



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 1-800-783-2197 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 ?	\$600 individual/\$1,200 family coverage in-network. \$1,200 individual coverage 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 \$5,200 individual coverage/\$12,700 family coverage in-network. \$13,275 individual/capital coverage out-of-network.	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, pre-certification penalties and specialty drug coupon program payments.	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	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/immunization	No Charge No overall deductible	Not Covered	Please visit AlabamaBlue.com/preventiveservices ; additional services are available. 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)	20% coinsurance	40% coinsurance	Benefits listed are physician services; facility benefits are also available; precertification may be required
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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	\$10 copay or 10% coinsurance (maximum of \$40) (retail) \$25 copay or 10% coinsurance (maximum of \$100) (mail) No overall deductible	Not Covered	Prior authorization required for specific drugs; generic, preferred brand, non-preferred brand and specialty drugs may be either Tier 1, Tier 2 or Tier 3 drugs; Preventive drugs are covered 100% of the allowed amount, no copay or deductible each 30-day prescription. Value Based Drugs are covered 100%, no copay or deductible. View the drugs at AlabamaBlue.com/SourceRxVBDDrugList ; additional benefits are available. Drugs on the Specialty Drug Coupon Program List are subject to the greater of the applicable Tier copay or the full amount of the available manufacturer cost share assistance program payments.
	Tier 2 Drugs	\$30 copay or 25% coinsurance (maximum of \$100) (retail) \$75 copay or 25% coinsurance (maximum of \$250) (mail) No overall deductible	Not Covered	
	Tier 3 Drugs	\$60 copay or 35% coinsurance (maximum of \$400) (retail) \$150 copay or 35% coinsurance maximum of \$1,000) (mail) No overall deductible	Not Covered	
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% 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 have outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	Accident: \$200 copay/visit & 20% coinsurance Medical Emergency: \$200 copay/visit & 20% coinsurance	Accident: \$200 copay/visit & 20% coinsurance Medical Emergency: \$200 copay/visit & 20% coinsurance	Physician charges will apply; subject to in-network overall deductible
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to in-network overall deductible
	Urgent care	\$35 copay/visit No overall deductible	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required or a \$500 penalty will apply
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Benefits listed are physician services; additional benefits are available; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

* 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	20% coinsurance	40% coinsurance	Precertification is required; benefits are also available for home infusion services
	Rehabilitation services	20% coinsurance	40% coinsurance	Unlimited visits/year; includes occupational, physical and speech therapy; no age or visit limitations for members with an autistic diagnosis
	Habilitation services	20% coinsurance	40% coinsurance	Precertification is required
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification is required; services must be authorized by a physician
	Hospice services	20% coinsurance	40% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not covered except as required by Health Care Reform	Not Covered	Please visit AlabamaBlue.com/preventiveservices
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	Not covered except as required by Health Care Reform	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"> • Cosmetic surgery • Dental care (Adult) • Glasses, child 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (only for morbid obesity in limited circumstances) 	<ul style="list-style-type: none"> • Chiropractic care • Infertility treatment (Assisted Reproductive Technology not covered) 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S.

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

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.

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	\$600	■ The plan's overall deductible	\$600	■ The plan's overall deductible	\$600
■ Specialist copay/coinsurance	\$0/20%	■ Specialist copay/coinsurance	\$0/20%	■ Specialist copay/coinsurance	\$0/20%
■ Hospital (facility) copay/coinsurance	\$0/20%	■ Hospital (facility) copay/coinsurance	\$0/20%	■ Hospital (facility) copay/coinsurance	\$0/20%
■ Other copay/coinsurance	\$200/20%	■ Other copay/coinsurance	\$200/20%	■ Other copay/coinsurance	\$200/20%
<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
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$600	Deductibles	\$580	Deductibles	\$600
Copayments	\$10	Copayments	\$580	Copayments	\$210
Coinsurance	\$2,390	Coinsurance	\$0	Coinsurance	\$370
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$40	Limits or exclusions	\$0
The total Peg would pay is	\$3,060	The total Joe would pay is	\$1,200	The total Mia would pay is	\$1,180

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.