20% coinsurance	In Alabama, out-of-network not covered; precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	0% coinsurance	20% coinsurance	In Alabama, out-of-network coinsurance is 50%

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	<u>Emergency room care</u>	Accident: No Charge <u>Deductible</u> does not apply Medical Emergency: \$300 <u>copay</u> /visit <u>Deductible</u> does not apply	Accident: No Charge <u>Deductible</u> does not apply Medical Emergency: \$300 <u>copay</u> /visit <u>Deductible</u> does not apply	Physician charges will apply
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$35 <u>copay</u> /visit <u>Deductible</u> does not apply	20% <u>coinsurance</u>	In Alabama, <u>out-of-network coinsurance</u> is 50%
If you have a hospital stay	Facility fee (e.g., hospital room)	\$450 per admission <u>deductible</u> & \$75 <u>copay</u> /day days 2-6	\$600 per admission <u>deductible</u> & 20% <u>coinsurance</u>	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	0% <u>coinsurance</u>	20% <u>coinsurance</u>	In Alabama, <u>out-of-network coinsurance</u> is 50%
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge EPS No Charge <u>Deductible</u> does not apply	20% <u>coinsurance</u>	In Alabama, <u>out-of-network coinsurance</u> is 50% for professional services; precertification is required for intensive outpatient, partial <u>hospitalization</u> and <u>inpatient hospitalization</u> ; if no precertification is obtained, no benefits are available
	Inpatient services	Physician: No Charge EPS 0% <u>coinsurance</u> <u>Deductible</u> does not apply Inpatient Hospital: \$450 per admission <u>deductible</u> & \$75 <u>copay</u> /day days 2-6	Physician: 20% <u>coinsurance</u> <u>Deductible</u> does not apply Inpatient Hospital: \$600 per admission <u>deductible</u> & 20% <u>coinsurance</u>	
If you are pregnant	Office visits	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound); in Alabama, <u>out-of-network coinsurance</u> is 50% for professional services; precertification may be required; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$450 per admission <u>deductible</u> & \$75 <u>copay</u> /day days 2-6	\$600 per admission <u>deductible</u> & 20% <u>coinsurance</u>	

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	<u>Home health care</u>	No Charge <u>Deductible</u> does not apply	20% <u>coinsurance</u>	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required; if no precertification is obtained, no benefits are available
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Benefits listed are for <u>Rehabilitation & Habilitation services</u> ; each service has a combined maximum of 30 visits for occupational, physical and speech therapy per year; in Alabama, <u>out-of-network coinsurance</u> is 50%; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	Not Covered	Not Covered	Not covered; member pays 100%
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	In Alabama, <u>out-of-network coinsurance</u> is 50%; precertification may be required; if no precertification is obtained, no benefits are available
	<u>Hospice services</u>	No Charge <u>Deductible</u> does not apply	20% <u>coinsurance</u>	In Alabama, out-of-network not covered; precertification may be required; if no precertification is obtained, no benefits are available
If your child needs dental or eye care	Children's eye exam	No Charge <u>Deductible</u> does not apply	No Charge <u>Deductible</u> does not apply	Benefits listed are mandated <u>preventive services</u> ; please visit AlabamaBlue.com/preventiveservices ; additional benefits are available; limitations apply
	Children's glasses	No Charge <u>Deductible</u> does not apply	No Charge <u>Deductible</u> does not apply	Benefits listed are mandated <u>preventive services</u> ; please visit AlabamaBlue.com/preventiveservices ; additional benefits are available; limitations apply
	Children's dental check-up	Not Covered	Not Covered	Not covered; member pays 100%

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	• Hearing aids	• Skilled nursing care
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	
• Dental check-up, child	• Routine foot care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

• Bariatric surgery	• Infertility treatment (Assisted Reproductive Technology not covered)	• Routine eye care (Adult) (Limitations apply)
• Chiropractic care (limited to 18 visits per member per calendar year)	• 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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or Blue Cross and Blue Shield of Alabama at 1-800-292-8868. 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 on how 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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or Alabama Department of Insurance at 1-334-269-3550 or InDept@insurance.alabama.gov.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 copayment	\$50
Hospital (facility) copayment	\$75
Other copayment/coinsurance	\$35/20%

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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles*	\$500
Copayments	\$500
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$1,060

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 copayment	\$50
Hospital (facility) copayment	\$75
Other copayment/coinsurance	\$35/20%

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	\$5,600
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	\$500
Specialist copayment	\$50
Hospital (facility) copayment	\$75
Other copayment/coinsurance	\$35/20%

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	\$2,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles*	\$500
Copayments	\$500
Coinsurance	\$0

Cost Sharing

Deductibles*	\$500
Copayments	\$200
Coinsurance	\$80

What isn't covered

Limits or exclusions	\$40
The total Joe would pay is	\$820

In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles*	\$500
Copayments	\$100
Coinsurance	\$200

Cost Sharing

Deductibles*	\$500
Copayments	\$100
Coinsurance	\$200

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$800

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.

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

Discrimination is Against the Law

Language Assistance Services, Auxiliary Aids Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.

Arabic: انتبه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意：如果您说普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-855-216-3144 (TTY 用户请拨 711) 或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાનએથાપોજોએતમેંગુજરાતીએબોલોએછો, તોએતમારાએમાટેએનિઃશુલ્કએભાષાએસહાયએસેવાઓએઉપલબ્ધએછેએસુલભએફોર્મેટમાંએમાહિતીએપ્રદાનએકરવાએમાટેનીએયોગ્યએસહાયએઘનેએસેવાઓએપણાએવિનાએમૂલ્યેએઉપલબ્ધએછે ૧-૮૫૫-૨૧૬-૩૧૪૪ (TTY: 711) પરએખથવાએગ્રાહકએસેવાએપરએકોલએકરોએ

Hindi: ધ્યાન દેં: અગર આપ હિન્દી બોલતે હોય, તો આપકે લિએ નિઃશુલ્ક ભાષા સહાયતા સેવાએં ઉપલબ્ધ હોયાં. આસાન પ્રારૂપ મેં સૂચના ઉપલબ્ધ કરાને કે લિએ ઉપયુક્ત સહાયક સાધન ઔર સેવાએં ભી નિઃશુલ્ક ઉપલબ્ધ હોયાં। 1-855-216-3144 (TTY: 711) પર કોલ કરો યા ગ્રાહક સેવા કો કોલ કરો।

Japanese: ご案内: 日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144 (TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເວົ້າໄລໃນໆ: ຖ້າຈະໆເວົ້າ, ການບໍລິການຈ່າຍເຫຼືອດ້ານພາຫຼາຍືແມ່ນມີໃຫ້ທ່ານ. ການຈ່າຍເຫຼືອ ດະວີການບໍລິການທີ່ເໝັ້ນມີໃນການຈະໜ້າທົ່ງໝູນໃນກູບແບບທີ່ສ້າມາດເຄີຍໄດ້ແມ່ນຫຼັງສ້າມາດໃໝ່ໄດ້ແລ້ວບໍ່ແຍ້ງ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທທີ່ກ່າງໆລົບບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardım hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

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