BlueCross BlueShield of Alabama

State of Alabama (13000)

Coverage 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 1-800-824-0435 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 1-800-824-0435 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 per person per calendar year Maximum of three deductibles per 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 up to a maximum of three deductibles per family.
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. $250 per inpatient facility deductible; $250 outpatient facility deductible. There are 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?	$9,450 individual/$18,900 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, pre-certification penalties and specialty drug manufacturer assistance amounts for provider-administered drugs.	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 Annual deductible applies	Subject to $35 in-network copay for nurse practitioner, nurse midwife, or physician's assistant; includes office surgery and consultations; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	$35 copay/visit Deductible does not apply	20% coinsurance Annual deductible applies	
	Preventive care/screening/ immunization	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	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)	$7.50 copay per lab test Deductible does not apply	20% coinsurance Annual deductible applies	Benefits listed are physician services; subject to overall deductible for out-of-network; facility benefits are also available; lab/pathology copay may apply; precertification may be required for coverage; if no precertification is obtained, no benefits are available †Limited to 2 copays per date of service for each of the following: Angiography/arteriography, cardiac cath/arteriography, colonoscopy, UGI endoscopy, CAT Scan, MRI, MUGA-Gated Cardia Scan, ERCP, PET/PECT and Thallium Scan
	Imaging (CT/PET scans, MRIs)	$75 copay per test† Deductible does not apply	20% coinsurance Annual 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 need drugs to treat your illness or condition **Administered by OptumRx** More information about **prescription drug coverage** is available at www.optumrx.com Note: Copays are based on a 30 day supply	Tier 1 Drugs	$10 copay (retail) † Deductible does not apply	Not Covered	Prior authorization required for specific drugs; When you get a prescription for a brand name drug that has a Tier 1 generic equivalent, you must first try the generic equivalent drug for your prescription to be covered by your prescription drug program. If you choose to get the brand name drug without trying the generic equivalent first, there will be no coverage for the brand name drug. • Tier 1 drugs - $10 copay per prescription limited to 30 or 60 day supply; †subject to $20 copay per prescription for 90-day supply; • Tier 2 drugs - limited to a 30, 60 or 90-day supply; • Tier 3 - limited to 30 day supply; • Tier 4 - limited to a 30 day supply; • Tier 5 - limited to a 30 day supply; ††Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs
	Tier 2 Drugs	20% coinsurance (retail) with a minimum copay of $45 and a maximum copay of $85 per prescription Deductible does not apply	Not Covered	
	Tier 3 Drugs	50% coinsurance (retail) with a minimum copay of $65 and a maximum copay of $125 per prescription Deductible does not apply	Not Covered	
	Tier 4 Drugs	50% coinsurance (retail) with a maximum copay of $150 per prescription Deductible does not apply	Not Covered	
	Tier 5 Drugs (preferred specialty)	$150 copay (retail) per prescription†† Deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay Deductible does not apply	20% coinsurance Annual deductible applies	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	Copay applies for surgery rendered at an in-network physician's office
If you need immediate medical attention	Emergency room care	Accident: No Charge Deductible does not apply Medical Emergency: $250 copay/visit Deductible does not apply	Accident: No Charge Deductible does not apply Medical Emergency: $250 copay/visit Deductible does not apply	Physician charges will apply

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	Emergency medical transportation	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	Ground Ambulance: If the provider is out of network, the member is responsible for the 20% coinsurance and any amount billed over the fee schedule
	Urgent care	$75 copay/visit Deductible does not apply	20% coinsurance Annual deductible applies	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 per admission deductible & $25 copay/day days 2-5 Deductible does not apply	$250 per admission deductible & 20% coinsurance Deductible does not apply	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	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit Deductible does not apply	20% coinsurance Annual deductible applies	Precertification is required for intensive outpatient and partial hospitalization; if no precertification is obtained, no benefits are available; benefits are available for Applied Behavioral Analysis (ABA) therapy (precertification required); residential treatment facility benefits are available limited to eating disorder treatment (precertification required)
	Inpatient services	Inpatient Facility: $250 per admission deductible & $25 copay/day days 2-5 Deductible does not apply Physician services: No Charge Deductible does not apply	Inpatient Facility: $250 per admission deductible & 20% coinsurance Deductible does not apply Physician services: 20% coinsurance Deductible does not apply	
If you are pregnant	Office visits	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	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); facility deductible and daily copay waived if the female employee or female spouse of an employee enrolls in the Baby Yourself Program within the first two trimesters
	Childbirth/delivery professional services	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	
	Childbirth/delivery facility services	$250 per admission deductible & $25 copay/day days 2-5 Deductible does not apply	$250 per admission deductible & 20% coinsurance Deductible does not apply	

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 Annual deductible applies	Not Covered	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification is required; if no precertification is obtained, no benefits are available
	Rehabilitation and Habilitation physical, speech, and occupational therapy	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	Each service is limited to 15 visits per therapy per member per calendar year; Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied; for out-of-network, member is responsible for the 20% coinsurance and any amount billed over the fee schedule
	Skilled nursing care	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	Precertification is required; if no precertification is obtained, no benefits are available; benefits only available if approved through case management
	Durable medical equipment	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	If the provider is out of network, the member is responsible for the 20% coinsurance and any amount billed over the fee schedule; precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	20% coinsurance Annual deductible applies	Not Covered	Precertification is required; if no precertification is obtained, no benefits are available; benefits only available if approved through case management

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)	
	Applied Behavioral Analysis (ABA) Therapy	$35 copay/visit Deductible does not apply	20% coinsurance Annual deductible applies	*Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied; benefits listed are for children 18 years or younger
If your child needs dental or eye care	Children's eye exam	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	Please visit AlabamaBlue.com/PreventiveServices
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge Deductible does not apply	20% coinsurance Annual deductible applies	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	• Glasses, child	• Routine eye care (Adult)
• Cosmetic surgery	• Hearing aids	• Routine foot care
• Dental care (Adult)	• Long-term care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (only morbid obesity in limited circumstances)	• Infertility treatment (Assisted Reproductive Technology not covered)	• Private-duty nursing precertification is required for coverage
• Chiropractic care (precertification is required after the 18th visit)	• Non-emergency care when traveling outside the U.S.	• Maternity Management (Baby Yourself Program)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or your plan administrator at the phone number listed in your benefit booklet. 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: Blue Cross and Blue Shield of Alabama at 1-800-824-0435

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.

* 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	$300
Specialist copayment	$35
Hospital (facility) copay	$25
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$460

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

The plan's overall deductible	$300
Specialist copayment	$35
Hospital (facility) copay	$25
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$840

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

The plan's overall deductible	$300
Specialist copayment	$35
Hospital (facility) copayment	$25
Other copay/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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$700

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 Access 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. 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 કોલ 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。