



 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?	\$1,000 individual/\$2,000 family in-network. \$2,000 individual/\$4,000 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?	Yes. \$1,200 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?	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	\$40 copay /visit No overall deductible	50% coinsurance	None
	Specialist visit	\$60 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 needed 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; \$10 copay/x-ray for in-network services; facility benefits are also available; precertification may be required
	Imaging (CT/PET scans, MRIs)	\$250 copay /test No overall deductible	50% 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	\$15 copay (retail) \$38 copay (mail order) No overall deductible	Not Covered	Prior authorization required for specific drugs; Covered insulin products may have lower patient responsibility
	Tier 2 Drugs	\$50 copay (retail) \$125 copay (mail order) No overall deductible	Not Covered	
	Tier 3 Drugs	\$100 copay (retail) \$250 copay (mail order) No overall deductible	Not Covered	
	Tier 4 Drugs	\$395 copay (retail) No overall deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copay No overall deductible	50% 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: \$250 copay /visit No overall deductible Medical Emergency: \$250 copay /visit No overall deductible	Accident: \$250 copay /visit No overall deductible Medical Emergency: \$250 copay /visit No overall deductible	Physician charges will apply
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$40 copay /visit No overall deductible	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay/day days 1-5 No overall deductible	\$1,200 per admission deductible & 50% 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	\$60 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 No overall deductible	50% coinsurance No overall deductible	
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Cost sharing does not apply for 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	\$250 copay/day days 1-5 No overall deductible	\$1,200 per admission deductible & 50% 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	50% coinsurance	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification may be required
	Rehabilitation services	20% coinsurance	50% 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; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational, physical and speech therapy
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	Not Covered	Not Covered	Not covered; member pays 100%
	Durable medical equipment	20% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	50% 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 .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Glasses, child • Hearing aids • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • 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 (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

[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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)																																											
■ The plan's overall deductible	\$1000	■ The plan's overall deductible	\$1000	■ The plan's overall deductible	\$1000																																										
■ Specialist copay/coinsurance	\$60/0%	■ Specialist copay/coinsurance	\$60/0%	■ Specialist copay/coinsurance	\$60/0%																																										
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■ Other copay/coinsurance	\$250/20%	■ Other copay/coinsurance	\$250/20%	■ Other copay/coinsurance	\$250/20%																																										
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>																																											
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800																																										
<p>In this example, Peg would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles*</td> <td>\$1000</td> </tr> <tr> <td>Copayments</td> <td>\$510</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$60</td> </tr> <tr> <td>The total Peg would pay is</td> <td>\$1,570</td> </tr> </tbody> </table>		Cost Sharing		Deductibles*	\$1000	Copayments	\$510	Coinsurance	\$0	What isn't covered		Limits or exclusions	\$60	The total Peg would pay is	\$1,570	<p>In this example, Joe would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles*</td> <td>\$170</td> </tr> <tr> <td>Copayments</td> <td>\$880</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$40</td> </tr> <tr> <td>The total Joe would pay is</td> <td>\$1,090</td> </tr> </tbody> </table>		Cost Sharing		Deductibles*	\$170	Copayments	\$880	Coinsurance	\$0	What isn't covered		Limits or exclusions	\$40	The total Joe would pay is	\$1,090	<p>In this example, Mia would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles*</td> <td>\$1000</td> </tr> <tr> <td>Copayments</td> <td>\$380</td> </tr> <tr> <td>Coinsurance</td> <td>\$120</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$0</td> </tr> <tr> <td>The total Mia would pay is</td> <td>\$1,500</td> </tr> </tbody> </table>		Cost Sharing		Deductibles*	\$1000	Copayments	\$380	Coinsurance	\$120	What isn't covered		Limits or exclusions	\$0	The total Mia would pay is	\$1,500
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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.

